Function First: Medical Benefits to Manage Chronic Disease or Aid Recovery

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This article is the third 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 benefits for organ and tissue transplantation, physical therapy, durable medical equipment, prosthetics, diabetes care management, and kidney dialysis.

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, 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 services for emergencies, emergency room visits, and ambulance services; the second article focused on selected benefits related to reproductive health care: maternity care, infertility treatment, sterilization, and gynecological exams and services. The third article presents data on medical benefits for organ and tissue transplantation, physical therapy, durable medical equipment, prosthetics, diabetes care management, and kidney dialysis.

Organ And Tissue Transplantation

Organ and tissue transplantation are medical procedures by which human organs or tissues are transferred from a donor to a recipient. To be included in the data for this survey, transplantation surgery for a major body organ, such as the kidney, liver, or heart, must not have been mentioned among the plan exclusions. Coverage was recorded for the organ or tissue recipient, not the donor.

Organ and tissue transplantation normally proceeds through several stages and takes place in more than one setting. Consultation and diagnosis may occur at a doctors office or transplantation center. Evaluation typically occurs at a transplantation center. After a suitable organ or suitable tissues have been located and matched to the patient, surgery generally occurs at a hospital or surgical center. The final stages, recovery, and follow-up examinations, can also occur in different settings. As a result, the survey recorded the coverage provided for the surgical procedure. When organ and tissue transplantation services were covered more generously (that is, at a lower cost to the patient) at a designated transplantation center, these more generous provisions were recorded.

As can be seen in table 1, organ and tissue transplantation was mentioned in plan documents for 45 percent of participants in medical care plans, but in plans in which this benefit was mentioned, nearly all participants were provided coverage. In the plans with coverage, limits applied to 7 in 8 participants (39 percent out of 45 percent). The remaining participants were evenly divided (3 percent each) between plans with full coverage and plans for which the extent of coverage was not mentioned. When there were limits, the plan limits were about twice as prevalent as separate limits (32 percent compared with 17 percent). 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 to a group of benefits. The most prevalent separate limit appearing in the survey was a copayment. A review of plan documents revealed that the other common forms of separate limits were dollar maximums (for each transplantation, or per year or lifetime, or for organ or tissue procurement), higher coinsurance rates (particularly if the transplantation was done in a designated transplantation facility), and copayments for physician office visits.

Both fee-for-service and health maintenance organization plans almost always provided coverage for organ and tissue transplantation *when mentioned in plan documents*. However, limits on the coverage differed between these types of plans. A

higher percent of fee-for-service participants were in plans that imposed limits (44 percent out of 48 percent) than of health maintenance organization participants (18 percent out of 31 percent). In fee-for-service plans imposing limits, the plan limits were far more common than separate limits (37 percent compared with 18 percent, respectively). In health maintenance organizations, about equal percentages of participants had coverage subject to the plan limits and separate limits (11 percent and 10 percent, respectively).

Table 1 summarizes the coverage and limits on coverage for organ and tissue transplantation.

Table 1. Organ and tissue transplantation: 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	45	48	31
Without coverage	—	—	—
Not mentioned in plan documents	55	51	69
Extent of coverage (1):			
Covered in full	3	—	7
Subject to limits	39	44	18
Not mentioned in plan documents	3	—	7
Limits on coverage (2):			
Subject to plan limits	32	37	11
Subject to separate limits	17	18	10
Not mentioned in plan documents	4	4	—

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 because of rounding and suppression of data that do not meet publication criteria.
(2) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Limits on coverage" may not equal the "Subject to limits" value because of 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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see “National Compensation Survey: Glossary of Employee Benefit Terms,” available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Physical Therapy

Physical therapy is defined as services to restore natural movement to the body, relieve pain, and prevent further injury. Physical therapy can occur in several settings, such as doctors offices, outpatient hospital departments, inpatient facilities, therapy centers, patients homes, and nursing facilities. For this survey, provisions for hospital inpatient facilities were not recorded. If plan provisions differed for other locations, the most generous provision (that is, the provision with the least cost to the patient) was recorded.

Physical therapy was mentioned in plan documents for 7 in 10 medical plan participants. In plans in which this benefit was mentioned, nearly all plan participants were covered. Nearly all participants who had access to this benefit were in plans imposing limits, most commonly both the plan limits and limits applying separately to physical therapy. About half of the participants in plans imposing separate limits (29 percent out of 55 percent) were required to make a copayment per visit or therapy session. Copayments generally ranged from $10 to $40, and the median was $20.

About 1 in 3 participants (22 percent out of 69 percent with physical therapy coverage) in fee-for-service plans was required to make copayments, while the large majority of health maintenance organization participants (55 percent out of the 72 percent covered) had a copayment requirement. However, the amounts of the copayments were similar between the two types of plans.

A review of plan documents revealed that many plans covering physical therapy also limit the number of paid days or visits per year. Common examples of annual limits were 20, 30, or 60 days or visits. Less frequently observed were provisions such as day or visit limits per illness or condition, or maximum dollar amounts payable per year.

Table 2 summarizes coverage for physical therapy.

Table 2. Physical therapy: 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	70	69	72
Without coverage	—	—	—
Not mentioned in plan documents	30	31	28
Extent of coverage (1):			
Covered in full	—	—	—
Subject to limits	68	68	69
Not mentioned in plan documents	—	—	—
Limits on coverage (2):			
Subject to plan limits	56	59	43
Subject to separate limits	55	51	67
With a copayment per visit	29	22	55
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	$35	$40
Not mentioned in plan documents	—	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 because of rounding and suppression of data that do not meet publication criteria.
(2) All data except dollar amounts are presented as a percent of workers participating in medical care plans. The sum of individual items under "Limits on coverage" may not equal the "Subject to limits" value because of 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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see “National Compensation Survey: Glossary of Employee Benefit Terms,” available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Durable Medical Equipment

This benefit was defined as the purchase or rental of equipment or therapeutic supplies to treat medical conditions or improve physical mobility. Examples include oxygen tents, wheelchairs, crutches, canes, walkers, circulatory aids, glucose monitors,

cervical collars, and special therapeutic shoes. Provisions for durable medical equipment were described in plan documents for 2 out of 3 medical plan participants. In nearly all plans that mentioned durable medical equipment, participants were covered for the purchase or rental of the equipment.

Most covered participants were in plans that imposed limits on this benefit. Overall, about 3 in 4 were in plans covering this benefit subject to plan limits (51 percent out of 67 percent of participants with durable medical equipment coverage). About 1 in 3 was in plans that imposed separate limits (24 percent out of 67 percent). For participants in fee-for-service plans, the limits were most often the plan limits only, whereas health maintenance organization participants often had separate limits as well as plan limits.

A review of plan documents revealed that the commonly observed separate limits were dollar maximums per year on the amount of durable medical equipment that the plan would pay. Limits of $2,500 or $5,000 per year were the most commonly observed maximums. Examples of other types of dollar limits, such as lifetime dollar maximums and dollar maximums per item of equipment, were much less common. Copayments were rarely imposed.

Table 3 summarizes the coverage for durable medical equipment.

Table 3. Durable medical equipment: 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	67	66	67
Without coverage	—	—	—
Not mentioned in plan documents	33	33	33
Extent of coverage (1):			
Covered in full	7	4	—
Subject to limits	57	61	45
Not mentioned in plan documents	2	2	—
Limits on coverage (2):			
Subject to plan limits	51	56	32
Subject to separate limits	24	21	36
Not mentioned in plan documents	2	3	—

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 because of rounding and suppression of data that do not meet publication criteria.
(2) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Limits on coverage" may not equal the "Subject to limits" value because of 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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see “National Compensation Survey: Glossary of Employee Benefit Terms,” available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Prosthetics

Prosthetics, or prostheses, are defined as artificial limbs or replacement devices necessitated by loss or impairment of part of the body. Provisions for prosthetics were mentioned in plan documents for 46 percent of the medical plan participants. When mentioned, prosthetics were nearly always covered by the plan.

In fee-for-service plans, most covered participants, 44 percent out of 49 percent, had limits on the coverage. Out of 35 percent of health maintenance organization participants covered for prosthetics, 21 percent were in plans imposing limits. Participants in fee-for-service plans were more likely to have coverage subject to plan limits than to separate limits (41 compared with 11 percent), whereas health maintenance organization participants were equally as likely to have separate limits as plan limits (both 14 percent).

A review of plan documents showed that, among the plans with separate limits for prosthetics, the most common limits were annual dollar ceilings on plan payments. As with durable medical equipment, dollar caps of $2,500 and $5,000 were common. Lifetime dollar maximums were relatively uncommon, as were other types of dollar limits such as those imposed per item. Copayments were infrequently observed.

Plan documents sometimes mentioned orthotics when describing the coverage of prosthetics. Orthotics are commonly defined as supplies or equipment that support or correct the function of a limb or torso. However, coverage of orthotics alone did not meet the survey definition of prosthetics. Sometimes separate limits such as annual dollar maximums applied to both prosthetics and orthotics. In these cases, the limits were recorded for prosthetics.

Table 4 summarizes the coverage for prosthetics.

Table 4. Prosthetics: 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	46	49	35
Without coverage	—	—	—
Not mentioned in plan documents	54	51	65
Extent of coverage (1):			
Covered in full	5	—	—
Subject to limits	39	44	21
Not mentioned in plan documents	2	—	—
Limits on coverage (2):			
Subject to plan limits	35	41	14
Subject to separate limits	12	11	14
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 because of rounding and suppression of data that do not meet publication criteria.
(2) All data are presented as a percent of workers participating in medical care plans. The sum of individual items under "Limits on coverage" may not equal the "Subject to limits" value because of 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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see “National Compensation Survey: Glossary of Employee Benefit Terms,” available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Diabetes Care Management And Kidney Dialysis

Benefits for diabetes care management and kidney dialysis were seldom mentioned in the plan documents, with only about 1 in 4 medical plan participants in plans in which they were mentioned. The data on employee benefits are collected as part of a voluntary survey, and obtaining accurate information on the specific details can sometimes be difficult. When the plan

documents do not mention these benefits, it does not necessarily mean that the benefits are not provided, but it does limit the possibilities for producing data that meet the appropriate criteria for confidentiality and reliability.

Diabetes care management. This service helps educate patients on how to manage their illness. For the purpose of this study, coverage for insulin and other diabetic supplies (e.g., test strips and needles) was not included under this benefit because these supplies are usually included under prescription drug plans.

As shown in table 5, diabetes care management was not mentioned in the plan for 73 percent of the medical care participants. Nearly all of the remaining 27 percent of medical care participants were in plans in which some form of coverage for diabetes care was provided.

Eighty-three percent of participants in health maintenance organizations had plans that did not mention diabetes care management, compared with 70 percent of participants in fee-for-service plans. However, for those participants with either type of plan, if diabetes care management was mentioned in the plan documents, they almost always had coverage.

Table 5. Diabetes care management: 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	30	17
Without coverage	—	—	—
Not mentioned in plan documents	73	70	83

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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see "National Compensation Survey: Glossary of Employee Benefit Terms," available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

Kidney dialysis. Also called renal dialysis or hemodialysis, kidney dialysis is the treatment of an acute or chronic kidney ailment by dialysis methods. Kidney dialysis can take place in a variety of locations, including hospitals, doctors offices, and outpatient centers. Plan coverage of home dialysis equipment did not meet the survey definition of kidney dialysis.

As can be seen in table 6, kidney dialysis was not mentioned in plan documents for 73 percent of medical plan participants. In plans in which this benefit was mentioned, nearly all participants were covered for dialysis treatment.

Table 6. Kidney dialysis: 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	30	19
Without coverage	—	—	—
Not mentioned in plan documents	73	70	81

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, available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf. For definitions of terms, see "National Compensation Survey: Glossary of Employee Benefit Terms," available at http://www.bls.gov/ncs/ebs/glossary20092010.htm.

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Notes

1 The first of the three articles—all by Paul A. Welcher—is “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 second article is “Fertile Ground: New Data on Reproductive Health Benefits,” *CWC Online*, June 29, 2011, available at http://www.bls.gov/opub/cwc/cm20110621ar01p1.htm. 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 National Compensation Survey (NCS) is an establishment-based national survey that provides comprehensive measures of employee compensation and detailed provisions of employee health benefit plans. For more information, see the NCS page on the BLS website at http://www.bls.gov/ncs/. For a complete description of the NCS scope and methods, see *BLS Handbook of Methods*, Chapter 8, “National Compensation Measures,” available on the Internet at http://www.bls.gov/opub/hom/pdf/homch8.pdf.

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.