Fertile Ground: New Data on Reproductive Health Benefits

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This article is the second in a three-part series on data recently released by the BLS National Compensation Survey on 12 employer-provided benefits.[1] The article presents data on four of the benefits, each within the general area of reproductive health benefits: maternity care, infertility treatment, sterilization, and gynecological exams and services.

The National Compensation Survey (NCS)[2] has recently published new data on 12 employer-provided medical benefits in private industry from the health plan documents of its 2009 sample of establishments.[3] The 12 types of medical benefits data are emergency room visits, ambulance services, maternity care, infertility treatment, sterilization, gynecological exams and services, diabetes care management, kidney dialysis, physical therapy, durable medical equipment, prosthetics, and organ and tissue transplantation. The estimates include the incidence of coverage as well as plan limits and copayment amounts.

The first article in this series focused on medical benefits related to emergencies: emergency room visits and ambulance services. This article, the second in the series, presents data on reproductive health benefits: maternity care, infertility treatment, sterilization, and gynecological exams and services.

Maternity Care

Maternity care can refer to a variety of services. It may mean care throughout the womans pregnancy, or it may mean care during the time spent in the hospital just before and after giving birth. For the purpose of this study, maternity care was defined as the medical coverage throughout the womans pregnancy; it included such diagnostic testing as ultrasounds and fetal monitor procedures.

Plan documents often separated maternity care into three stages: prenatal, delivery, and postnatal. The stages included different types of services; in some plans the stages were covered differently. Hospitalization for delivery was often covered in the same way as regular inpatient care; prenatal care was sometimes subject to a copayment per office visit or per pregnancy. When there were differences in coverage, provisions for prenatal care were reported. In addition, when coverage varied by the type of doctor performing the treatment, the copayment rate for a specialist was reported rather than the copayment rate for a primary care physician.

Two-thirds of the medical care participants in the survey had coverage specified for maternity care, with almost all of the remaining third in plans in which the benefit was not mentioned. The vast majority of workers with coverage were in plans that imposed some type of limitation (58 percent out of the 66 percent with coverage). A small group of workers were in plans in which maternity care was covered in full.

Maternity care was most likely to be subject to either plan limits or both separate limits and plan limits. Plan limits are restrictions on coverage that apply to most or all medical benefits in the plan. The most common types of plan limits are deductibles, plan coinsurance, maximum out-of-pocket expense provisions, and maximum lifetime dollar limits. Separate limits are restrictions that apply to an individual benefit, rather than a group of benefits. The most prevalent separate limit appearing in the survey was a copayment.

When there were separate limits on maternity care, it was usually in the form of a copayment per visit. The median copayment was $20, with amounts generally ranging from $10 to $40 per visit. Copayments per visit for maternity care applied either throughout the pregnancy or for a limited number of visits.

In addition to providing weighted estimates that represent all private industry workers, BLS reviewed plan documents to obtain additional plan features. This review showed that if the plan required copayments per visit for a limited number of

visits, the plan almost always required the copayment only for the initial visit. Another separate limit for maternity care less frequently found in plan documents was a higher coinsurance rate than the plan coinsurance rate.

Maternity care coverage was provided to 66 percent of those in a fee-for-service plan and 66 percent of those covered by a health maintenance organization. However, there were differences in the extent of coverage between these two types of plans. It was far more likely for health maintenance organizations to cover maternity care in full than fee-for-service plans (16 percent and 4 percent, respectively). Fee-for-service plans were more likely than health maintenance organizations to cover maternity care subject to plan limits (55 percent and 32 percent, respectively).

Table 1 summarizes coverage for maternity care:

Table 1. Maternity Care: Type of coverage, private industry workers, National Compensation Survey, 2009
(All workers participating in medical care plans = 100 percent)

Benefit coverage	All plans	Fee-for-service	Health maintenance organizations
Existence of Coverage:			
With coverage	66	66	66
Without coverage	—	—	—
Not mentioned in plan documents	33	33	34
Extent of Coverage (1):			
Covered in full	6	4	16
Subject to limits	58	61	49
Not mentioned in plan documents	2	2	1
Limits on Coverage (2):			
Subject to plan limits	50	55	32
Subject to separate limits	36	34	45
With a copayment per visit	30	27	41
Copayment at 10th percentile	$10	$15	$10
Copayment at 25th percentile	$15	$20	$15
Copayment at 50th percentile (median)	$20	$20	$20
Copayment at 75th percentile	$30	$30	$30
Copayment at 90th percentile	$40	$40	$40
Not mentioned in plan documents	2	2	—

Footnotes:
(1) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Extent of Coverage" may not equal the "With coverage" value due to rounding and suppression of data that do not meet publication criteria.
(2) All data other than dollar amounts are presented as a percent of workers participating in medical plans. The sum of individual items under "Limits on Coverage" may not equal the "Subject to limits" value due to rounding, suppression of data that do not meet publication criteria, and the fact that some plans may impose more than one limit.

NOTE: Because of rounding, sums of individual items may not equal totals. Dashes indicate that no data were reported or that data do not meet publication criteria. For standard errors see "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," April 15, 2011, online at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf; for definitions of terms, see "National Compensation Survey: Glossary of Employee Benefit Terms," online at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Infertility Treatment

Infertility treatments include services to diagnose and treat the causes of infertility, and may include many different methods for assisted reproduction such as artificial insemination, ovulation induction, in-vitro fertilization, and other advanced

reproductive techniques. Infertility treatment was not considered as covered in plans that covered only diagnosis and not treatment.

Infertility treatment can take place in a variety of settings, in large part because treatment can involve several stages. Some plans only pay for treatment of the underlying conditions causing infertility. Other plans pay for various methods of promoting pregnancy, which can require treatment ranging from consultations, examinations, and procedures accomplished during physician office visits to inpatient surgery.

Plan coverage provisions were fairly easy to summarize when the provisions were directly comparable; for example, a copayment for treatment at a doctors office and a copayment for treatment at a hospital outpatient facility. At the other extreme, the coverage provisions could include a mix of plan and separate limits for different treatment settings, so that the recording of plan provisions for the entire benefit was complex. If coverage for infertility services varied by location, the provisions for “outpatient settings” were recorded. Also, coinsurance rates for infertility services that differed from the overall plan coinsurance rate were recorded. Other separate limits, such as copayments for physician office visits and maximum dollar limits for infertility services, were recorded but not weighted to create national estimates.

Infertility treatment was mentioned in the plan documents for 47 percent of medical plan participants. Almost 3 in 5 participants were covered (27 percent out of 47 percent); the remaining 2 in 5 participants (20 percent out of 47 percent) were specifically excluded from coverage. Covered services were almost always subject to plan or separate limits. Participants in health maintenance organization plans that mentioned infertility treatment had coverage more often than those in fee-for-service plans (32 percent out of 44 percent that mentioned the benefit, compared with 26 percent out of 48 percent for fee-for-service plans).

Nearly all covered participants had limits on this benefit. For example, 30 percent out of 32 percent of participants in health maintenance organizations and 25 percent out of 26 percent of participants in fee-for-service plans had such limits. Coverage for participants in plans imposing limits more frequently included separate limits in health maintenance organization plans (28 percent out of 30 percent with limits) compared with fee-for-service plans (17 percent out of 25 percent with limits). The reverse was true for plan limits (16 percent out of 30 percent and 21 percent out of 25 percent, respectively).

Separate limits for infertility treatments were varied. Separate coinsurance rates for infertility services were observed in plans covering about 1 in 4 participants with separate limits for infertility treatments (5 percent out of 19 percent). The coinsurance rate most often seen was 50 percent, although the 50-percent coinsurance rate tabulated for the 75th percentile has a large standard error (17.5 percent).[4] A review of plan documents revealed that separate limits commonly included copayments for physician office visits and maximum dollar limits per year or per lifetime for infertility treatment coverage.

Table 2 summarizes the plan provisions for infertility treatment:

Table 2. Infertility Treatment: Type of coverage, private industry workers, National Compensation Survey, 2009
(All workers participating in medical care plans = 100 percent)

Benefit coverage	All plans	Fee-for-service	Health maintenance organizations
Existence of Coverage:			
With coverage	27	26	32
Without coverage	20	22	12
Not mentioned in plan documents	53	52	56
Extent of Coverage (1):			
Covered in full	(2)	—	(2)
Subject to limits	26	25	30
Not mentioned in plan documents	1	—	1
Limits on Coverage (3):			
Subject to plan limits	20	21	16
Subject to separate limits	19	17	28
With a coinsurance per visit	5	2	15
Coinsurance at 10th percentile	50	50	50
Coinsurance at 25th percentile	50	50	50
Coinsurance at 50th percentile (median)	50	50	50
Coinsurance at 75th percentile	50	90	50
Coinsurance at 90th percentile	90	100	70
Not mentioned in plan documents	2	1	—

Footnotes:
(1) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Extent of Coverage" may not equal the "With coverage" value due to rounding and suppression of data that do not meet publication criteria.
(2) Less than 0.5 percent
(3) All data other than coinsurance rates at the 10th percentile and other percentiles are presented as a percent of workers participating in medical plans. The sum of individual items under "Limits on Coverage" may not equal the "Subject to limits" value due to rounding, suppression of data that do not meet publication criteria, and the fact that some plans may impose more than one limit.

NOTE: Dashes indicate that no data were reported or that data do not meet publication criteria. For standard errors see "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," April 15, 2011, online at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf; for definitions of terms, see "National Compensation Survey: Glossary of Employee Benefit Terms," online at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Sterilization

Sterilization includes surgical procedures for men and women to prevent future pregnancies, commonly vasectomy for men and tubal ligation for women. Sterilization reversal was not included as part of this benefit. Sterilization can take place in a variety of treatment settings: physician offices and surgical centers, as well as outpatient and inpatient hospital surgical facilities. Additionally, surgery is often preceded by visits to the surgeons office for examinations and consultations.

As shown in table 3, sterilization coverage was not mentioned in plan documents for 73 percent of plan participants. When it was mentioned, sterilization was a covered benefit for about 9 in 10 participants.

Because sterilization was mentioned in so few documents, information on the extent of coverage did not meet publication standards.

Table 3. Sterilization: Type of coverage, private industry workers, National Compensation Survey, 2009
(All workers participating in medical care plans = 100 percent)

Benefit coverage	All plans	Fee-for-service	Health maintenance organizations
Existence of Coverage:			
With coverage	26	27	20
Without coverage	2	2	1
Not mentioned in plan documents	73	71	79

NOTE: Because of rounding, sums of individual items may not equal totals. For standard errors, see "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services," April 15, 2011, online at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf; for definitions of terms, see "National Compensation Survey: Glossary of Employee Benefit Terms," online at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Gynecological Exams And Services

Gynecological exams and services include routine gynecological exams and pelvic examinations, which often include Papanicolaou (PAP) tests. Plan documents often called gynecological exams “well woman exams” and “pelvic exams.” Gynecological services were considered as covered if the plan included coverage for a PAP test or if the plan made any reference to the obstetrical and gynecological medical specialties. Plan references only to “preventive care” and “annual physicals” were not considered gynecological exams and services.

Sixty percent of participants had coverage for gynecological exams and services; for almost all of the remaining 40 percent of participants, plan documents did not mention these services.

In plans in which gynecological exams and services were mentioned, the services were almost always subject to plan or separate limits. Separate limits were imposed on 9 in 10 participants in plans with limits on this service (51 percent out of 56 percent), and for a sizeable majority of them (33 percent out of 51 percent), a copayment was required for physician office visits. Copayments commonly ranged from $15 to $25. Copayments for physician office visits often varied by type of doctor. The copayment rate for a specialist was recorded instead of the copayment rate for a primary care physician unless the plan stated otherwise or indicated that the obstetrician-gynecologist medical specialist was considered a primary care physician. The copayment estimates for this service represent a mix of primary care physician and specialist copayment rates.

The plan documents also included information on other separate limits; however this information was not weighted to create estimates. Other separate limits for gynecological exams and services commonly included a limit on the number of exams per year (one per year was most common), a dollar limit on the covered costs for the exam, and higher coinsurance rates than paid by the plan (100 percent was common).

When plan documents for fee-for-service and health maintenance organization plans mentioned gynecological exams and services, coverage provisions were somewhat similar. If the benefit was mentioned in the plan, both types of plans almost always provided coverage. Regardless of plan type, 9 in 10 of those covered had limits on these services (56 percent out of 60 percent). However, the use of plan limits was far more common in fee-for-service plans (49 percent out of 62 percent) than in health maintenance organizations (28 percent out of 52 percent).

Table 4 summarizes the plan provisions for gynecological exams and services:

Table 4. Gynecological Exams and Services: Type of coverage, private industry workers, National Compensation Survey, 2009
(All workers participating in medical care plans = 100 percent)

Benefit coverage	All plans	Fee-for-service	Health maintenance organizations
Existence of Coverage:			
With coverage	60	62	52
Without coverage	—	—	—
Not mentioned in plan documents	40	38	48
Extent of Coverage (1):			
Covered in full	—	—	—
Subject to limits	56	58	47
Not mentioned in plan documents	—	—	—
Limits on Coverage (2):			
Subject to plan limits	44	49	28
Subject to separate limits	51	53	45
With a copayment per visit	33	31	39
Copayment at 10th percentile	$10	—	$10
Copayment at 25th percentile	$15	—	$15
Copayment at 50th percentile (median)	$20	—	$20
Copayment at 75th percentile	$25	—	$30
Copayment at 90th percentile	$35	—	$40
Not mentioned in plan documents	—	—	—

Footnotes:
(1) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Extent of Coverage" may not equal the "With coverage" value due to rounding and suppression of data that do not meet publication criteria.
(2) All data other than dollar amounts are presented as a percent of workers participating in medical plans. The sum of individual items under "Limits on Coverage" may not equal the "Subject to limits" value due to rounding, suppression of data that do not meet publication criteria, and the fact that some plans may impose more than one limit.

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The third article in this three-part series will discuss data on health benefits involving chronic illness, care for limited mobility, and rehabilitation and related services. These benefits include diabetes care management, kidney dialysis, physical therapy, durable medical equipment, prosthetics, and organ and tissue transplantation. It will be published in an upcoming issue of *Compensation and Working Conditions Online*.

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End Notes

1 The first of the three articles is Paul A. Welcher, “In Case of Emergency: New Data on Medical Benefits,” *CWC Online*, April 15, 2011, available on the Internet at http://www.bls.gov/opub/cwc/cm20110325ar01p1.htm. The third article is forthcoming. For a more comprehensive recent study of these data, see Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services, April 15, 2011, available on the Internet at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

2 The NCS is an establishment-based national survey that provides comprehensive measures of employee compensation and detailed provisions of employee health benefit plans. Data are collected and published annually.

3 The 12 additional benefits come from the same sample that yielded estimates for the publication *National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009*, Bulletin 2749 (Bureau of Labor Statistics, July 2010), available on the Internet at http://www.bls.gov/ncs/ebs/detailedprovisions/2009/ebbl0045.pdf. For a more complete description of the NCS scope and methods, see *BLS Handbook of Methods*, Chapter 8, “National Compensation Measures,” on the Internet at http://www.bls.gov/opub/hom/pdf/homch8.pdf.

4 For standard errors of the 12 additional benefits see the Technical note of “Report from the Department of Labor to the Department of Health and Human Services,” April 15, 2011, available online at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf.

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