Health Insurance Provisions Captured by the EBS and the NCS

The Employee Benefits Survey monitored developments and captured relevant health insurance data in the employee benefits arena since its inception in 1979. This process continues as the Employee Benefits Survey becomes part of the National Compensation Survey.

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Ensuring the reliability of health data and capturing the rapidly changing circumstances surrounding health care benefits requires the Bureau of Labor Statistics (BLS) to eliminate, revise, and expand the details of plan provisions that are surveyed.[1] This article explores how the Employee Benefits Survey (EBS) has evolved into its present form in terms of its ability to provide useful data on the details of health insurance plans. It also explains why the health portion of the survey has undergone myriad changes since its inception in 1979, and what changes are envisioned for the future as the EBS is incorporated into the National Compensation Survey (NCS).[2]

Health insurance provisions surveyed by the EBS

Since 1979, the specific health insurance provisions captured by the EBS have changed. Surveyed provisions have been expanded to reflect emerging trends and streamlined to eliminate superfluous details, those not readily available from plan documents or those too uncommon to support published estimates.

Expansions due to changing plan provisions. During the 1980s, the cost of medical care grew rapidly. The Consumer Price Index registered a 119-percent increase in the price of all medical care between 1979 and 1989.[3] All medical items grew sharply—hospitalization at the highest rate, 162 percent or 2.5 times the general rate of inflation.

Many insurers began to offer managed care provisions within plans other than health maintenance organizations (HMOs) to help contain these rising costs.[4] (See appendix 1 for definitions of health insurance terms used in this article.) By their nature, HMOs have their own built-in forms of managed care provisions. In 1985, the EBS began surveying various managed care features contained within these plans, such as incentives

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for preadmission hospital testing and lower reimbursement for nonemergency weekend admissions. In 1986, the EBS began surveying provisions for preadmission certification requirements. As managed care provisions became increasingly prominent, the EBS surveyed the specific details of each feature (for example, penalties for failing to undergo preadmission certification). However, published estimates included only the penalties for preadmission certification—the most common of the health care cost containment features captured by the survey.

In 1992 and 1993, the EBS expanded surveyed plan provisions for managed care plans. It published estimates that compare preferred provider organization (PPO) and traditional fee-for-service (FFS) plans for coverages such as coinsurance rates. In addition, the EBS expanded the details it captured for HMOs to include data on selected features such as point-of-service options and Federal qualification. In 1993, estimates were published separately for HMOs and non-HMOs for all categories of medical care[5] and prescription drugs collected.

Contractions to facilitate streamlining. Over the years, the Bureau eliminated some surveyed provisions because the data were duplicative, hard to obtain, not prevalent, of little interest to the benefits community, or because they followed the same pattern year after year. For example, during the early years, the Bureau eliminated plan provision details for types of hospital coverage, such as emergency care and intensive care, because they mirrored coverage for other hospital services. In addition, it eliminated coverage details for dependents because coverage rarely varied for dependents.

The Bureau also had other reasons for eliminating plan provisions or provision details. In 1993, for example, the EBS began using a new data capture system. During the development of this system, BLS eliminated previously captured details that lacked identifiable users or purpose. The development of the new data capture system afforded the Bureau an opportunity to streamline the survey without decreasing the number of published estimates.

Comparison of health insurance provisions between the EBS and the NCS

The transition from the EBS to the NCS has engendered extensive research. Through this research, BLS identified the effectiveness of current health insurance details, the changes needed for the production of more timely and relevant estimates, and the final design of the NCS. (See appendix 2.)

The Bureau's mandate is to provide users with the most relevant data within program limitations. The Bureau has traditionally maintained communications with the benefits community. With the advent of the NCS, BLS conducted a coordinated outreach effort to identify the needs and concerns of the data users. To ensure adequate input, the Bureau contacted users from different disciplines, such as academia, government, insurance companies, unions, research organizations, and the print media. In the health area, users were asked to explain their needs for information on "basic" medical provisions,[6] alternatives to hospital care,[7] dental care, vision care, prescription drugs, mental health care and substance abuse treatment provisions, major medical limits, and managed care plans and provisions.

The research demonstrated that the data users are generally comfortable with the amount of detail the survey publishes. However, among the very broad EBS user community, some would like to see expanded details published on alternatives to hospital care, mental health care and substance abuse treatment provisions, prescription drugs, and vision care. Others would like published incidence estimates of establishments offering benefits and additional breakouts by establishment size, industry, occupation, and geographic area.

The NCS will streamline plan provisions and publish more breakouts of the data. For example, it will publish estimates of plan incidence by "key" plan attributes and also by industry, occupation, and region. In addition, published estimates of the incidence of employee benefits will be for the entire civilian nonfarm, non-Federal workforce every year. The NCS will also publish annual benefits incidence data for all private establishments and State and local governments from a sample of establishments that is approximately 70 percent larger than the EBS sample. In addition, the NCS will provide breakouts of data centered on types of health plans. The survey will also reflect the Bureau's internal process needs. For example, the EBS captured and published estimates for dental care fee arrangements. Users have shown little interest in dental care fee arrangements and as the tabulation below shows, since 1989, the vast majority of participants are in traditional fee-for-service plans. Therefore, the Bureau considered eliminating dental care fee arrangements, but it was determined that the NCS will capture these data solely to impute missing data.

Eliminated details. Under the NCS, the provisions for hospital room and board will be cut back considerably. The actual dollar and day amounts used as limits in some plans will be eliminated because these provisions have become less prevalent over the last decade. Since 1988, there has

Dental care fee arrangement	*Percent*				
	1989	*1991*	*1993*	*1995*	*1997*
Total with dental care	100	100	100	100	100
Traditional fee-for-service	91	91	87	85	81
Preferred provider organization	4	3	6	6	11
Health maintenance organization	5	6	7	8	8

been a marked increase in the proportion of participants in non-HMOs with hospital room and board coverage subject only to major medical limits. These plans have no other limitations in addition to major medical deductibles, coinsurance requirements, and lifetime dollar maximums. The following tabulation shows the percent of non-HMO participants covered by these hospital room and board arrangements from 1988 through 1997.

Year	Percent
1988	47
1989	51
1991	55
1993	58
1995	69
1997	68

The NCS will not capture data on second surgical opinions, which is a cost containment measure designed to prevent unnecessary surgical procedures. Second surgical opinions are becoming less relevant in medical care plans because (1) coverage for participants in non-HMOs declined from 75 percent in 1993 to 53 percent in 1995, and (2) surgeries are generally performed despite second or even third opinions. Usually, second surgical opinion provisions only require patients to get the second opinion, not to accept it.[8] Moreover, the second surgical opinion, as a cost containment feature, has never been of particular interest to EBS users. Their interest in cost containment features has generally focused on preadmission certification and utilization review.

Expanded details. The NCS, while maintaining current details for skilled nursing facilities, expanded the details that will be captured for alternatives to hospital care (hospice and home health care) by capturing separate coinsurance rates for each service and separate dollar amount limits for hospice care. In addition, the NCS also expanded details for orthodontia procedures, which frequently have lifetime dollar limits for employees that are different from the comparable limits for employee dependents.

Finally, the survey expanded the types of medical care fee arrangements captured. The EBS historically published details for three major types of fee arrangements: FFS, PPO, and HMO. In recent years, these classifications have not always corresponded to the fee arrangements described in plan documents. It has become more difficult to assign correct fee arrangements using only these three classifications. Therefore, the NCS will capture data for an expanded group of medical care fee arrangements. It will keep the traditional FFS, PPO, and HMO classifications and, in addition, will expand published details for traditional HMOs and HMOs that have point-of-service features. In traditional HMOs, participants must use a service provider within the HMO network to receive any benefits. In HMOs with point-of-service features, enrollees may go outside the network to receive services. However, the services are more costly—enrollees are subject to deductible amounts and coinsurance requirements—than the services provided within the network.

Summary

Historically, the EBS has monitored developments in the health insurance industry to capture relevant data and reflect emerging trends. Although the general thrust will be to slightly reduce the amount of detail captured by the EBS, some expansion will occur in the NCS. This expansion will improve the usability of the data published without adversely effecting the major published estimates. The streamlined set of surveyed provision details will allow for more timely publications and increase the resources to pursue ad hoc surveys on topical issues. ■

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[1] For more information, see Allan P. Blostin, John J. Kane, and Jordan N. Pfuntner, "Changing Survey Strategies in the Evolution of Health Care Plans," *Compensation and Working Conditions*, September 1996, pp. 3-10.

[2] For more information about producing benefit incidence and provision estimates in the NCS, see Allan P. Blostin, "An Overview of the Employee Benefits and the National Compensation Surveys" in this issue of *Compensation and Working Conditions*, pp.2-5.

[3] For more information, see U.S. Department of Labor, Bureau of Labor Statistics, *Consumer Price Index for All Urban Consumers Historical Tables*.

[4] For a discussion of changes in the health industry, see *Source Book of Health Insurance Data, 1996*, by Health Insurance Association of America, 1997. Also, see *The Handbook of Employee Benefits: Design, Funding and Administration*, 3rd Edition, 1992, ed., Jerry S. Rosenbloom.

[5] Medical care excludes estimates for dental care, vision care, and prescription drugs.

[6] Basic medical provisions are hospital room and board, inpatient physicians' visits, office visits, surgery, and diagnostic x-ray and laboratory tests.

[7] Alternatives to hospital care provide medical care coverage in less expensive settings. These alternatives include skilled nursing facilities, home health care, and hospice care.

[8] For a discussion on second surgical opinions see *The Handbook of Employee Benefits: Design, Funding and Administration*, pp. 229-230 and 273-276.

APPENDIX 1. **Health insurance terms**

Coinsurance: The percentage of a participant's medical expenses covered by the plan and by the participant. Most plans pay a rate of 80 percent, with the participant paying the remaining 20 percent.

Deductible: Amount of expenses participants are required to pay prior to receiving benefit coverage. Deductibles are usually on an annual basis; they are commonly $100, $150, and $200.

Fee arrangement: Type of plan (for example, FFS, PPO, and HMO) that delivers care.

Fee-for-service plan: See traditional fee-for-service plan.

Health maintenance organization (HMO): Type of plan that provides a prescribed set of benefits to the participant for a prepaid fee. Enrollees are limited to specific care providers, and most services are paid in full. HMOs are responsible for both delivering the care and bearing the associated financial risk.

Lifetime dollar maximum: The maximum amount payable for covered expenses for the insured and each covered dependent while under the medical plan. Most plans have a lifetime maximum of $1 million per individual.

Major medical: Means of covering a wide range of services and providing protection for catastrophic illness or injury. Participant is generally required to pay an annual deductible or a coinsurance before benefits are paid out.

Managed care plan: Type of plan that is an alternative to or replacement for traditional indemnity insurance—health maintenance organization and preferred provider organization. These plans arrange with selected health care providers to furnish a comprehensive set of services and to implement cost containment and quality measures.

Managed care provisions: Features within non-HMOs that provide the insurers cost containment and quality measures. These include preadmission certification, concurrent review, and utilization review.

Point-of-service: Type of health maintenance organization plan that allows enrollees to receive services outside the network at a higher cost.

Preadmission certification: A requirement that the participant notify the insurer of the necessity and appropriateness of non-emergency hospitalization, prior to admission. If precertification is not obtained, a penalty typically applies.

Preadmission testing: A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospitalization. The testing is designed to reduce the length of hospital stay.

Preferred provider organization (PPO): Type of fee-for-service plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and doctors). The enrollees may go outside of the network of providers, but they would pay a greater percentage of the cost of coverage.

Provisions: Services and benefits received by the plan participant, or limits and restrictions to these services and benefits.

Traditional fee-for-service plan (FFS): Type of plan that allows the participant to select any provider for care. These plans reimburse the patient or provider or both as expenses are incurred.

Utilization review: The process of reviewing the appropriateness and quality of care provided to patients. It may occur before, at the same time, or after the services are rendered.

APPENDIX 2. **Health plan provisions and provision details in the NCS**

Plan provision	Provision details
Dental	Coverage limitations for dental treatments such as exams, fillings, crowns, and orthodontia; and plan deductible and maximum
Fee arrangement	Type of arrangements: fee-for-service, preferred provider organization, exclusive provider organization, traditional HMO, and point-of-service HMO
Financial intermediaries	Type of intermediaries: self-insured, commercial insurance, Blue Cross/Blue Shield, and independent organizations
HMO characteristics	Type of HMO and Federal qualification status
Home health care	Coinsurance limitations
Hospice care	Dollar and coinsurance limitations
Hospital room and board	Coverage limitations such as deductibles, day restrictions, coinsurance, and dollar maximums
Inpatient surgery	Dollar and coinsurance limitations
Major medical limitations	Coinsurance, deductible, out-of-pocket maximum, and plan maximum coverage
Managed care provisions	Preadmission certification and utilization or concurrent review
Mental health care and substance abuse treatment	Inpatient and outpatient mental health, alcohol, and drug abuse
Office visits	Deductible, dollar, and coinsurance limitations
Other benefits	Standard benefits such as immunizations, physical examinations (surveyed annually), additional services such as chiropractic and podiatry benefits (surveyed in a flexible cycle or as needed)
Outpatient surgery	Deductible, dollar, and coinsurance limitations
Plan sponsor	Type of sponsors: private, State and local governments, multi-employer, and employer associations
Prescription drugs	Brand name prescription drugs, generics, and mail order drugs
Skilled nursing facilities	Days and coinsurance limitations
Vision	Eye exams, eyeglasses, and contact lenses