ACLA Urges Congress Not to Apply Cost-Sharing for Medicare Part B Clinical Laboratory Services

- Laboratory test results have an immeasurable impact on diagnostic and treatment decisions made by clinicians; however, lab services represented just 1.7% of Medicare spending in 2012.
- If cost-sharing requirements for lab services were implemented, approximately 30 million elderly and disabled Americans each year would be impacted.
- Imposition of cost-sharing will disproportionately affect access to vital diagnostic lab services for Medicare's most vulnerable beneficiaries, namely those receiving skilled nursing or home health services, since smaller labs often serve these populations. When smaller labs face lower revenues and increased costs, they may no longer be able to serve these beneficiaries, forcing hospitals to serve them instead, which increases program costs.
- The Institute of Medicine has stated: "Cost sharing is unlikely to significantly reduce overuse or increase the detection of fraud and abuse; it could create barriers to access for the most vulnerable Medicare beneficiaries; and it would be financially and administratively burdensome for laboratories, patients, and the Medicare program."

Cost-Sharing for Clinical Laboratory Services Is Not the Right Policy Solution

Millions of Small Bills Will Be Created, Translating Into More Paperwork and Higher Health Care Costs

- The volume of new bills would be staggering – estimated at over 143 million new Medicare claims each year.
- About 50% of the new claims will be for $5.00 or less, with approximately 73% for $10 or less. About 14 million of the new claims would be for $1 or less.
- Each of the new claims is estimated to cost labs an average of $3.50 to process and collect. Indeed, for almost 40% of the new claims, the $3.50 cost of collecting the coinsurance would exceed the coinsurance liability. Putting this in perspective, estimates show for every net dollar in savings generated for the Medicare program through implementation of cost-sharing for Part B laboratory services, the lab sector will pay close to $0.50 in costs.

New Cost Burdens Will Be Added to the Sector; Small Laboratories Could Be Lost

- Collecting coinsurance is uniquely difficult for labs because, unlike all other health care providers, labs typically do not have face-to-face encounters with patients. Most of the time, a Medicare beneficiary's specimen is obtained somewhere else, such as a physician's office, and sent to the lab, which then performs the prescribed testing.
- As such, labs must rely on billing and collections to obtain the cost-sharing amount from beneficiaries. If those good faith efforts do not succeed, laboratories must absorb those losses along with the added costs of collecting the cost-sharing.
- For many smaller laboratories, a George Washington University study found that almost half operate with margins of 3% or less. Therefore, the decreases in reimbursement stemming from cost-sharing, coupled with the additional administrative costs, could put them out of business.
- Thousands of small laboratories are the sole providers of lab services to nursing homes, who routinely care for low-income, dual-eligibles. Due to the likely decreases in revenue from unsuccessful collection efforts and increased administrative costs, these labs may have to cut their service offerings or even cease operations. As a result, access to these critical diagnostic services may be reduced for beneficiaries since they may be forced to receive their lab services at hospital outpatient departments at much higher costs.

Barriers to Patient Access Could Be Created for the Use of New Genetic Technologies

- Genetic and genomic laboratory tests are becoming increasingly vital services for the diagnosis and treatment of cancer and other serious medical conditions.
- Coinsurance for these genetic and genomic tests could create a significant barrier by saddling Medicare beneficiaries with bills in the hundreds of dollars. These innovative tests, while costlier than more routine lab services, save thousands of health care dollars per patient by diagnosing and guiding treatment sooner and more effectively through targeted, personalized medicine. Significant out-of-pocket costs risk scaring patients away.