Trends in Healthcare Payment

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ASCLS and other laboratory groups are alert to trends in Medicare payment, often the largest source of payment for a laboratory or a hospital. Developments in Medicare payment policy, such as competitive bidding, freezes to the Medicare Outpatient Laboratory fee schedule, threats of instituting a co-pay for Medicare beneficiaries, and others, have been the focus of advocacy efforts at the Legislative Symposium and in other campaigns.

Legislators, businesses, and the public remain concerned about the rising cost of healthcare and the growing number of uninsured citizens in the United States. Many proposals have been made to control the rate of increase in healthcare costs. Laboratorians often feel that the laboratory is unfairly singled out for more than a fair or proportionate share of freezes or cuts in reimbursement.

Concern from Congress about Medicare spending on Part B (outpatient) laboratory services stems from a significant increase in total dollars spent for laboratory services, despite the fact that the individual fees for tests have been frozen in 11 of the last 15 years. In the years 1991 and 1998, Medicare spending for laboratory services was $3.6 billion. There was a slight increase to $4.3 billion in 1993 and 1994, then a gradual decrease back to $3.6 billion in 1998. Since 1998, however, there has been an increasingly steep rise in total spending for laboratory services, averaging 8.8% annually, to $6.0 billion in 2004, the latest year for which data is available. (Data from the 2005 Medicare Trustees Report) Despite this growth, laboratory spending is still just 4.4% of Medicare Part B expense, and 2.0% of total Medicare expense.

The reasons for the increase in laboratory expenses are a combination of the aging population swelling the numbers of beneficiaries needing services, and new technology providing additional tests. With these factors and the additional expense to Medicare of the Part D prescription drug benefit, we know that the Medicare program officials will continue to look to the laboratory for cost savings.

But what about other payers? Many of us have already experienced, in our employer-provided plans, the movement toward consumer-directed health plans (CDHPs). CDHPs may take a number of forms, but the common theme is to get away from "first dollar" coverage and place more financial responsibility on the individual.

Health insurance was introduced in the US in the 1930's, and employer-provided health insurance became common during World War II, when wages were frozen and employers offered insurance as additional compensation to attract workers. Utilization of healthcare services increased in the 1950's through 1970's as technology boomed. In the 1980's and 1990's, managed care slowed the growth of healthcare expenditures, but apparently only temporarily. In the 2000's, attention has focused on the contribution of lifestyle-induced chronic diseases to the utilization and expense of healthcare. There is a belief that the cost of employer-provided insurance has made US businesses less competitive in the global marketplace. Many businesses have increased the amount of employee contribution to their insurance premiums, added co-pays and co-insurance, and generally provided plans that place responsibility for more out-of-pocket expenses on the employee.

Congress has facilitated the consumer-driven movement by providing for health reimbursement accounts (HRAs) and health savings accounts (HSAs). The assumption is that the individual will take on more responsibility for healthcare decisions and finances when more expenses are out of pocket. The psychology changes from "use it or lose it" (HRAs) to "use it or keep it" (HSAs).

The consumer-driven movement raises many questions and concerns:

- Do consumers have the necessary knowledge and information to make appropriate choices about their healthcare?

Washington Beat is intended to provide a timely synopsis of activity in the nation's capitol of importance to clinical laboratory practitioners. This section is coordinated jointly by Kathy Hansen, Chair of the ASCLS Government Affairs Committee, and Don Lavanty, ASCLS Legislative Counsel. Direct all inquiries to ASCLS (301) 657-2768 extension 3022; (301) 657-2909 (fax); or mail to ASCLS, 6701 Democracy Blvd., Suite 300, Bethesda MD 20814, Attention: Washington Beat.

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- Will consumers forgo or postpone needed care, and ultimately need more complex and expensive care?
- Will cost reductions or stabilization be permanent?
- Will lower socio-economic groups and less well-educated consumers be unfairly harmed?

While it is too early to be able to answer these questions definitively, early research suggests some interesting trends. A survey from the McKinsey consulting group[1] finds that only 40% of those covered by traditional employer-paid plans ever ask about the cost of any aspect of their care, as contrasted with 64% of those in a CDHP and 70% of the uninsured. Patients are much more likely to ask about the cost of their prescription drugs than about procedures or tests, however. In addition, patients in a CDHP are significantly more likely to consider alternative treatment options, such as those found by doing independent research on the Internet. A majority of patients say that they do not have enough information about quality of care and price to make informed decisions.

So far, only a small percentage of patients admit to forgoing needed care – four percent of those covered by traditional plans versus six percent of those in CDHPs. These individuals cite cost as the primary factor for these decisions to forgo care. CDHP participants are much more likely to choose a less expensive treatment (excluding medications), such as a less expensive home glucose meter for a diabetic patient.

Preliminary data also indicates that CDHP participants are more likely (69% to 55%) to engage in healthier lifestyle behavior (diet, exercise, non-smoking) than those covered by traditional employer plans. If this trend proves to be true over the long term, it is possible that costs of managing chronic illness long-term could indeed be reduced.

CDHP participants are more likely to state that they have annual physicals because it is important for long-term health, whereas those in traditional plans are more likely to say that their reason is because it is covered by their health plan.

Finally, CDHP members with a chronic disease (such as hypertension or diabetes) are more likely to "very carefully" follow treatment regimens than those with traditional insurance. An impressive difference of 51% to 31% is seen in those with hypertension.

Is it true that "you get what you pay for" – that more expensive care is better care? A study published in Health Affairs, February 2002: Dartmouth Atlas examines cost and quality of Medicare services in five metropolitan areas. Total spending varies by over 100% among the five areas studied, with Minneapolis being lowest and Miami highest. Specialist visits vary six-fold. But a measure titled "effective care index" is almost identical in all five.

What will be the impact of all of this on the laboratory? Hospitals and laboratories are already experiencing more difficulty in collecting those patient co-pays and co-insurance amounts from individuals. Despite all the rules involved in billing Medicare and insurance companies, they are still easier to collect from than individuals. For self-pay patients, there will be pressure for "retail" charges to more realistically reflect costs, rather than being marked up to cover discounts taken by insurance companies, as has been common. Hospitals and laboratories are likely to experience more bad debt; this then results in pressure on laboratories and other departments to operate more efficiently.

Laboratories, along with other healthcare providers, will continue to face new challenges in getting paid for the vital services we provide, as pressure continues from both the government payers and from the private payers.

[1] Presented at the Executive War College on Laboratory and Pathology Management; 2006 May; Miami (FL).

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