American
Clinical Laboratory
Association

August 25, 2011

The Honorable Fred Upton
Chairman, House Energy and Commerce Committee
2183 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representative Upton:

I am writing you today on behalf of the American Clinical Laboratory Association (ACLA), which represents the leading national, regional, esoteric, pathology and ESRD clinical laboratories. As a member of the Joint Select Committee on Deficit Reduction, you and the other Joint Committee members face significant challenges in achieving the savings required to meet the requirements of the debt ceiling legislation enacted earlier this month. As the Joint Committee begins its work, the ACLA stands ready to work with you.

I did want to bring to your attention, however, both the significant reductions in Medicare reimbursement for laboratory services over the past few decades and, moreover, some serious concerns that ACLA has regarding proposals for imposing copayments or coinsurance for laboratory services under Medicare.

Given the potential for these adverse consequences, we request that ACLA have the opportunity to meet with the Joint Select Committee and its staff, and also testify at any hearings or public forums that the Committee may have.

Laboratory services – while comprising only 1.7% of Medicare spending – inform an estimated 70% of physician medical decisions. Compromising these services could have adverse consequences for some of Medicare's most vulnerable beneficiaries, raise administrative and bad debt costs exponentially for laboratories, and result in the loss of many thousands of jobs.

Among the options that were under consideration during the debt ceiling negotiations were to change cost-sharing structures for Medicare beneficiaries by either adding 20% coinsurance for laboratory services or imposing a flat copayment per laboratory test.

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Both of these alternatives would have the same negative consequences for patients and the providers that perform their laboratory testing, and represent an unworkable policy for laboratory services. Over the past nearly three decades, coinsurance or copays for laboratory services have been considered and rejected time and again by independent outside organizations, government agencies, and Congress. The proposals have been rejected for the following reasons:

(1) **For most laboratory tests, the amount of the coinsurance or copay would be small in comparison to the cost of collection**. The average coinsurance per claim would be only $6.20, and the average copayment per claim would be $3.00-$6.00. This compares with collection costs estimated to be at least $3.50 per bill (and could be many times that if repeated collection attempts were necessary). Thus, in many cases, **the cost of collection will exceed the coinsurance or copay**, adding additional unnecessary administrative costs to the health care system.

(2) **The volume of bills generated for small amounts would be staggering; over 215 million new bills to beneficiaries for an average of $6.20, with 70 million of those bills being for less than $2**.

(3) **The cost of collection, and the ability of laboratories to collect, is uniquely difficult because laboratories do not usually have a face-to-face encounter with the beneficiary that all other providers who bill patients have. It is this relationship that typically facilitates collection of copays and coinsurance, but without which will require laboratories to rely on billing and collections to get paid**.

(4) The impact of these new costs will be devastating to the thousands of smaller laboratories who are often the sole provider of laboratory services to Medicare's most vulnerable beneficiaries in nursing homes and other similar settings. These smaller laboratories that serve these populations tend to have high concentrations of "dual eligibles" (Medicare and Medicaid) for whom collection of the coinsurance/copays is unlikely. While $6 lost per claim may not sound like a significant amount of money, in fact, when the average claim is only $20, a loss of $6 per claim amounts to a 30% reduction in reimbursement to these laboratories – an amount that could swiftly put them out of business. Nursing homes could be left with no choice but to send beneficiaries by ambulance to the hospital for routine blood work, at considerable cost to Medicare.

(5) Ironically, while the stated purpose of laboratory cost sharing is to impact utilization, virtually every outside group that has looked at this question – including HCFA/CMS and the Institute of Medicine – has concluded that laboratory cost sharing would have little if any impact on utilization. And, if cost sharing did impact utilization of laboratory tests, it would be at cross purposes with the move toward removing cost sharing for preventative services.

(6) While most laboratory test claims are for small amounts, there is another critically important area of testing that, because of its complexity and sophisticated technology, are necessarily more expensive – specifically advanced clinical diagnostics. These tests for cancer and other serious diseases and conditions are used for early detection and choosing the best treatment while saving countless lives as well as billions of dollars in the process. A coinsurance of 20% for these tests could cost beneficiaries hundreds of dollars or more and provide a true disincentive to order the necessary tests that could reduce future costs.

These proposals would hit a clinical laboratory industry that has little left to cut. Reimbursement under Medicare has been systematically reduced over the decades, raising concerns about the ability of many laboratories to continue to serve Medicare beneficiaries. Payments have been reduced by about 40% in real (inflation-adjusted) terms over the past 20 years. The actual payment today (not inflation adjusted) for a hypothetical test reimbursed at $10.00 in 1984 is $8.32 today, due to reductions over time in the Medicare Clinical Laboratory Fee Schedule (CLFS). However, that same test would be reimbursed at $21.72 in today's dollars if it had been updated for inflation as it was supposed to be under the Deficit Reduction Act of 1984 (DEFRA), which established the CLFS. Medicare reimbursement for laboratory services is scheduled to decline by an additional 19% over the next 10 years due to PPACA.

Clinical laboratories produce good paying, US-based jobs throughout the nation. While it is difficult to pinpoint the exact number of jobs that would be cut as a result of the Medicare cost-sharing proposals, job losses could easily reach the tens of thousands, hitting the smaller, regional laboratories the hardest.

For these reasons, we urge that the Joint Select Committee reject further reductions in Medicare reimbursement to clinical laboratories and cost sharing (coinsurance or copays) for laboratory services under Medicare. ACLA members are available and eager to discuss these issues with you and your staff as you consider various proposals to reduce the Federal deficit. If you or they have any questions or would like additional information about clinical laboratory testing, billing and reimbursement, I can be reached at 202-637-9466 or amertz@acla.com.

Sincerely,

Alan Mertz
President