Hospital Room and Board Benefits

An analysis of changes in employer-sponsored health plans between 1979 and 1995 discloses that employers sought to contain rising hospital room and board expenditures through changes in plan designs. These changes necessitated revisions in the presentation of the EBS hospital room and board data.

BY JAMES H. MOORE, JR.

The expense for hospital room and board is one of the most commonly covered provisions in medical insurance plans. During the 1980s and the first half of this decade, the costs for hospital room and board rose dramatically, along with other health care costs. As measured by the Consumer Price Index for All Urban Consumers from 1979 to 1995, all medical care items increased by an annual average of 7.7 percent, and hospital room costs increased by an annual average of 9.9 percent.[1] All expenditures for national health care during this period increased from $215 billion to $988 billion, 10 percent annually, on average.[2] From 1979 to 1995, total personal health care expenditures increased from $187 billion to $879 billion, also an annual average increase of 10 percent; at the same time, hospital expenditures, the single largest component of personal health care expenditures, increased from $88 billion to $350 billion, an annual average increase of 9 percent.

Over the years, the Employee Benefits Survey (EBS) has captured and published data on prevailing hospital room and board benefits offered in employer-sponsored health benefit plans.[3] Hospital room and board benefits cover expenses for occupancy of the room and bed, general nursing and nurse's aid services, food and beverages, and personal hygiene items. Hospital room and board benefits relate to costs of occupancy and not the professional services of physicians, intensive-nursing care, or many of the other costs associated with inpatient care.

Since 1979, the health care delivery system in the United States and the employer-sponsored health benefit plans that support it have evolved in an effort to provide more comprehensive medical services at manageable prices. One change has been in how hospital room and board benefits are provided to plan participants. As a reaction to these changes, the EBS has changed how it captures, organizes, and presents data on hospital room and board benefits collected from employer-sponsored health plans.

This article shows how the EBS data presentation has changed, and identifies significant trends in hospital room and board benefits over the 1989-95 period. It uses a historical summary of the EBS data on hospital room and board benefits for private sector establishments employing 100 or more workers. Throughout, this article uses the percent of health plan participants to measure the prevailing plan designs and hospital room and board provisions.

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The early years, 1979-86

The health insurance scene was considerably different in 1979, the first year the EBS was conducted, than it is today. In 1979, virtually all employer-sponsored health care was provided by fee-for-service or indemnity plans.[4] Coverage was provided primarily through commercial insurance carriers or Blue Cross/Blue Shield plans; only 11 percent of plan participants were in self-insured plans. Health maintenance organizations covered less than 5 percent of plan participants.

From 1979 to 1986, the EBS presented several major characteristics of hospital room and board benefits that reflected the prevailing design of this benefit. First, most fee-for-service plans covered benefits under major medical provisions[5] as basic benefits,[6] or as basic benefits in combination with major medical coverage. Second, the survey described the limits on days of coverage per hospital confinement,[7] and other limits.[8] Lastly, the survey detailed how the amount of actual hospital room and board benefits were paid: As a daily dollar allowance or the usual and customary semiprivate room rate for the area.

Basic benefits are sometimes referred to as "first dollar coverage," because initial expenses are paid by the plan rather than by the patient. This is in contrast to major medical coverage, which calls for cost sharing through the imposition of deductibles or coinsurance arrangements or both.

Between 1979 and 1986, the proportion of participants with some form of basic hospital room and board benefits declined. (See table 1.) In 1979, basic hospital room and board benefits were available to 93 percent of medical plan participants. Of these, about four-fifths had extended coverage—beyond the period covered by basic benefits—subject to major medical cost-sharing arrangements. The remaining 7 percent were subject to major medical cost-sharing arrangements from the outset. By 1986, basic hospital room and board benefits were available to 64 percent of medical plan participants. Of these, three-fifths had extended coverage subject to major medical cost-sharing arrangements. The proportion of participants with hospital room and board benefits subject to major medical cost sharing from the outset increased fivefold over the period, to 35 percent.

Table 1. Percent of participants in employer-sponsored health plans by extent of coverage for hospital room and board benefits payments, 1979-86

(In percent)

Year	All participants[1]	Participants covered by		
		Basic benefits only[2]	Major medical only[3]	Both basic and major medical
1979	100	17	7	76
1980	100	16	12	72
1981	100	18	13	69
1982	100	18	12	70
1983	100	16	19	65
1984	100	17	28	54
1985	100	20	33	47
1986	100	24	35	40

[1] Excludes participants without a hospital room and board benefit.

[2] A provision was classified as a basic benefit when it related to the initial expenses incurred for a specific medical service. Under these provisions, a plan covered expenses in one of several ways: (1) In full with no limitations; (2) in full for a specified period of time, or until a dollar limit was reached; or (3) a cash scheduled allowance benefit that provided up to a dollar amount for a service performed by a hospital or physician.

[3] Major medical benefits cover many categories of expenses, some of which are not covered under basic benefits and others for which basic coverage have been exceeded. These benefits are characterized by deductible and coinsurance provisions.

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals.

The proportion of participants with limits on their basic hospital room and board benefits also declined between 1979 and 1986, from 95 percent to 75 percent. (See table 2.) Over the entire period, between 58 and 72 percent of participants had a limit on the number of days of basic benefits. These limits were mainly split between 120 days or fewer and 365 or more days per confinement. Other types of limits included those with a maximum dollar amount per confinement.

In 1979, 9 out of 10 medical plan participants had hospital room and board benefits equated with the cost of a semiprivate room; the remainder had benefits set to a daily dollar allowance. By 1986, the daily allowance form of room and board benefits had all but disappeared in favor of the semiprivate room benefit.

The middle period, 1988-91

During the late 1980s, many health care plans adopted "cost containment" provisions to stem the tide of rising health plan costs.[9] With the erosion of first dollar ("basic") coverage for hospital room and board, health plan designers developed a variety of ways to limit hospital benefits. To keep pace with these changes, the EBS revised the way it captured and presented benefits data.

From 1988 to 1991, EBS presented hospital room and board benefits by whether services were covered in full, were subject only to internal limits, were subject to overall plan limits only, or were subject to both internal and overall plan limits. Internal limits were defined as those applying to individual categories of care, for example, separate limits on benefits for hospital room and board. These limits were expressed in terms of dollar ceilings on benefits, restrictions on the number of days of coverage, requirements that the participant pay a per-

Table 2. Percent of particpants in employer-sponsored health plans by type and limit of basic hospital room and board benefit payments, 1979-86

(In percent)

Year and type of payment	All participants[1]	Subject to a limit on the days of coverage per hospital confinement				Subject to other limits[2]	Unlimited
		All	120 or fewer days	121 - 364 days	365 or more days		
1979							
All payment types	100	72	33	4	35	23	5
Daily dollar allowance ...	10	7	5	1	1	3	–
Semiprivate rate	90	65	28	3	34	20	5
1980							
All payment types	100	72	34	3	34	21	7
Daily dollar allowance ...	9	8	6	([3])	1	1	–
Semiprivate rate	91	64	28	3	33	20	7
1981							
All payment types	100	72	31	3	36	19	9
Daily dollar allowance ...	8	8	7	([3])	1	([3])	–
Semiprivate rate	92	64	26	3	35	19	9
1982							
All payment types	100	71	32	4	35	19	10
Daily dollar allowance ...	8	7	5	([3])	1	([3])	–
Semiprivate rate	92	64	26	3	34	18	10
1983							
All payment types	100	71	30	4	36	20	10
Daily dollar allowance ...	6	6	5	([3])	([3])	([3])	–
Semiprivate rate	94	65	25	4	36	19	10
1984							
All payment types	100	70	30	4	35	18	12
Daily dollar allowance ...	6	5	4	([3])	1	1	–
Semiprivate rate	94	65	26	4	35	17	12
1985							
All payment types	100	66	27	4	35	19	15
Daily dollar allowance ...	5	4	2	([3])	1	1	–
Semiprivate rate	95	62	23	4	34	18	15
1986							
All payment types	100	58	23	4	30	17	25
Daily dollar allowance ...	4	4	2	([3])	1	1	–
Semiprivate rate	96	54	21	4	29	16	25

[1] Excludes participants without a hospital room and board benefit.

[2] Includes workers in plans that limit basic benefits to maximum dollar amount per confinement or per year, and in other plans that also limit the number of days of coverage to within a specified time period.

[3] Less than 0.5 percent.

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals. Dash indicates no employees in this category.

centage of costs (coinsurance), requirements that the participant pay a specific amount (deductible or copayment) before reimbursement begins or services are rendered, or similar provisions. Overall limits (also called major medical limits) were expressed only in terms of total benefits payable under the plan, rather than for individual categories of care. Limits were set as deductibles, coinsurance percentages, and overall dollar limits on plan benefits.

During these years, the EBS also presented data on how hospital room and board benefits were paid. The presentation essentially categorized these data by whether benefits were geared to semiprivate rates or a daily dollar allowance, and further classified semiprivate rate provisions by whether the full semiprivate rate or selected percentages of it were paid. For example, 31 percent of participants in 1988

Table 3. Percent of participants in employer-sponsored health plans by extent of coverage for hospital room and board benefits payments, 1988, 1989, and 1991

(In percent)

Year	All participants[1]	Covered in full	Coverage is subject to		
			Specific limits only[2]	Overall plan limits only[3]	Both specific and overall plan limits
1988	100	23	2	38	37
1989	100	22	3	45	31
1991	100	17	4	46	34

[1] Excludes participants without a hospital room and board benefit.

[2] Subject to specific limits for hospital care only. For example, these limits can include a limit on days per confinement, a dollar ceiling, or a copayment requirement.

[3] Overall plan limits can include dollar deductibles for all medical care, which must be met before a benefit is paid; coinsurance requirements; and limits on overall plan benefits for the participant's lifetime.

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals.

were in plans that paid the full semiprivate rate; 24 percent were in plans that paid the full semiprivate rate for a limited period, and then a percentage of the semiprivate rate (almost always 80 percent); and 42 percent were in plans that paid a percentage of the semiprivate rate (80 percent in about 3 out of 4 cases). Daily dollar allowances were rare. Each of these provisions was, in turn, categorized by the presence or absence of day or dollar limits.

EBS data showed how limits on hospital room and board benefits continued to change from 1988 to 1991. (See table 3.) In 4 years, the proportion of plan participants whose hospital room and board benefit was subject only to overall plan limits (major medical) increased from 38 to 46 percent; the proportion whose benefit was paid in full was 23 percent in 1988 and 17 percent in 1991; and the proportion whose benefit was subject to both internal and overall plan limits was 37 percent in 1988, compared with 34 percent in 1991.

Cross-currents in hospital room and board benefits, 1979-91

By 1991, the EBS data indicated that 17 percent of plan participants had basic hospital room and board benefits equivalent to the semiprivate room rate without limits. In 1979, it was 5 percent. This appears to run counter to the cost containment efforts that characterized health plan design in the late 1980s. This change reflects a different phenomenon—the market penetration of prepaid plans like health maintenance organizations (HMO) and the advent of preferred provider organizations (PPO) among medical plan participants. (See box, "Glossary of Health Care Terms.") During the late 1980s, these alternatives to traditional fee-for-service plans captured a large share of the health care market, rising to 27 percent of plan participants in 1989 from 7 percent in 1985.[10] (See table 4.)

However, factoring out increases in participation in prepaid plans like HMO's and PPO plans without limits for use of preferred hospitals, there was little verifiable increase in the percent of participants in all other plans with unlimited basic hospital room and board benefits. HMO participants accounted for 2 percent of all health plan participants in 1979 and 17 percent by 1991. (See table 4.) These HMO hospital room and board benefits would probably have been without limits for almost all their participants in 1979, and without limits for roughly 7 out of 8 participants in 1991. PPO's, unknown in 1979, covered 16 percent of all health participants by 1991. Later EBS data suggest some PPO participants also had basic hospital room and board benefits without limits in 1991, if they used a preferred hospital provider.

Between 1979 and 1991, the proportion of participants subject only to major medical (overall) limits on their hospital room and board benefits increased from 7 to 46 percent (from 7 to 55 percent if HMO participants are excluded). This represents the loss of a basic hospital room and board benefit paid on the first day of confinement, even if that basic benefit was limited in amount or number of days. Instead, basic hospital room and board benefits and major medical benefits coalesced. Plans imposed cost-sharing arrangements associated with major medical coverage at the beginning of each hospital confinement instead of after a basic benefit limit had been reached. So, while in 1979, 93 percent of all medical plan participants had a basic hospital room and board benefit paid for the first day of confinement, only 55 percent did in 1991. (See chart.)

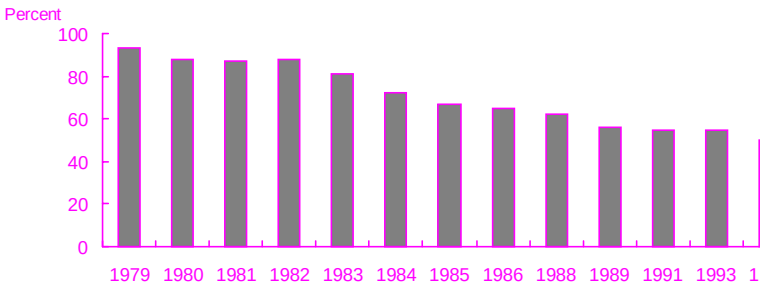
Neither the growth of participation in HMO and PPO plans, nor the loss of first day basic hospital room and board benefits were easily discerned in the presentation of EBS data on hospital room and board benefits through 1991. Yet, as shown, both had a dramatic effect on these statistics.

Current EBS data on hospital room and board benefits

Beginning in 1993, the presentation of the EBS hospital room and board benefits data was revised again by categorizing plans into non-HMO (i.e., fee-for-service) and HMO plans. This change allowed the EBS to explore differences in coverage between these two major approaches to delivery of health care services. The EBS can now provide more detailed data on hospital room and board coverage relevant to plan type.

Detailed data for hospital room and board benefits are presented separately for the two classifications of plans. For non-HMO plans, detail follows the scheme of prior years: The percent of

Chart. Percent of participants in medical plans with "first dollar" hospital benefits, selected years, 1979-95



NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Basic benefits are sometimes called "first dollar" coverage because initial expenses are paid by the plan rather than by the patient.

participants whose hospital room and board benefits were covered in full; were subject only to separate limits on hospital room and board benefits; were subject to these limits and major medical coverage limits; and were subject only to major medical coverage limits. Additional data present the prevailing major medical coinsurance rates for medical benefits, including hospital room and board. Other data present the limits imposed on just hospital room and board benefits such as separate deductibles, separate coinsurance rates, limits on days of confinement, and limits on dollars. Further data on PPO plans include the percent of plan participants with an incentive for using a network provider, and the type of incentive such as a lower hospital deductible or higher coinsurance rate. For HMO plans, additional data show the percent of participants whose hospital room and board benefits were covered in full, or were subject to limits.

From the data on hospital room and board benefits presented for 1993 and 1995, the erosion of the basic hospital room and board benefits continues. The proportion of HMO participants with hospital room and board benefits covered in full declined from 82 percent in 1993 to 77 percent in 1995. (See table 5.) This reflects increased imposition of hospital copayments. HMO's accounted for 23 percent of all health plan participants in 1993 and 27 percent in 1995. The proportion of non-HMO participants with some level of basic coverage before major medical fell from 42 percent in 1993 to 31 percent in 1995. This reflects the continued decline of first-dollar basic benefits.

Major medical coverage for hospital room and board benefits

In 1979, 92 percent of the participants with hospital room and board coverage were provided a substantive basic benefit on the first day of confinement, compared with 50 percent in 1995. This decline signified a shift in plan designs, where major medical limits on coverage were imposed at the outset of each confinement, requiring the participant to pay a deductible and coinsurance prior to receiving any benefit. Participants with major medical coverage are also commonly limited to a lifetime maximum amount of benefits payable under the plan.

Under major medical coverage, the most common coinsurance rate paid by the plan has been 80 percent. (See table 6.) However, other coinsurance rates have become more common in recent years, for example, 90 or 100 percent if an in-network provider is used in a PPO plan.

Not surprisingly, the EBS data show an increase in the amounts of major medical deductibles imposed on plan participants between 1979 and 1995. In 1979, deductibles usually were $100 or less. By 1995, deductibles less than $100 were almost nonexistent, while the $100 deductible was imposed only half as frequently—on one-fifth versus one-half of plan participants with major medical coverage.

One area where coverage has expanded has been in lifetime dollar limits. In 1983, the first year data are available, four-fifths of participants had a lifetime limit of less than $1million; the remainder, $1 million. By 1995, nearly four-fifths had a lifetime limit of $1 million or more.

Typical coverage for hospital room and board by type of plan

Traditional fee-for-service plans. Room and board benefits in a traditional fee-for-service plan are usually subject to major medical plan limits, such as deductibles and coinsurance requirements, before any benefits are received. Deductibles are typically a flat dollar amount of $100 to $200 per year for each covered individual. In 1995, 91 percent of participants in this type of medical plan were required to pay an individual deductible. Coinsurance requirements specify what percent of costs the plan and insured will each pay after the annual deductible is met. In 1995, 95 percent of the employees in traditional fee-for-service plans participated in plans with a coinsurance arrangement—commonly 80 percent of covered expenses were paid by the plan.

Preferred provider organization plans. A preferred provider organization is a network of hospitals and physicians that contract to provide comprehensive medical services at pre-arranged prices. To encourage use by organization members, the health care plan limits the reimbursement rate or imposes a deductible when participants use non-member services. The coverage in a preferred provider organization resembles that of a traditional fee-for-service plan; usually, a deductible and a coinsurance are required before any expenses are paid by the plan. However, benefits in a preferred provider organization are usually more liberal for plan participants who use in-network providers compared with

Table 4. Percent of participants in employer-sponsored health plans by type of plan benefits for medical care plans with hospital room and board benefits, selected years, 1979-1995

(In percent)

Year	All plans[1]	Fee-for-service plans	Preferred provider organizations	Health maintenance organizations
1979	100	98	([2])	2
1980	100	98	([2])	2
1981	100	97	([2])	3
1982	100	96	([2])	4
1983	100	97	([2])	3
1984	100	95	([2])	5
1985	100	93	([2])	7
1986	100	86	1	13
1988	100	74	7	19
1989	100	74	10	17
1991	100	67	16	17
1993	100	50	26	23
1995	100	37	34	27

[1] Includes participants in some plans not presented separately, for example, exclusive provider organization plans.

[2] Data are not available.

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals.

Table 5. Percent of participants in employer-sponsored health plans, extent of coverage for hospital room and board by type of plan, 1993 and 1995

(In percent)

Extent of coverage for hospital room and board	1993	1995
Non-health maintenance organizations[1]		
Covered in full	5	6
Subject to limits	37	25
Specific room and board limits only[2]	3	3
Specific and major medical limits	34	22
Major medical limits only[3]	58	69
Health maintenance organizations		
Covered in full	82	77
Subject to limits[4]	18	23

[1] Includes all fee-for-service and preferred provider organization plans.

[2] Limits may be dollar or day ceilings, a coinsurance percentage, a copayment, or a deductible that must be paid before plan benefits begin.

[3] Major medical limits are on total benefits payable under the plan, rather than on individual categories of care. Limits are generally in the form of deductibles, coinsurance percentages, and overall dollar limits on plan benefits.

[4] Limits are usually a dollar copayment per confinement.

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals.

traditional fee-for-service plans. In 1995, 63 percent of preferred provider organization participants had to pay a deductible and 75 percent had a coinsurance arrangement if an in-network provider was used.

Health maintenance organization plans. A health maintenance organization provides a prescribed set of benefits to enrollees for a fixed prepayment. The participant's choice of providers and facilities is usually limited to those affiliated with the organization. HMO's both finance and deliver health care services, with emphasis on preventive care. Usually, most health maintenance organization services, particularly room and board, are covered in full or require only a nominal copayment. For instance, in 1995, 23 percent of all participants in health maintenance organization plans were subject to a limit for hospital room and board. In nearly all cases, these limits were in the form of separate copayments, often $100 to $200 per confinement. The remaining participants had hospital room and board paid in full.

Table 6. Percent of participants [1] in employer-sponsored health plans by prevailing major medical plan limits, selected years, 1979-95

(In percent)

Year	Coinsurance rate				Individual deductible[3]				Lifetime dollar limit[4]			
	All	80 percent	85 percent	Other[2]	All	Under $100	$100	Over $100	All	Under $1 million	$1 million	Over $1 million
1979	100	91	5	4	100	35	52	13	([5])	([5])	([5])	([5])
1980	100	89	5	5	95	33	53	8	([5])	([5])	([5])	([5])
1981	100	90	4	6	95	31	55	8	([5])	([5])	([5])	([5])
1982	100	90	5	6	94	30	56	7	([5])	([5])	([5])	([5])
1983	100	88	5	6	94	29	52	13	74	60	14	([6])
1984	100	86	5	9	94	25	47	22	72	53	19	([6])
1985	100	85	5	9	94	19	44	30	74	52	22	([6])
1986	100	86	5	9	96	14	44	38	68	45	22	1
1988	([5])	([5])	([5])	([5])	91	11	40	40	71	33	38	1
1989	97	79	4	12	93	6	34	54	71	29	40	2
1991	93	74	3	16	86	4	27	55	72	27	43	2
1993	90	71	3	15	81	3	22	56	75	24	46	6
1995	84	60	4	19	68	2	17	49	70	14	47	9

[1] Includes participants in plans with stated major medical limits, 1979-91. Data for 1993 and 1995 excluded participants in HMO plans.

[2] Includes participants in plans where the overall coinsurance varies or coverage is not at a rate of 80 or 85 percent. Prior to 1989, "Other" included all other coinsurance rates. Whereas, from 1989 to 1995, "Other" did not include plans where the coinsurance rate was 100 percent; these data were included in the "without coinsurance" catergory. Thus, the totals between 1989 and 1995 will not equal 100 percent.

[3] Specified flat amounts per year.

[4] Specified flat amounts per lifetime only.

[5] Data are not available.

[6] Less than 0.5 percent

NOTE: Data are for full-time employees in private establishments employing 100 or more workers. Because of rounding, sums of individual items may not equal totals.

Glossary of Health Care Terms

Coinsurance provisions require the insured to pay a portion of covered medical expenses, with the plan paying the remaining portion. For example, the employee may pay 20 percent and the plan pay the remaining 80 percent of the covered charges.

Deductibles are a specified amount of covered medical expenses that must be paid by the insured each calendar year before any expenses are reimbursed by the plan. Deductibles are typically specified as an annual flat-dollar amount, such as $100 per year for individuals and $300 a year for a family.

Fee-for-service is a type of health care plan that pays for specific medical procedures as expenses are incurred. Payments can be made directly to health care providers or to the plan participants. Fee-for-service plans generally include deductibles and coinsurance.

First-dollar coverage is a feature of a health care plan which does not require its participants to pay any deductibles or copayments before benefits are received.

Health maintenance organization (HMO) is a type of health care plan that provides a prescribed set of benefits to enrollees for a fixed premium payment. Enrollees are restricted to specific care providers, and have charges for most services covered in full. Types of HMO's include the group/staff type, in which providers are located in central facilities, and independent practice associations (IPA's), in which providers work from their own offices.

Lifetime maximum benefit is the maximum lifetime amount payable for covered expenses for the insured and each covered dependent while under the medical plan. For example, a lifetime maximum of $1 million per individual is common.

Preferred provider organization (PPO) is a type of health care plan that, like a fee-for-service plan, pays expenses as they are incurred. Participants can choose any health care provider, but receive higher benefits for services rendered by designated hospitals, physicians, and other health care providers.

—ENDNOTES—

[1] Price indices for hospital room and board were discontinued after July 1994.

[2] Data are from the Health Care Financing Administration, Office of the Actuary, National Health Expenditures By Type Of Service And Source Of Funds: Calendar Years 1960-95.

[3] In addition to medical care benefits, the BLS Employee Benefits Survey provides data on life and disability insurance, retirement and capital accumulation plans, paid and unpaid leave, and other benefits. Results for medium and large private establishments are available for 1979-86, 1988-89, 1991, 1993, and 1995. Results for small private establishments are available for 1990, 1992, 1994, and 1996. Results for State and local governments are available for 1987, 1990, 1992, and 1994.

[4] In this article, the term "fee-for-service" is used for indemnity plans. (See box, "Glossary of Health Care Terms," for definitions.)

[5] Major medical benefits include many categories of expenses, some of which are not covered under basic benefits and others for which basic coverage has been exceeded. These benefits are characterized by deductible and coinsurance provisions.

[6] A provision was classified as a basic benefit when it related to the initial expenses incurred for a specific medical service. Under these provisions, a plan covered expenses in one of several ways: (1) In full with no limitations; (2) in full for a specified period of time, or until a dollar limit was reached; or (3) a cash scheduled allowance benefit that provided up to a specific dollar amount for a service performed by a hospital or physician.

[7] In some plans, the limit on days of coverage varied by length of participation in the plan. In these cases, the participant was assumed to have been in the plan for 15 years.

[8] These included limits on maximum dollar amounts per confinement or per year, and limits on the number of days of coverage within a specified time period.

[9] For a more extensive discussion on cost containment provisions in health plans, see Stephanie L. Hyland, "Health care benefits show cost-containment strategies," *Monthly Labor Review*, February 1992, pp. 42-47; Robert Grant, "Outpatient surgery: Helping to contain health care costs," *Monthly Labor Review*, November 1992, pp. 33-36; and Thomas Burke, "Alternatives to hospital care under employee benefits plans," *Monthly Labor Review*, December 1991, pp. 9-15.

[10] For a discussion of overall changes in health plan design during this period, see John J. Kane, Allan P. Blostin, and Jordan N. Pfuntner, "Changing Survey Strategies in the Evolution of Health Care Plans," *Compensation and Working Conditions*, September 1996, pp.3-10.