Alternatives to hospital care under employee benefit plans

As hospital costs rise, employer-provided health care plans are offering increased coverage for alternative care, such as skilled nursing services, home health care, and hospice care

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The sharp rise in hospital room and board costs, nearly 3 times the general inflation rate during the 1980's, has heightened interest in lower cost alternatives to hospitalization. Although in existence earlier, skilled nursing care facilities, home health care organizations, and hospices became considerably more prominent features of the health care scene during the 1980's. Reflecting this development, coverage for these alternatives has become a prevalent feature in employer-sponsored health care plans.

In 1979, the first year for which Bureau of Labor Statistics data are available, 54 percent of all participants in medical care plans in medium and large establishments had coverage for skilled nursing care benefits. (See chart 1.) By 1989, the proportion had grown to 80 percent. Similarly, the incidence of coverage for home health care services increased from 37 percent of participants in health care plans in 1983 to 75 percent in 1989; for hospice care, coverage rose from 11 percent of participants in 1984 to 42 percent in 1989.[1]

Most provisions for alternative care benefits limit the extent of care that will be financed by the plan. Restrictions may be in the form of limits on number of days of care or on dollar benefits, or requirements for partial payments by covered individuals. For example, a traditional fee-for-service medical care plan[2] may cover skilled nursing care for 60 days during each confinement.

This article focuses on skilled nursing care, home health care, and hospice care provisions in employer-provided health care plans. In addition, long-term care insurance, a related benefit, is considered briefly. Data for the analysis are from the Bureau's Employee Benefits Survey, an annual study of the incidence and characteristics of employee benefits. The majority of data in the article is from the 1989 survey of benefits for full-time employees in medium and large private establishments. The survey provides representative data for 32 million employees in 109,000 establishments employing 100 workers or more in private nonfarm industries.[3]

Rising hospitalization costs

Rapidly rising expenses associated with spells of hospitalization undoubtedly have been a major spur to the growth of alternative health care facilities. The average cost for a day of hospital care increased from $256 in 1980 to $691 in 1989,[4] according to the American Hospital Association.

From a different perspective, hospital expenses are the single largest component of health care outlays; 44 percent of all personal health care expenditures in the United States in 1988 were for hospital care, totaling $232.8 billion.[5] And total health care costs continue to increase, in part because of the rising price of hospital and related services. From 1979 to 1989, the hospital care component of the Consumer Price Index for

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All Urban Consumers (CPI-U) increased 162 percent, compared with a 119-percent increase for all medical care products and services.[6] During that same period, the CPI for all goods and services rose 64 percent. Increases in hospital costs, however, also reflect the introduction of new and expensive treatments for many illnesses.

Alternative care

There are now many facilities, agencies, and services that are available as alternatives to hospitals. Each type meets a specific medical care need and employs professionals to provide its services. But in all instances, the medical care rendered at these facilities or in home settings is less costly than hospitalization.

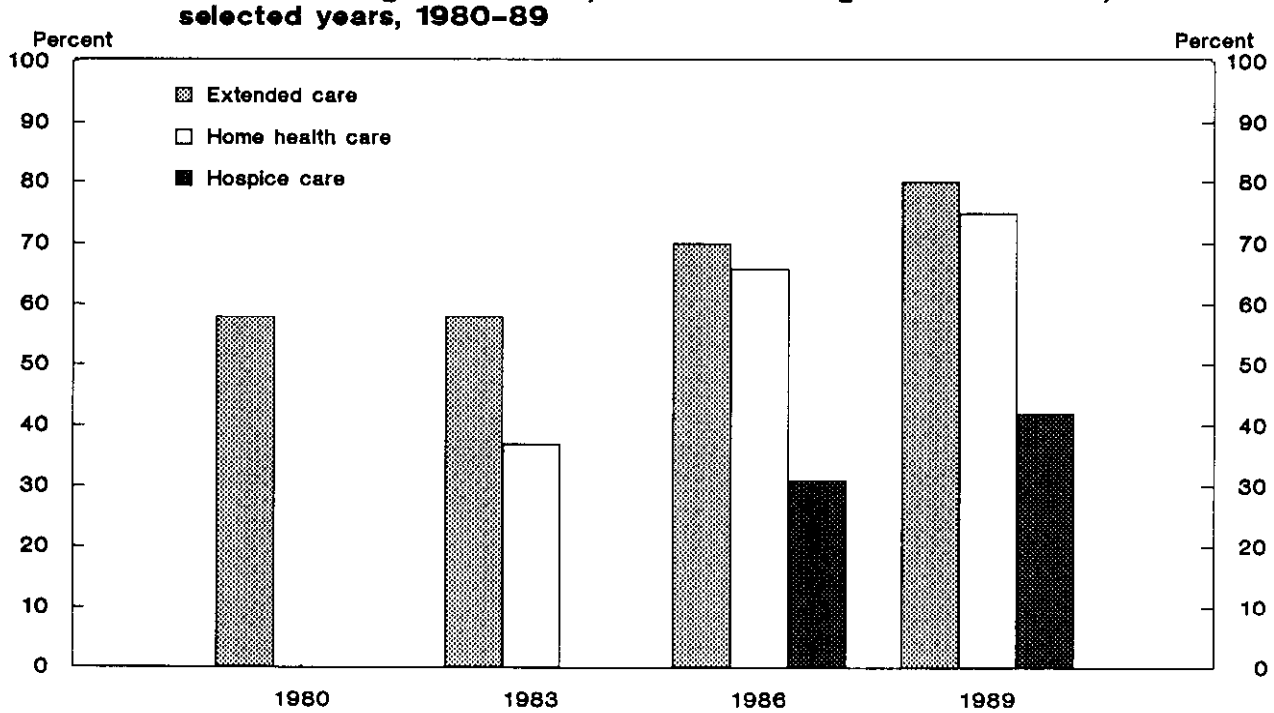
Among alternatives to hospitalization are skilled nursing care facilities, home health care, and hospices. Skilled nursing care facilities provide inpatient skilled nursing and 24-hour nursing services sufficient to meet the needs of individuals not requiring the acute level of care provided by a hospital. A skilled nursing care facility, which can be either a freestanding institution or part of a hospital, provides an intermediate level of care when acute care is no longer necessary, until the maximum possible level of recovery is reached. This intermediate level of care differs from long-term care, which generally provides custodial care for indefinite periods. (See the appendix for a discussion of the characteristics of long-term care.)

Home health care provides medical products and services to patients in their homes. Such care is typically provided by a Home Health Agency or by others under arrangements made by a Home Health Agency.[7] It furnishes professional nursing services, home health aid services, medical supplies, equipment, and appliances suitable for use in the home. Like skilled nursing care services, home health care is intended to provide an intermediate level of care until a patient's condition or illness is stabilized.

The hospice is an alternative for terminally ill individuals, stressing palliative care[8] as opposed to curative or restorative care. Hospice care focuses upon the patient and his or her family as the unit of care. Supportive services are offered to the family before and after the death of the patient. This type of care addresses the physical, social, psychological, and spiritual needs of the patient.

Hospice care is typically provided under active physician and nursing management through a State-licensed Hospice Agency, which is re-

Chart 1. **Percent of full-time participants in medical plans with coverage for selected categories of care, medium and large establishments, selected years, 1980-89**



NOTE: Data were first tabulated for home health care in 1983 and for hospice care in 1984 (when 11 percent of medical care plan participants had this coverage).

sponsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. The care is provided in a health care plan member's home or on an inpatient basis in a licensed health care facility.

These alternatives to hospitalization typically cost less per day than inpatient care in a general hospital. In 1985, the average cost for a day of hospital care was $460,[9] while the average monthly charges in skilled nursing facilities were $1,905 (which translates into $63 per day),[10] or approximately 14 percent of the hospital's daily cost. Although utilization data are scarce for the home health care industry, medicare reports indicate that costs for this care are similar to or less than those for skilled nursing care services.

Growth in the use of these facilities has been dramatic in recent years. For example, between 1976 and 1986, the number of available nursing home beds rose by 25 percent.[11] In addition, the share of health service employment accounted for by nursing and personal care facilities increased from 12 percent in 1970 to nearly 17 percent in 1988. Over the same period, hospital personnel, as a proportion of all health service

Exhibit 1. **Typical medical care services by source of care, 1989**

Whether a particular medical care service is provided can vary depending upon where a patient is treated. The following illustrates, by source of care, typical goods, services, and providers that are included or excluded:

Services	Hospital	Skilled nursing care	Home health care	Hospice care
Bed and board, including special diets and general nursing care	Included	Included	Excluded	Included
Intensive Care Unit and Cardiac Unit	Included	Excluded	Excluded	Excluded
Use of operating, delivery, recovery, and other specialty service rooms	Included	Excluded	Excluded	Excluded
Casts, surgical dressings and supplies	Included	Included	Varies	Varies
All drugs and medications for inpatient care commercially available to hospitals	Included	Included	Varies	Included
Physical, occupational, or speech therapy	Included	Included	Included	Included
Radiation therapy, chemotherapy, and oxygen therapy	Included	Included	Excluded	Varies
Rental or purchase of durable medical equipment	Not applicable	Included	Included	Included
Laboratory and x-ray examinations	Included	Included	Varies[1]	Included
Mental health, alcohol abuse, or drug abuse care	Included	Excluded	Excluded	Excluded
Physician for consultant or case management only	Not applicable	Included	Included	Included
Physician care	Included	Excluded	Excluded	Included
Private duty nursing	Included	Excluded	Excluded	Included
Registered nurse or health aide	Included	Included	Included	Included
Social worker	Included	Varies	Varies	Included
Psychological and dietary counseling	Included	Included	Varies	Included
Custodial care[2]	Excluded	Excluded	Excluded	Excluded
Caretaker services or respite care[3]	Excluded	Excluded	Excluded	Varies
Household member's service[4]	Excluded	Excluded	Excluded	Excluded

[1] Laboratory services by a hospital are usually covered if they also would have been covered if the patient had remained in the hospital.

[2] Any type of service that is designed essentially to assist an individual, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medication that can normally be self-administered.

[3] Caretaker service provides care not solely related to the care of the person. It includes: sitter or companion services for either the person who is ill or other family members; housecleaning; transportation; and maintenance of the house. Respite care provides temporary relief for the member's family from the daily demands of care for the member.

[4] Any service or supply provided by an immediate relative or a person who is ordinarily a member of the patient's household. "Immediate relative" includes spouse, parent, child, and brother or sister, by blood, marriage, or adoption.

workers, decreased almost 19 percent.[12] In many cases, these alternative facilities provide the same services as hospitals. In addition, they often overlap each other in terms of the types of services provided. Exhibit 1 presents an overview of the services typically available in hospitals and in several hospital alternatives.

Plan coverage for alternatives

Employer-provided medical care plans regularly cover hospital room and board charges. In general, coverage for such charges is furnished with fewer restrictions than is coverage for care at alternative sites. However, some plans do provide incentives to use alternatives, such as lower deductibles or lower coinsurance rates than those required for hospital stays. For example, a plan may require a 20-percent coinsurance payment for hospital room and board, but only a 10-percent coinsurance payment for care in a skilled nursing facility.[13]

Table 1. **Percent of full-time participants in medical plans with skilled nursing care coverage by limitations imposed, medium and large establishments, 1989**

Limits on coverage	Health maintenance organization	Fee-for-service plan
Total	100	100
With limitations	66	97
Directed specifically at skilled nursing care	65	77
Limit on dollars[1]	([2])	10
Percent of hospital charges	—	18
Separate copayment or deductible	([2])	([2])
Separate coinsurance rate	([2])	4
Day limitations	65	70
Per year	50	22
Fewer than 60 days	6	2
60 to 99 days	6	8
100 days	34	6
101 days or more	5	6
Per confinement	14	43
Fewer than 60 days	3	2
60 to 99 days	2	16
100 days	4	2
101 to 125 days	2	10
126 days or more	3	12
Per lifetime	1	2
Hospital room and board related[3]	([2])	9
Other limitations	([2])	1
Overall limitations	2	82
Without limitations	34	3

[1] May include limit on dollars per day, per confinement, per year, or per lifetime.

[2] Less than 0.5 percent.

[3] Days available are a proportion of unused hospital days. For example, a medical plan may provide 2 days of skilled nursing care for every 1 day of unused hospital room and board coverage.

NOTE: Sums of individual items may be greater than total because some employees are covered by more than one type of limitation on benefits. Dash indicates that no workers were covered under this provision.

In 1989, 92 percent of all full-time employees in medium and large private establishments were provided medical care benefits. A majority of these participants—82 percent—were covered for skilled nursing care, and 76 percent had coverage for home health care. Hospice care for the terminally ill was available to 43 percent of medical plan participants.[14]

In 1987, similar findings on the incidence of employee coverage for alternatives to hospitalization were noted in the Bureau's survey of benefits in State and local governments. Ninety-three percent of all full-time employees in State and local governments were provided medical care benefits. Skilled nursing care was available to 78 percent and home health care to 76 percent of plan participants, while hospice care was available to 26 percent.

Incidence of coverage of hospital alternatives in medium and large establishments in the private nonfarm sector varied between traditional fee-for-service medical care plans and health maintenance organizations (HMO's).[15]

Virtually all HMO participants were provided home health care services in 1989, while 72 percent of fee-for-service plan participants had such coverage. Ninety-three percent of HMO participants had skilled nursing care provisions, compared with 80 percent of traditional plan participants. Conversely, hospice care coverage was more common in fee-for-service plans, with 45 percent of participants covered; in HMO's, 30 percent of participants were covered.

Some medical care plans provide skilled nursing care and home health care coverage only to a patient who was previously hospitalized and is recovering without need of the extensive care provided by a hospital. Such a prerequisite ensures that a patient is indeed ill and does require an intermediate level of care. Forty-five percent of participants in traditional medical plans with skilled nursing care coverage were required to have had prior hospitalization; 19 percent of the participants with home health care coverage were subject to this requirement. Hospital prerequisites were more common in fee-for-service plans; virtually no HMO participants had hospitalization requirements for skilled nursing care or home health care. To satisfy the hospital prerequisite, a patient typically must have been hospitalized for the same condition or illness for 1 to 3 days.

Limitations on coverage

Fee-for-service medical care plans also differed from HMO's in the number and types of limitations they placed on coverage of hospital alternatives. The tabulation below shows that tradi-

tional plans offering such coverage were much less likely than HMO's to cover the costs in full:

	Percent of plan participants covered for—		
	Skilled nursing care	*Home health care*	*Hospice care*
Covered in full:			
All plans	9	26	21
HMO's	34	87	88
Fee-for-service	3	9	12
Subject to limitations:			
All plans	91	73	79
HMO's	66	13	12
Fee-for-service	97	90	88

For purposes of the Employee Benefits Survey, a service was considered covered in full if the medical plan provided full payment up to the usual, customary, and reasonable charge (UCR) for the service. The UCR is a rate that is 1) not more than the provider's usual charge; 2) within the customary range of fees in the locality; and 3) reasonable, considering the circumstances. A service was considered fully covered even if the plan required that the patient have been previously hospitalized for the same illness or condition. Restrictions on service coverage ranged from overall limitations on plan benefits, such as deductibles and coinsurance requirements, to limitations applying specifically to the type of alternative care, including ceilings on the number of days of coverage; maximum dollar payments by the plan; requirements for coinsurance payments by the patient; and separate deductibles or copayments (nominal fees) for the given type of care.

Skilled nursing care. Nearly all participants in fee-for-service plans had limits on their skilled nursing care coverage in 1989, while 2 in 3 HMO plan participants had such limits. The most common restrictions on skilled nursing care coverage found in fee-for-service plans were overall limitations. Eighty-two percent of traditional plan participants with skilled nursing care coverage faced such restrictions. Under HMO plans, however, this type of restriction was rare. (See table 1.)

Another common limitation restricted the number of days of skilled nursing care coverage. Among employees with such coverage, 65 percent of HMO participants and 70 percent of traditional plan participants had day limits. HMO participants usually were limited to 100 days of coverage per year, while fee-for-service participants most often received between 60 and 125 days of coverage per confinement. Day limits under fee-for-service plans typically were applied in conjunction with other restrictions. For example, a plan might pay 80 percent of the cost of skilled nursing care for 120 days per confinement, after an overall plan deductible is met.

Nearly 10 percent of participants in fee-for-service plans had day limitations that were related to hospital room and board day limits. Typically, 2 days of skilled nursing care coverage were provided for every day of unused hospital coverage, where hospitalization coverage was usually provided for 365 days per confinement. HMO participants seldom had this limitation, because HMO's do not set limits on days of hospitalization benefits.

Traditional plan participants were more likely than HMO participants to be subject to dollar limitations on payments or coinsurance requirements. A dollar payment limit set a maximum amount that the plan will pay for covered services within a given period.[16] A separate coinsurance feature, imposed on 4 percent of traditional plan participants with skilled nursing care coverage, requires the patient to pay a portion of covered expenses, most often 20 percent.

Home health care. Home health care services were provided in full to 87 percent of HMO plan

Table 2. **Percent of full-time participants in medical plans with home health care coverage by limitations imposed, medium and large establishments, 1989**

Limits on coverage	Health maintenance organization	Fee-for-service plan
Total	100	100
With limitations	13	90
Directed specifically at home health care	11	61
Limit on dollars[1]	([2])	8
Separate copayment or deductible	4	1
Coinsurance limitations	3	3
Day limitations	4	59
Per year	4	48
Fewer than 60 days	1	13
60 to 99 days	1	9
100 days	2	15
101 days or more	([2])	12
Per confinement	([2])	7
Per lifetime	—	([2])
Hospital room and board related[3]	([2])	4
Other limitations	—	([2])
Overall limitations	3	77
Without limitations	87	10

[1] May include limit on dollars per day, per confinement, per year, or per lifetime.

[2] Less than 0.5 percent.

[3] Days available are a proportion of unused hospital days. For example, a medical plan may provide 2 days of skilled nursing care for every 1 day of unused hospital room and board coverage.

NOTE: Sums of individual items may be greater than total because some employees are covered by more than one type of limitation on benefits. Dash indicates that no workers were covered under this provision.

Table 3. **Percent of full-time participants in medical plans with hospice coverage by limitations imposed, medium and large establishments, 1989**

Limits on coverage	Health maintenance organization	Fee-for-service plan
Total	100	100
With limitations	12	88
Directed specifically at hospice care	12	53
Limit on dollars[1]	2	37
Per year	([2])	([2])
Per lifetime	2	34
Coinsurance limitations	([2])	1
Day limitations	8	21
Per year	2	2
Per lifetime	6	19
Other limitations	2	1
Overall limitations	([2])	69
Without limitations	88	12

[1] May include limit on dollars per day, per confinement, per year, or per lifetime.
[2] Less than 0.5 percent.

NOTE: Sums of individual items may be greater than total because some employees are covered by more than one type of limitation on benefits.

participants. This largely reflects a requirement of the Health Maintenance Organization Act of 1973 that federally qualified organizations provide unrestricted home health care services as part of a package of basic health services.[17] Most HMO plans studied in 1989 were federally qualified.[18]

Participants in traditional plans often had some restriction placed on coverage for home health care services. (See table 2.) Overall limitations, previously discribed, were imposed on 77 percent of participants. Fifty-nine percent of participants had day limitations imposed, typically in conjunction with overall limitations. Under such restrictions, coverage was often limited to between 60 and 100 days per year. (A day of home health care service is usually a 4-hour session.) Another 7 percent of participants had restrictions on number of days of coverage per illness. Eight percent of traditional plan participants were restricted by dollar limits and 3 percent had coinsurance requirements.

Hospice care. Hospice care, when provided, was covered without restrictions for 7 in 8 HMO participants. When restrictions applied, HMO participants were usually limited to a specified number of days of care, usually over a lifetime. In contrast, 7 in 8 participants in traditional plans with hospice care had some type of restriction. The majority of these participants (69 percent) were subject to overall plan deductible and coinsurance requirements. Restrictions imposed strictly on hospice coverage usually limited the number of days or amount of dollar payments during a lifetime. (See table 3.)

CONCERNS OVER RISING hospital costs have engendered a response by the health care industry. Today a variety of alternatives to hospital care are provided in specialized facilities and in the home. The Bureau's Employee Benefits Survey has expanded the available data on skilled nursing care, home health care, and hospice care in response to increased public interest. These data provide a background for future debates on lower cost alternatives to hospital care. □

Footnotes

[1] The Bureau's analysis of home health care services and hospice care began in 1983 and 1984, respectively.

[2] Under such a plan, an individual seeks treatment from his or her own provider, after which the benefit plan reimburses the provider or the patient.

[3] In addition to medical care benefits, the Employee Benefits Survey provides data on life and disability insurance, retirement and capital accumulation plans, paid and unpaid leave, and other benefits. The results of the survey are available in *Employee Benefits in Medium and Large Firms, 1989*, Bulletin 2363 (Bureau of Labor Statistics, 1990). Benefit data for State and local governments are available in *Employee Benefits in State and Local Governments, 1987*, Bulletin 2309 (Bureau of Labor Statistics, 1988). In these bulletins, data are presented separately by occupational groups. For this article, data are not presented separately by occupational groups because no significant differences among the groups were found.

[4] *National Hospital Panel Survey Reports* (Chicago), monthly issues for January 1980–December 1989. In addition, see *Health Care Financing Review* (U.S Department of Health and Human Services, Health Care Financing Administration), Summer 1990, table 1.

[5] Source is Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates. See *Health Care Financing Review*, Winter 1990, table 1.

[6] See *CPI Detailed Report* (Bureau of Labor Statistics, December 1990).

[7] A Home Health Agency is a licensed organization providing skilled nursing and other therapeutic services in a patient's home. The agency may be 1) hospital based, 2) skilled nursing facility based, or 3) a freestanding home health agency.

[8] Medical care performed to make the symptoms of a patient's condition or illness less severe and more bearable.

[9] See *Health United States 1989*, PHS 90-1232 (U.S. Department of Health and Human Services, U.S. Public Health Service, National Center for Health Statistics, 1990), table 108.

[10] See *Health United States 1989*, table 113.

[11] Nursing homes, as defined by the U.S. Department of Health and Human Services, include skilled nursing facilities and personal care homes with or without nursing care. For further information, see *Health United States 1989*, table 99.

[12] In 1988, hospital personnel represented 51.5 percent of all health service personnel, down from 63.4 percent in 1970. See *Health United States 1989*, table 83.

[13] Coinsurance is a percentage of covered expenses beyond the deductible paid by the individual; a deductible is the amount of covered expenses that an individual must pay before any charges are paid by the health care plan.

[14] These percentages reflect, in part, requirements of many States that health insurance policies include coverage for care in hospital alternatives. For more details on such requirements, see "Provisions concerning outpatient coverage of State-mandated benefits," *Spencer Research Reports*, March 1986, pp. 325.2–.3.

[15] An HMO is a health care plan that provides a wide range of comprehensive health care services to subscribers and dependents on a prepaid basis. A preferred provider organization (PPO) is a newer alternative to traditional health care coverage. It provides coverage on a fee-for-service basis and lowers out-of-pocket expenses of covered individuals if designated hospitals, physicians, or dentists are used. Because participation in PPO's is small, separate data are not available for such plans; instead, data for PPO's are combined with data for fee-for-service plans.

[16] This includes maximum payments that are a percentage of the hospital room and board rate—for example, benefits will not exceed 50 percent of the average room and board rate in the local area.

[17] The act defines "basic health services" to include: 1) physicians' services; 2) inpatient and outpatient hospital services; 3) emergency health services; 4) short-term outpatient mental health services; 5) medical treatment and referral services for the abuse of or addiction to alcohol or drugs; 6) diagnostic laboratory and diagnostic and therapeutic radiologic services; 7) home health services; and 8) preventive health services (including voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

[18] For a closer look at HMO's and other health care benefit providers, see Thomas P. Burke and Rita S. Jain, "Trends in employer-provided health care benefits," *Monthly Labor Review*, February 1991, pp. 24–30.

APPENDIX: Defining and measuring long-term care

Skilled nursing care, discussed in this article, must be distinguished from long-term custodial care, even though both may be provided in similar facilities. Long-term care is health, social, emotional, and/or personal care provided for a period generally longer than 30 days to individuals with functional impairments inhibiting total independent living. It includes all forms of services, both institutional and noninstitutional, that are required by people with chronic health conditions.

Unlike skilled nursing care, which provides care during the period of recovery from illness, injury, or surgery, long-term care generally provides custodial and maintenance services. Such maintenance care is designed to keep the patient's condition at a level to which it has been restored, when no significant practical improvement can be expected.

Considerable debate is currently under way over the financing of long-term care in a nursing facility, which now averages $25,000 to $30,000 a year, and in some areas considerably more. Nursing home care is the largest out-of-pocket medical expenditure for the elderly.[1] To date, only a small number of companies have incorporated coverage for long-term care into their benefits programs. Data from the Employee Benefits Survey reveal that, in 1989, only 3 percent of employees were offered coverage for long-term care. Such coverage typically was offered to employees on a voluntary basis, with employees required to pay the entire premium, but at group rates. Coverage may be available for the employee, a spouse, or a dependent (such as a parent).

Funding for long-term care currently comes primarily from two sources— private out-of-pocket expenditures by individuals and medicaid payments. Medicaid is a welfare-based system that does not provide assistance to individuals until all of their other financial resources have been depleted. The medicaid program accounted for $14.7 billion of the $16.5 billion spent in 1985 by public sources on long-term care, representing 41.8 percent of total nursing home expenditures.[2] Medicare offers payments for post-acute care; it typically provides skilled nursing services when they are needed after a hospital stay of at least 3 days, but it does not provide custodial services.

Regulation and promotion of long-term care insurance by State governments is on the rise. By 1987, 26 States had statutes that 1) regulated long-term care policies, 2) provided incentives for the marketing and purchase of such policies, or 3) established a task force or mandated a study to help advise on future directions for the financing of long-term care.[3] Premium subsidies, income tax breaks, and changes in medicaid eligibility are some of the approaches being explored.

By the year 2030, it is estimated that 8.6 million people, or 2.8 percent of the population, will be over the age of 85, compared with 1 percent of the population in 1980. Between 1990 and 2010, the "age 85 and over" cohort will grow 3 to 4 times as fast as the general population.[4] Based on these projections, the need for long-term care is likely to increase in the future.

Footnotes to the appendix

[1] For a discussion of the issues relating to the private financing of long-term care, see *Report to the Secretary on Private Financing of Long-Term Care for the Elderly* (U.S. Department of Health and Human Services, Health Care Financing Administration, 1986).

[2] Daniel R. Waldo, Katharine R. Levit, and Helen Lazenby, "National Health Expenditures, 1985," *Health Care Financing Review*, Fall 1986, p. 19.

[3] Debra J. Lipson, "Long-Term Care Insurance and Related Financing Mechanisms: Status of State Legislation and Regulation," *Intergovernmental Health Policy Project* (Washington, The George Washington University, July 1987).

[4] See *Fact Sheet on Long-Term Care* (U.S. Department of Health and Human Services, Health Care Financing Administration, 1987).