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MECHANISM FOR PAYMENT FOR SERVICE - HEALTH INSURANCE

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Americans spent close to \$ 200 billion in 1979 on health care. Since 1965, health spending in the United States has risen approximately 12% per year compared to a 9.0% annual growth rate for the economy as a whole. Comprising a substantial part of these health expenditures are clinical laboratory services, amounting to 10% of the health care dollar, and increasing at an annual rate of 15%. If clinical laboratory services continue to grow at this rate, the United States may be spending almost \$ 50 billion on these services alone by 1985.

The responsibility for spiralling health care utilization and cost, especially for those portions represented by laboratory services, is diffuse. A myriad of interrelated factors affect the production, the demand, and the cost of these services. For example:

- rapidly expanding technology,
- attitudes by the public and physicians toward new, ultra-sophisticated technologies,
- physician training, and the desire to have the patient "completely worked up",
- the lack of evidence linking benefits gained by specific laboratory tests for defined patient conditions and problems,
- an aging population which typically requires mere health services,
- increased accessibility to medical care,
- the enormous effect that runaway inflation has had on service industries, and
- malpractice fears which lead to defensive medical practices.

While all of the above causes must be addressed in any national plan to lower health care costs, perhaps the most significant cause for the rise in clinical laboratory costs has been the development of health insurance. Now, health insurers are in the position of trying to control the very inflationary incentives which they helped to create.

During the past three decades, the United States experienced a major change in the way in which hospital services are paid. In 1950, consumers paid 68% of medical bills directly while insurance programmes paid 30% of the total expenditures. Now, those proportions are essentially reversed. By 1980, consumers paid only 29% of costs out-of-pocket. At least 88%

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of the United States population has some form of health insurance; administratively known as third party payment. The two largest third party payers are the Federal Government (through the Medicare and Medicaid programmes which serve our aged, disabled, and poor Americans), and the Blue Cross/Blue Shield plans. Together, these insurance programmes finance more than half of the nation's health expenditure. The arrangement for funding health insurance is prepayment, either through voluntary premiums or, in the case of Medicare and Medicaid, which are mandated programmes, through compulsory contributions from wages and allocations of tax revenues. This widespread use of prepayment has led to an unusual situation where most services are free at the point of consumption; a situation which has had severe cost consequences.

As medical care costs were increasingly covered by third party payers, overall demand and expenditure for health care rose, since the price of services became less of a barrier. Existing incentives to find the least costly physician and services were removed. Once in the hospital and covered by insurance, the patient had no reason to question the desirability of a "total work up" and to avoid the application of the latest technologies, despite unknown or tangential benefits. In essence, the advent of wide scale insurance brought the demise of the market place for health care and the price benefits which attend free competition.

Accessibility to services increased significantly with the Federal Government's enactment of Medicare and Medicaid in 1965. While this could be said to be one measure of success for public programmes, new demand for services was placed on a health care system with a limited ability to step-up production. The result was higher cost of services and, eventually, substantial increases in prepayment contributions to health care. In order to reduce the demand for services, coinsurance and deductibles also had to rise dramatically. Today, the aged pay more out-of-pocket for health care in terms of real dollars than when Medicare was established 15 years ago.

Further, Federal programmes began unleashing billions of dollars for health care without having had adequate time to implement proper audit and enforcement mechanisms. Consequently, the door was open for a variety of money-making schemes that gave little of substance to patients. In some large cities, the infamous Medicaid Mills sprang up. Here, patients were pushed rapidly through a series of unneeded visits by "specialists", and subjected to a variety of laboratory tests in the name of health prevention, or for treatment of a simple primary care problem. The government was billed for these services without the opportunity to effectively regulate what was provided.

On patient's bills physicians could place excessive mark-ups over what it actually cost them to have laboratory tests performed. The important abuse here was not so much the percentage increase on each test, although it frequently reached hundreds of percentages, but the conflict of interest inherent to both deciding what and how many tests to order and what those tests should cost.

In the face of rapidly expanding technologies, training programmes for physicians began to emphasize the values of testing the patient; evolving an approach to medical care which Victor Fuchs would later call the "technologic imperative". When in doubt, take action. While physicians and the public were formulating the attitude that even marginal information on the patient was worth acquiring, third party payers were developing reimbursement formulae that assigned higher dollar values to the simplest procedures and services done in-office than it assigned to direct patient care by the physician. Therefore, technology was rewarded over physician time, and perverse reimbursement incentives were established.

Computerization brought the capability of rapidly providing physicians with even larger amounts of data, often using the same specimen. The fact that there would not be any additional discomfort to the patient increased the temptation to have complete and serial profiles. Thus, data became piled upon data with very marginal or nonexistent patient care

benefits, but with additional unwarranted costs. Further, it has been suggested that unnecessary tests generate even more tests due to the high chance (7-20%) of receiving a false positive test result which then must be investigated.

The economic problems accompanying technological proliferation were exacerbated by reimbursement policies that were reluctant to question the efficacy of tests or the benefits of the new technologies which they financed. Most technology did not have to be proven in the research setting before it became reimbursable. Avid salesman for new laboratory instruments found easy markets in hospitals which simply passed their costs along to the insurers and further fuelled the fires of inflation.

Realization of these trends has led to some major changes in the manner in which third party payers are reacting to laboratory costs. Fiscal intermediaries are no longer passive conduits of dollars, and a new mix of cost-containment measures has been implemented to address the loss of market place forces.

The mission of government health insurance is to provide beneficiaries with access to services and to protect the public interest while purchasing these services. While we have diligently concerned ourselves with the former objective, we cannot be completely satisfied with the way in which accountable parties have addressed the waste of the tax payer's dollar accompanying inappropriate utilization and abuse. We must redirect these wastes in order to have the resources we need to solve many of our significant health care problems. As a major purchaser of services, the Federal Government has taken some initial steps aimed at assuring that we receive quality laboratory services at a reasonable price.

For instance, Medicare has followed the lead of the Blue Cross, the major private insurer, and will no longer pay for routine admission tests which have not been ordered directly by a physician. Often, routine admission tests are considered to be obsolete, without proven value, or superfluous. In addition, studies have shown that screening tests in asymptomatic populations seldom demonstrate significant disease.

The National Center for Health Care Technology was recently established to advise the Secretary of Health and Human Services (formerly DHEW) on the potential implications, in terms of the benefits, risks and costs, of new and existing technologies; and to disseminate this information to the public. Among its areas of interest, the Center will be assessing the influence that laboratory practices have on overall health care costs. Ultimately, changes in laboratory workload will be pursued as the Center advises the Secretary on which reimbursement policy changes should be implemented for laboratory services, and what should and should not be paid for by Federal programmes. A comprehensive review of technologies and their role in health care is one of the most important activities that we can undertake.

In the area of acquisition of laboratory technologies, Health Systems Agencies (HSAs), the major health planning arm of State and Federal government, have already placed restrictions on major capital expenditures by hospital and institutionally-based laboratories. Although the benefit from these restrictions should not be underestimated, experience has taught us that overly rigorous constraints on purchases of equipment has simply caused institutional laboratories to move into commercial settings where government control has been very limited.

Limits now exist on how much a physician can mark-up the costs of laboratory work done outside his office. However, these controls do not always work the way we hope they will. For example, there is a \$ 3 maximum that a physician can charge Medicare for collecting a laboratory specimen. But if a physician has a panel of tests run on one specimen and charges Medicare multiple \$ 3 fees, the abuse is not easily detected without detailed reporting requirements.

Also, a physician may choose to bill Medicare directly for tests done in laboratories outside his office and then compensate the laboratory accordingly. In such cases, Medicare pays the physician at a rate equal to approximately the seventy-fifth percentile of locally prevailing charges. But for administrative ease, we rely on the accuracy of self-reported information by the physician and the clinical laboratory. Should the physician have an arrangement with the laboratory to purchase their services at below market cost (i.e. below the seventy-fifth percentile) and not report this to Medicare, then the physician can realize a substantial profit.

We are exploring, and have implemented in a restricted manner, a provision in the law that allows us to pay at the lowest charge for which a service is widely and consistently available. This has been interpreted by us to mean that we can reimburse at the twenty-fifth percentile in a locality, instead of the seventy-fifth which we are now using. However, we are in the process of carefully studying the impact that such a drop in our reimbursement structure would have on a laboratory's capacity to make appropriate, but large capital expenditure, such as for durable medical equipment. If we determine that we can fully implement this provision to cover most laboratory services, the cost-savings impact for the Federal Government will be significant. Many Americans fear that controlled costs will result in decreased quality of services. Though probable, this is not necessarily true, and the Federal Government will not sacrifice quality merely for economy. In order for a laboratory to be certified to receive public funds, certain standards must be met. The Federal laboratory personnel standards grew out of the principle that competent people maintain quality outcomes and contain costs through fewer errors and less waste. In addition, laboratories must meet proficiency requirements in order to be certified for government use, accredited by private organizations, and licensed by States.

Recently we instituted a voluntary programme to help laboratories improve their overall performance by achieving higher proficiency and quality control standards and by establishing other good laboratory practices. This voluntary programme parallels our Federal regulatory programmes: the voluntary programme provides technical assistance to laboratories to help improve operations, while the regulatory system, through enforcement measures, ensures that laboratories meet minimal Federal standards.

In 1972, Professional Standards Review Organizations (PSROs) were established by law to assure the medical necessity and quality of services rendered to Federal beneficiaries through the mechanism of peer review by physicians. PSROs are increasing their review of ancillary services and have a great potential for improving the use of clinical laboratory services. To date, about one fifth of our nation's PSROs have developed specific protocols in this area, and more are beginning to do so.

According to the American Hospital Association, in 1977, hospitals spent \$ 865 million complying with only eight Federal health regulations. It was projected that by the end of 1979, the expense of these eight regulations to those being regulated and, through them to consumers, would be \$ 1 billion. Federal regulations are often complex and uneven despite our efforts. In addition, at least three separate Federal agencies have some regulatory authority over laboratories. Taken individually, each regulatory programme appears worthwhile, but in the aggregate, and measured by system impact, the overall regulatory structure looks less beneficial and very costly. Consequently, we have begun to examine the regulatory system as a whole in order to reduce the numbers of overlapping surveys and the unnecessarily involved regulations to which a laboratory must comply. Already, some surveys have been eliminated and uniform regulations for use by all agencies are under development.

Since hospital laboratories perform a significant proportion of all laboratory tests done, hospital cost-containment measures have had an important affect on national laboratory price schedules. Fiscal intermediaries have placed rigid limits on the overall revenues available to operate a hospital through fixed per diem reimbursement rates, and many states established rate review commissions with the authority to cap hospital costs. However, no such limits

are placed on the number of laboratory procedures which can be performed per patient. Hence, there is pressure on hospital laboratories to perform more tests while upwardly adjusting their charges to overcome potential hospital deficits. Since the hospital-owned laboratory has a monopoly on providing services for its hospital's inpatients, market place competition is not working against the inflation of these charges; the basis upon which some third party payers reimburse, and often the standard for commercial laboratory prices. The circle becomes completed and vicious when the hospital begins to purchase new laboratory equipment and hire new staff based upon projected revenues rather than upon what is needed for cost-effective medical care.

Medicare pays hospital laboratories on the basis of costs, not charges. Regulations can exclude certain costs from being entered into the reimbursement formula and may place additional limits on the increase in reimbursement rates from one year to the next. However, there is little to prevent hospitals from charging their laboratories excessive overhead and indirect costs to enable the hospital to support other, non-revenue producing cost centres. It has been alleged that hospitals shift many of their costs into the laboratory cost centres, thereby causing the Federal Government to pick up a substantial percentage of costs which should be attributed to private pay patients. We have a regulation which states that the public insurance programmes should not shoulder the burden of non-federal beneficiary costs nor should private pay patients subsidize our beneficiaries. Better accounting practices are necessary and should be required in order that there be accurate financing of overall health care. Costs may not change, but accurately derived disaggregated costs would provide the basis for appropriate cost containment measures.

We need to begin to explore more seriously the use of overall cost limits on the total reimbursement for laboratory tests. The decision when, what, and how many times specific tests should be ordered should in its essentials remain with the physician; but a reimbursement ceiling, however, may force individual physicians into making more rigorous allocation decisions. We know that we are paying for thousands of tests which do not favourably affect the course of patients or change the operating decisions of physicians. While the medical profession should take the lead in researching the indications for specific tests, little has been done to date. If the medical profession will not undertake this responsibility, reimbursers will need to become increasingly active in this area. No longer can third party payers ignore the fact that we frequently pay the bill regardless of what little potential the tests had for improving the patient's condition. Specific dollar caps are certainly not easy to administer when escalating inflation fluctuates prices almost daily. Nor do they necessarily protect against sacrificing quality or ensure the optimal use of resources, but they do certainly deserve closer scrutiny. As it is now, the same test in two different urban centres of the country can vary 200-300% due to our policy of reimbursing locally prevailing charges.

How can we help clinical laboratories to be more cost effective? One way is to reward laboratories for cost effective practices in meeting patient care objectives, rather than rewarding productivity. Again, better accounting practices would have to be required by financing agencies in order to accomplish this. Preferably, uniform cost reporting should be mandated in order that inter-laboratory comparisons can be made by financing agencies, hospital administrators and Boards. It is impossible to think of rewarding laboratories for cost-effective practices when there is no consistency of the elements that comprise laboratory costs or their magnitude. We also need better administrative procedures to detect inappropriate accounting activities that escalate laboratory charges.

To implement such a system, good management practices would have to be accompanied by more effective ways of utilizing laboratory information. More and more clinical laboratory data without plans for its use is not the answer and only leads to increased health care costs with few benefits. Financial incentives should be explored which would encourage health care providers to examine their overall approaches to diagnosis and treatment. Physician's orders put in motion up to 70% of the total cost of medical care. There is a need to question the reason for and benefits of each test ordered and not to order a test without a plan to use the

information gained. Better education of medical students and physicians would help as would increased communication between the laboratory pathologist and the practising physicians. When the pathologist is keenly aware of the problems of patient care process, he/she can be a critical educator who will enable the physician to effectively use the laboratory. Knowing the physician's particular objectives, the pathologist can advise on the tests with the greatest sensitivity/specificity, and can help physicians avoid duplicative, excessively long turn-around time, or ineffective tests. Together, they can arrive at efficient solutions to the physicians' objectives.

We must begin to educate the public and medical profession. We must begin to publicize the risks, limitations and costs of medical technologies in order to limit the public demand for and their attitudes about clinical testing. Too often news of ultra-sophisticated tests which benefit only a relatively small number of patients reaches the public, while information on health prevention is less widely disseminated. Interpretive reporting by laboratories may assist physicians in learning which tests give marginal or no information and which are beneficial to specific care problems, but that is only a small solution to the problem. Physicians are trained to do everything possible for their patients, and not think in terms of marginal costs curves.

Finally, National Health Insurance has been a long awaited ideal for Americans, a dream which has recently regained momentum in Congress. Third party payers must work together and in conjunction with Congress to develop a creative reimbursement system which is as fair and just as can be made and still be administratively feasible. The system must reward the proper incentives. Otherwise, National Health Insurance superimposed on the current problems would fail to meet many of our expectations.