Preventive care provisions, other benefits: are they described in plan documents?

It is not very common for preventive care provisions, such as cancer screening tests, to be specifically mentioned in plan documents; these benefits are usually covered under a more general clause

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Provisions in medical care plans that emphasize coverage for preventive care tests have risen sharply in recent years.[1] The attention generated by such preventive care measures as cancer screening and cholesterol tests led the Bureau of Labor Statistics (BLS) and the Agency for Healthcare Research and Quality (hereafter, called Healthcare Research) to conduct a joint study to determine if employer health insurance documents specifically describe certain medical provisions. The study was conducted under the auspices of the Interagency Committee on Employment-Related Health Insurance Surveys. The primary motivation behind the test was the need for more information on preventive care services, as expressed by the U.S. Preventive Services Task Force.[2]

The Committee was formed as a means for Government agencies to coordinate statistical survey data related to health insurance, share information, and identify and fill data gaps.[3] Since its inception in 1998, the Committee's coordination efforts have focused on collection, analysis, and dissemination of statistical estimates. In addition to the Government agencies that produce health insurance statistics, the Committee's efforts are geared toward the wider data-user community and health policymakers.

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How the test was conducted

The Agency for Healthcare Research and Quality role. The joint study by Healthcare Research and BLS was undertaken in several steps. Initially, Healthcare Research identified medical care provisions that it was interested in studying, data for which BLS does not presently collect. These provisions include various cancer screening and other preventive care tests, and medical procedures, such as laser eye surgery, that have become more prominent in recent years. Next, Healthcare Research conducted three separate studies to collect preliminary information on these provisions from plan documents collected as part of its 1996 household and establishment surveys.[4] The main purpose was to provide feedback on information available from booklets to assist with additional study and to develop a data collection form for use by BLS. As a result of this study, definitions of terms and the design of the collection form were refined, and the list of provisions to be included in the BLS study was expanded.

The first study consisted of 31 booklets randomly selected from those collected during the Healthcare Research 1996 health survey, booklets that described medical care provisions. The second study included 100 booklets; however, about half were eliminated because of limited information on benefit provisions. In order to be used in the Healthcare Research study, plan booklets had to describe the benefits in some detail. The third and final study used a sample of 75 plans. The requirements to be included in this study were not as stringent as in the second

study. For example, if a summary sheet was provided that gave limited details of the benefits, it would be included in the third study (but not included in the second). After Healthcare Research completed its preliminary studies, BLS conducted the official study using the final version of the collection form, which included definitions of each of the provisions.

The BLS role. The BLS study was conducted during its 2000 survey of private employee benefits.[5] The study consisted of a sample of 100 medical care plans; they were randomly selected using only the booklets that described the plans in the most detail. Summary plan descriptions (SPDs) furnished by the employer are the main source used in the benefits survey. Healthcare plan sponsors are required by law to provide SPDs to plan participants, giving the employees a detailed description of their benefits under a particular plan. (More details on SPDs are discussed later.) Documents with only limited information—such as one-page summaries—were excluded from the study. One problem that surfaced during the test was that many plan documents only had limited information. This was especially true for health maintenance organizations.[6] Thus, the overwhelming amount of plans in the test came from conventional indemnity plans and preferred provider organizations.[7] The minimal information found in many plan documents made it difficult to accurately assess the frequency with which the company booklets included in the study described a particular medical provision.

The medical care provisions studied included various cancer screening tests, other preventive care measures, and several other provisions currently of interest in the health arena.[8] Specifically, the study included plan features such as screening or testing for both colorectal and prostate cancer, mammograms, acupuncture, chiropractic care, formulary drugs, and smoking cessation programs. BLS tabulated the percentage of plans for which provisions were covered, excluded, or not mentioned in the plan booklets, and also tabulated details on how the provisions are covered, such as whether they are subject to special limits. Estimates in the study have not been weighted. The sample of companies used in the study was not intended to be statistically representative of the economy. Therefore, the results can only been seen as a rough indication of how plan documents describe certain medical provisions; they should not be viewed as a true statistical measure of the incidence of certain medical provisions.

Study results

The main finding revealed from the study was that only a few provisions were described in the majority of company plan booklets. Note that the study only measured whether the provisions were described in the plan documents, not whether they were covered under the plan. The following are the key results from the study:

- Screening or testing for both colorectal and prostate cancer is not commonly described in the plan documents. Barium enema, colonoscopy, sigmoidoscopy, and digital rectal exam for prostate cancer are rarely specifically mentioned in the summary plan descriptions. (See table 1.) The prostate specific antigen (PSA) test is more frequently mentioned in the plan documents than are other screening tests. While most of the cancer screening tests are not commonly described in the plan documents, they are often covered as part of the coverage for physical examinations and/or diagnostic x-ray procedures.

- Mammograms and pap smears, two other cancer screening tests, were the most commonly described provisions in the study. Plans commonly provide for one baseline mammogram between ages 35 and 39 and some age-related schedule for ages 40 and older. Pap smears are usually limited to once a year, and occasionally are associated with a dollar limit.

- For other preventive care measures, the results were mixed on the frequency with which they were described in the plan documents. Well-child care was among the most commonly described provisions in the study. Well-child care is an extension of well-baby care, which usually covers babies up to age 2 years. Sometimes, this provision is also grouped under wellness or preventive care, with age limits of 6 years, 12 years, or 18 years. On the other hand, bone mass measurements—sometimes referred in plan documents under osteoporosis—was rarely specifically mentioned in the summary plan descriptions (SPDs). It is often covered under well-woman examinations. Finally, cholesterol blood tests, another rarely mentioned provision, is almost always included as part of an annual physical examination.

- The test also included other provisions of current interest in the health field. Laser eye surgery—often referred to in the plan documents as radial keratotomy and related surgical procedures—is the provision that is most commonly found in the plans' exclusions section.[9] It was also only rarely specifically mentioned as a covered benefit in the plans.

Table 1. Medical plans with preventive care and other provisions in summary plan descriptions, 2000

[In percent]

Provision	Mentioned		Not mentioned	Specific details provided
	Coverage	Exclusion		
Acupuncture	16	25	59	Usually mentions a limit on visits.
Bone mass measurements	5	0	95	Rarely mentioned, but never specifically excluded. A couple of times, osteoporosis is mentioned.
Cholesterol blood test	13	0	87	Never mentioned as an exclusion. Noted as part of adult physical, or a limit of once every 5 years after a certain age.
Chiropractic care	63	9	28	Limit on dollar amounts or on visits. Referred to quite often as spinal manipulation, adjustment, or subluxation.
Colorectal cancer-screening or testing	13	0	87	Never mentioned as an exclusion. The various cancer tests are under preventive care benefits. In addition, there is usually a minimum age for which the tests become covered. There is also usually a limit of one screening every 1 to 5 years. Sometimes there is a limit on the dollar amount.
Fecal occult blood test (or hemoccult test)	16	0	84	…
Sigmoidoscopy	9	0	91	…
Colonoscopy	5	0	95	…
Barium enema	2	0	98	…
Formulary drugs	16	1	83	When mentioned, it is usually under HMOs. Some list outpatient drugs for specific illnesses; a couple of plans mentioned copayments. One plan mentioned "voluntary or open formulary."
Laser eye surgery	4	38	58	Exclusions usually mention "radial keratotomy" and related surgical procedures. A couple of plans listed coverage only beyond a certain level of myopia and/or coinsurance up to a dollar amount. Some referred to photorefractive keratotomy, keratoplasty, and LASIK.
Office visit for prenatal care	49	0	51	Often noted coverage under preventive care or wellness care, like any other office visit, or 100 percent coverage after initial copayment.
Prostate cancer screening	33	0	67	PSA is the most commonly mentioned prostate test. Tests usually begin at age 40 or later. Coverage is often limited to one visit annually. Some plans noted coinsurance or 100 percent coverage after copayment. One plan noted coverage for "detection exam."
Digital rectal exam	11	0	89	…
Prostate specific antigen (PSA) test	34	1	65	…
Routine mammograms	84	2	14	Most commonly mentioned benefit. Most plans have an age schedule, starting at age 35. Typical schedule: 35–39, one baseline; 40–49 every 2 years; 50 and older annually. Several plans noted coverage under normal coinsurance or 100 percent coverage after copayment. Some plans noted coverage up to a dollar amount limit.
Routine pap smears	80	5	15	Also very common. Limited to once every 1 to 3 years. Some plans mentioned a dollar amount limit.
Smoking cessation program	8	32	60	Often mentioned in exclusions. Some plans distinguish between programs and drugs for smoking cessation. One plan referred to nicotine addiction and another to "goal oriented behavior modification." One plan covered this provision under "wellness benefit."
Well-child care	71	3	26	Very commonly mentioned. Coinsurance or 100 percent coverage after copayment is often noted. Sometimes coverage is under pediatric care. Age limits may be 6, 7, 12, 18, or 19. A few plans noted "wellness" or "preventive care" coverage. One plan noted coverage of visits at specific ages (in months).

Smoking cessation programs also were frequently specifically excluded from the plan booklets. Smoking cessation is sometimes covered under an employee assistance program, instead of the medical plan.[10]

- Another provision of current interest to health users is formulary drugs, which is not commonly described in the booklet. Formulary drugs are a group of medications approved by a third-party organization, such as a managed care company. These drugs are covered by the health plan on a cost-effective basis. Formularies are also established for clinical reasons. When formulary drugs were mentioned, they were often at a lower cost to the plan participant than were nonformulary drugs. In some cases, nonformulary drugs were not covered in the plan.

With few exceptions, it was not common for the plan documents to mention the provisions from the BLS study—only four provisions were described in at least 50 percent of the plan booklets. As stated earlier, this does not mean that these provisions are not covered by the plan—it merely means that the provisions are not specifically described in the plan booklets.

Comparing the results of the BLS study with the second study of the Healthcare Research revealed that 6 percent of the plans in the Healthcare Research test specifically described acupuncture as a covered benefit, while 16 percent did so in the BLS study. Chiropractor care was mentioned for 35 percent of the plans in the Healthcare Research test and 63 percent in the BLS study. Another provision for which the results differed between Healthcare Research and BLS was office visits for prenatal care. Under this provision, the doctor monitors a pregnancy. Prenatal care may also include counseling for nutrition and substance abuse problems. In the Healthcare Research study, 67 percent of the plans specifically mentioned office visits for prenatal care, compared with 49 percent for the BLS study. For the remainder of the provisions, the percentages generally were similar between Healthcare Research and the BLS. Because both studies had small and different samples and were not weighted, some differences in results were expected.

Why do plan documents commonly not mention most of the provisions by name? Are these provisions not covered by the plan, or is there another explanation? For example, provisions for cancer screening tests such as sigmoidoscopy and colonoscopy are rarely described in the plan booklets, but commonly are covered by the plan. Are SPDs the best source of obtaining information on medical provisions? While plan documents always describe the most important medical provisions such as hospitalization and physician care, that does not appear to be the case for certain of the preventive care provisions that were part of the BLS study.

Summary plan descriptions

Requirements. Before addressing why the plan documents do not specifically mention certain preventive care provisions, it is important to understand the purpose of the documents. Under the Employee Retirement Income Security Act (ERISA) of 1974, employers are required to provide their employees with SPDs of their pension and welfare benefit plans. The descriptions must be written in a fashion that the plan participants are able to clearly understand and must be detailed enough to reflect accurately the benefits provided to the employees.

In November 2000, the Department of Labor issued new regulations on what must be described in SPDs for pension and welfare benefit plans.[11] The main focus of the new rules revolves around what information must be included in the SPDs for group health plans. The SPDs must include the following:

- Any cost sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts;
- Any annual or lifetime maximums or other limits on benefits under the plan;
- The extent to which preventive services are covered by the plan;
- Whether and under what circumstance, existing and new drugs are covered by the plan;
- Whether, and under what circumstance, coverage is provided for medical tests, devices or procedures;
- Any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the plan.

The regulations were effective in January 2001. The SPDs, however, are not required to specifically mention these provisions until January 2003. The new regulations are intended to provide a clearer and more accurate reflection in the SPDs of the benefits provided to the employees.

Employers must provide an SPD to their employees, but are no longer required to file the plan with the U.S. Department of Labor. Under amendments to the Taxpayers Relief Act of 1997 (TRA 97), plan administrators are no longer required under

Definitions of Provisions

Acupuncture: A technique of inserting hair-like, fine needles into acupoints on the body's surface in order to affect the physiological functioning of the body. Acupuncture is usually used as an anesthesia for surgical procedures.

Bone mass measurements: (also referred to as Bone Densiometry) A non-invasive test to detect weakness of the bones due to osteoporosis.

Cholesterol blood test: A test that can detect an elevated blood cholesterol level - one of the major modifiable risk factors for coronary heart disease.

Chiropractic care: Manual manipulation of the bones and associated muscles and joints (particularly of the spine and extremities) in order to relieve acute pain.

Colorectal cancer—screening or testing: Includes the four major types of screening or testing for colorectal cancer.

1) **Fecal occult blood test**—A stool sample is taken to test for the presence of fecal occult blood.
2) **Sigmoidoscopy**—A tube is inserted into the rectum and the lower two feet of the colon. Doctors inspect the lining of the colon for bowel disease, cancer, or polyps that may increase the risk of colon cancer.
3) **Colonoscopy**—Similar to sigmoidoscopy, but the flexible viewing tube is long enough to reach the entire colon. During the colonoscopy, doctors can also treat or remove polyps.
4) **Barium enema**—An x-ray study in which a tube is inserted into the rectum and the large intestine is filled with barium, allowing the radiologist to diagnose many conditions including colorectal cancer.

Formulary drugs: Drugs approved by the health provider. Drugs not approved by the health provider are non-formulary—enrollees receive limited or no reimbursement.

Laser eye surgery: Performed for correcting common eye disorders—near sightedness, far sightedness, and distorted vision—not for specific eye diseases. There are two types of laser surgery: PRK and LASIK. In PRK, the surgery reshapes the cornea with an ultraviolet beam of light. LASIK is used for all types of nearsightedness. The surgeon cuts a flap of corneal tissue, removes the targeted tissue beneath it with the laser, and then replaces the flap.

Office visit for prenatal care: Detects and manages the complications of pregnancy, rather than the prevention of low birth weight. Doctor checks the mother for infectious diseases, gestational diabetes, and vital signs, and assesses the baby's condition. Prenatal care may also include counseling for nutrition and substance abuse problems. Follow-up visits are provided to minimize pregnancy risks.

Prostate cancer screening (digital rectal exam and/or prostate specific antigen (PSA) test): The two primary tests for prostate cancer. In the digital exam, the doctor palpates the prostate gland, examining it for irregularities. The prostate-specific antigen blood test measures the level of PSA in men. A high reading signals the possibility of prostate cancer.

Routine mammograms: An x-ray image of the breast to detect for the existence of breast cancer.

Routine pap smears: A precancer or cancer screening test of the cervix.

Smoking cessation program: An organized effort to break the habit of smoking. The program includes classes, counseling, poster campaigns, employee incentive programs, anti-smoking literature, and products such as nicotine patches. Programs were excluded if the plan only provided literature or a video, but was not part of an organized program. Smoking cessation programs may be in-house or from outside organizations.

Well-child care: A program to provide preventive care for children. This should not be confused with well-baby care—usually provided up to age 2. Services for well-child care include routine physical exams, laboratory tests, immunizations, vision and hearing tests, and related office visits.

ERISA to file SPDs and summaries of material modifications with the Department.[12] Prior to the amendments to TRA 97, plan administrators were required under ERISA to file SPDs with the Department every 10 years, or after 5 years if there were any changes. They were also required to file information about plan modifications at the end of each year during which there was a change.

Expert views. To better understand why many of the preventive care measures that were part of the BLS study were not commonly mentioned by name in the SPDs, BLS contacted health benefits experts from the following: Government, research organizations, consulting firms, trade associations from the insurance industry, and insurance companies.[13]

Different reasons were given among the experts as to why SPDs often do not specifically mention such provisions as cancer screening and certain other preventive care tests, but a common thread was generally seen among the responses. Most respondents agreed that preventive care provisions, such as cancer screening tests, were usually covered under the plan. There was a general consensus that, when specifically not mentioned, most of these preventive care features often would fall under some "umbrella" provision. Such general "umbrella" provisions include physical exams, health appraisals, health assessments, health screening tests, diagnostic procedures, and X-ray and laboratory services.

Most respondents agreed that the plan documents cannot list every procedure, as there are too many procedures that can be classified under preventive care. Preventive care benefits can vary based on age, sex, and personal history of the individual. By using an overall category (for example, health screening tests), the insurers can be flexible as to what they can provide in the plan. While specifically mentioning a procedure and giving specific guidelines in the plan document will tell the enrollee exactly what is covered, it also has the opposite effect of saying what is not covered. For example, if the plan document specifically says colonoscopies are covered for ages 50 and older, it does not allow for clinical judgement based on the personal history of the individual to cover that cancer screening test at a younger age.

Regulations issued by the Department of Labor governing the content of SPDs are consistent with the views of benefits experts contacted. It was not the intent of the Department of Labor to have the SPDs specifically describe every single benefit provision under the health plan.[14] According to Department regulations, if the health plan covered an extensive schedule of benefits, the SPDs only had to describe them in general terms, as long as, upon request, the participant in the plan was informed about all benefits.

The continuing introduction of new covered medical care measures is another reason it is not feasible to specifically list all procedures. It is more practical to cover these procedures under some general category. The other reason given for certain procedures that are not specifically stated in the plan documents is that they are so well known that it is not necessary to describe them. In this case, a procedure such as cholesterol blood testing would fall under some overall category of preventive care—physical exams, for instance.

As stated, the general consensus of the respondents was that if not specifically mentioned, many of the preventive care procedures from the BLS study were covered under the plan. Specifically, the procedures that fall into this category included all of the cancer screening tests, cholesterol blood testing, and bone mass measurements. (There was, however, one dissenting view: one of the individuals contacted believed that if the plan did not specifically mention a procedure, it was unlikely that the insurer covers that benefit.)

Are there other sources that will give an individual more information about whether specific procedures are covered? An SPD is designed to provide a "summary" rather than a detailed description of the benefits the employers provide to their employees. More detailed information may be found from such sources as the complete company plan documents, insurance contracts, evidence of coverage, and third-party administrator contracts. There was general consensus among the respondents that a written document existed within the company that described all of the covered benefits in detail.

What's next?

As in past surveys, one of the goals of future benefits surveys is to capture data on the most current trends in health insurance. In recent years, cancer screening tests—especially colonoscopy—have gotten much publicity. This is one of the reasons these various screenings were included in the BLS test. The problem with attempting to capture data for the various cancer screening procedures—along with certain other preventive care provisions—as was demonstrated from the results of the study, is that those procedures are not mentioned very often in the SPDs. They are, instead, quite often included under a more global medical category. Assuming that the SPDs continue to be the main source used in the benefits survey, it does not seem that this source will provide an accurate measure on how often various cancer screening provisions are covered. Thus, it does not seem wise in the future to try to capture data on cancer screening tests.

As far as other provisions in the BLS study, the benefits survey has begun to capture data on formulary drugs, due in large part to the widespread publicity of the high cost of prescription drugs. Capturing data on other provisions studied in the BLS study is currently under discussion.

SUMMARY PLAN DESCRIPTIONS often do not mention cancer screening tests and certain other preventive care provisions

as covered benefits. Therefore, SPDs are not the best source for describing these provisions. These summary documents are most likely to specifically mention major health benefits such as hospitalization, surgery, and physician visits, rather than most preventive care provisions. Research conducted for this article showed that generally preventive care provisions were covered by the plan. Discussions with experts in the medical care industry and those involved with SPDs revealed that when cancer screening tests and certain other preventive care provisions are not described in the plan documents, they almost universally fall under a more general category, such as physical exams and diagnostic procedures. By including cancer screening tests and other preventive care provisions under some all-inclusive provision, it allows the insurer more flexibility in providing the benefits. With the constant growth of new preventive care provisions, it makes sense for the plans to include these benefits under some "umbrella" category. □

Notes

[1] *Employee Benefits in Medium and Large Private Establishments, 1997,* Bulletin 2517, (Bureau of Labor Statistics, 1999), table 7, p. 11.

[2] See the U.S. Preventive Services Task Force on the Internet at **http://www.ahrq.gov/clinic/prevenix.htm.**

[3] Since its formation, the Committee has undertaken many projects to achieve its goals. One example was the development of a standard set of health insurance definitions that will be used by many Government agencies for survey collection and dissemination of data. Additionally, these definitions will be distributed to the broader health community. The health definitions are currently available from the Bureau of Labor Statistics on the Internet at **http://www.bls.gov/ncs/home.htm** (visited October 15, 2002), and from the Agency for Healthcare Research and Quality on the Internet at **http://www.meps.ahrq.gov/mepsdata/ic/icdefinitions.htm** (visited October 10, 2002). For more information on the work of the Committee, see Holly Harvey, Katharine R. Levit, and William J. Wiatrowski, "Employment-Related Health Insurance: Federal Agencies' Roles in Meeting Data Needs," *Health Care Financing Review*, Spring 2002, Volume 23, Number 3, pp. 115–130.

[4] The Medical Expenditure Panel Survey (MEPS) is conducted by the Agency for Healthcare Research and Quality in conjunction with the National Center for Health Statistics. The MEPS is a nationally representative survey that collects detailed information on health status, access to care, healthcare use and expenses, and health insurance coverage of the civilian noninstitutionalized population of the United States.

[5] The 2000 BLS private survey contains data from all sizes of establishments for both full-time and part-time workers. Prior to 1999, surveys of different size classes were conducted in alternating years; medium and large private establishments—those establishments of 100 workers or more—were studied during odd years and small private establishments—those establishments with less than 100 workers—during even years. The BLS private benefits survey provides data on the incidence and detailed characteristics of medical, dental, and vision care, private retirement plans, and other benefits.

[6] A health maintenance organization (HMO) is a healthcare system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for healthcare delivery in a particular geographic area to HMO members, usually in return for a fixed prepaid fee. Financial risk may be shared with the providers participating in the HMO.

[7] A conventional indemnity plan is a type of medical plan that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred. A preferred provider organization is an indemnity plan where coverage is provided to participants through a network of selected healthcare providers (such as hospitals and physicians). The enrollee may go outside the network, but would incur larger costs.

[8] The appendix to this article lists each medical provision in the BLS test and a corresponding description of that provision. The main source used for the definition of the medical provisions in the test was *Guide To Clinical Preventive Services: A Report of The U. S. Preventive Task Force, U. S. Department of Health and Human Services, Office of Public Health and Science, and Office of Disease, Prevention, and Health Promotion, 2nd edition, 1996.* In addition, a variety of other sources were used in defining the medical provisions, including the summary plan descriptions used in the test.

[9] Radial Keratotomy is rarely, if ever, performed in this country anymore. The most common laser procedures performed are photorefractive keratotomy (PRK), keratoplasty, and lasik.

[10] An employee assistance program (EAP) is an employment-based plan that assists individuals and their dependents for both personal and work-related problems. EAPs provide assistance for such issues as substance abuse, family/marital problems, and legal and family concerns. In 1999, the last time data on EAPs were published by BLS, 33 percent of private industry employees had access to such plans.

[11] 65 Fed Reg 70226 (November 21, 2000).

[12] The Taxpayers Relief Act was signed into law on August 5, 1997.

[13] Individuals contacted for this article are from organizations that included the following: U.S. Department of Labor's Pension and Welfare Benefits Administration, Employee Benefit Research Institute, Health Insurance Association of America, R.H. Wohl and Associates Inc, and insurance companies.

[14] 65 Fed Reg 70228.