

**Comments by the Clinical Laboratory Coalition
regarding**

**Financing Comprehensive Health Care Reform:
Proposed Health System Savings and Revenue Options**

**Senate Finance Committee
May 20, 2009**

The Clinical Laboratory Coalition (CLC) is committed to ensuring access to high quality laboratory testing for all Americans. We join together in calling upon the nation's policymakers to ensure that any effort to reform the nation's health care system adequately addresses and incorporates the important role that laboratory medicine, and the professionals performing laboratory tests, play in the diagnosis, prognosis, and management of disease.

The Coalition believes that the increasing attention to – and emphasis on – the need to contemporaneously improve quality while reducing unnecessary costs, are critical to addressing the myriad challenges facing the nation's health care system. Laboratory tests are extremely valuable tools for improving patient outcomes while reducing overall costs and serve as an essential basis for subsequent critical medical decision-making. As such, laboratory testing can play an essential role in supporting related health care reform goals of increasing investment in prevention and wellness and improving patient safety and outcomes.

We appreciate the opportunity to provide specific comments to the Senate Finance Committee document *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*. The nation's clinical laboratories and laboratory professionals wish to work collaboratively with others to meet the challenges and achieve the goals of national health reform efforts. To that end, as individual organizations and as the Clinical Laboratory Coalition, we stand ready to work with all policymakers to help shape and improve the future of health care in our nation.

Our comments largely address the Senate Finance Committee proposed option which leaves open the possibility of imposing a "uniform" 20% coinsurance for all Medicare Part B services, including preventive and diagnostic clinical laboratory services, which are not currently subject to coinsurance. CLC strongly opposes copayments for clinical laboratory services. The below section is taken directly from the May 20 Senate Finance Committee document with sections of concern highlighted.

Modifying Beneficiary Contributions

Making Beneficiary Contributions More Predictable (pages 14-15)

Current Law

Current law includes Medicare cost sharing requirements (i.e., deductibles, copayments and coinsurance amounts paid by beneficiaries at the point of care). Medicare cost sharing can be significant, complex and vary by the type of service. For instance, beneficiary Part A cost sharing varies according to the length of the hospitalization: in 2009, for the first 60 days of hospitalization, the deductible is \$1,068; for days 61-90 the beneficiary pays a daily coinsurance charge of \$267; after 90 days and up to 150 days, the beneficiary may draw on one or more 60 lifetime reserve days, provided they have not been previously used, for which the beneficiary pays a daily coinsurance charge of \$534 (each of the 60 lifetime reserve days can be used only once during an individual's lifetime); and for hospitalization beyond 151 days there is no coverage so a beneficiary would be required to pay out-of-pocket for this care. For part B, in addition to a monthly premium (\$96.40 in 2009), beneficiaries are responsible for an annual deductible (\$135 in 2009) as well as a coinsurance payment of 20 percent of the fee schedule amount for most covered services, although some outpatient hospital care could require higher cost-sharing while other services, like home health visits and laboratory tests, require no cost sharing. Medicare Advantage (Part C) and prescription drug plans (Part D) also have their own cost sharing requirements that can differ from traditional Medicare and may include separate deductibles, copayments, and caps.

In addition, current law lacks fundamental protections for the total amount of cost sharing expenses that Medicare beneficiaries could face in any given year. As a result, about two-third of beneficiaries have supplemental coverage to help meet cost sharing obligations—including Medigap purchased from private insurers and retiree benefits offered by former employers. Beneficiaries who purchase Medigap policies pay monthly premiums to private insurers in exchange for full coverage of many or all of their Medicare benefits. Employers that provide retiree benefits do so for their Medicare-eligible retirees by covering some or all of the cost sharing requirements in Medicare.

While supplemental coverage helps beneficiaries make their Medicare contributions more predictable, it also prevents Medicare from being able to use cost sharing as a policy tool. Incentives to encourage (or discourage) cost-conscious decision-making may be blunted by the complex structure of beneficiary obligations as well as the interactions between cost-sharing requirements and supplemental coverage. In addition, several studies have found that beneficiaries with supplemental coverage use more services than beneficiaries without such coverage. Recent research presented to the Medicare Payment Advisory Commission (MedPAC) suggests spending for beneficiaries with supplemental coverage tends to be higher relative to beneficiaries without such coverage, especially for elective hospital procedures, medical specialists, and imaging.

Proposed Options (page 15)

The Committee may want to consider proposals to simplify Medicare beneficiary cost-sharing obligations and make them more consistent with benefits that are available in the private sector. This might be accomplished by making changes to Medicare's cost-sharing requirements while simultaneously placing certain restrictions on Medigap policies. By making both changes, beneficiaries with supplemental policies would not be insulated from the effects of Medicare cost-sharing modifications. These proposals could include the following:

- 1) Introduce an out-of-pocket maximum on beneficiary cost sharing for all Part A and B services;
- 2) Replace the current complicated mix of cost-sharing provisions with consistent cost sharing and a combined annual deductible covering all Part A and B services;
- 3) Modify Medigap to require some cost sharing for services along with catastrophic protection (e.g., prohibit Medigap policies from paying for the first \$100 of a beneficiary's cost-sharing liabilities (first-dollar coverage) and limit coverage to 95% of the next \$5,000 in Medicare cost sharing);
- 4) Impose nominal cost sharing in Medigap, e.g., \$5-10 copayments for primary care visits and \$20-\$25 copayments for specialists; and
- 5) Index all cost sharing to the growth rate in average Medicare costs.

COMMENTS TO THE PROPOSAL:

The CLC notes with concern that the second proposed option on page 15 (highlighted) leaves open the possibility of imposing a "uniform" 20% coinsurance for all Medicare Part B services, including preventive and diagnostic clinical laboratory services, which are not currently subject to coinsurance.

RATIONALE:

CLC strongly opposes copayments for clinical laboratory services and believes any attempt to impose coinsurance (co-pays) on preventive and diagnostic laboratory services is at odds with the Senate Finance Committee's previously stated goals to emphasize prevention and wellness and would shift an entirely new cost burden to Medicare beneficiaries.

- Charging senior citizens for laboratory co-pays is at odds with Congress' intent to encourage more prevention and early detection of chronic diseases such as diabetes, heart disease, kidney disease and cancer – and laboratory tests are at the center of prevention and early detection. The Senate Finance Committee's *Expanding Health Care Coverage* (May 20, 2009) dedicated an entire section to "Incentives to Utilize Preventive Services and Engage in Health Behaviors." The *Coverage* document (page 44) provided supporting arguments for the need to utilize preventive services and stated: "Evidence indicates that cost-sharing reduces Medicare beneficiaries' utilization of preventive services. For example, Medicare beneficiaries with supplemental insurance were substantially more likely to have had a mammogram screening than women without

supplemental insurance. In addition, a National Bureau of Economic Research Working Paper concluded the elderly are “very price sensitive,” finding that a \$10 co-payment increase lead to an almost 20 percent decline in physician office visits.” The *Financing* document proposal to apply copayments to preventive services would defeat the Senate Finance Committee’s earlier stated goal to encourage appropriate utilization of preventive services.

- If the presumption for this latest *Financing* proposal is that lower utilization of services is cost effective, this is a misguided premise that discourages prevention and can be expected to result in costly unintended consequences. The Institute of Medicine (IOM) noted in a 2000 report *Medical Laboratory Payment Policy*, “...cost sharing could create a barrier to appropriate use of laboratory services for chronically ill and financially disadvantaged beneficiaries, which could ultimately lead to greater program costs if deferred testing delays diagnosis and leads to more costly treatment.”
- In addition, imposing a new co-pay requirement for laboratory services does not “save” our health care system money because it merely shifts an estimated \$24 billion in costs from the government to the nation’s most vulnerable population. Not only does this proposal dramatically increase seniors out of pocket health care costs, it would, according to Institute of Medicine (IOM), hit the sickest and poorest seniors the hardest.
- Utilization of diagnostic, as opposed to preventive, clinical laboratory services is driven more by ordering health care providers than by the beneficiaries who would be responsible for the co-pay. Therefore, the policy justification for co-pays – reducing utilization – is inapplicable to diagnostic clinical laboratory services.

American Association of Bioanalysts
American Association for Clinical Chemistry
American Clinical Laboratory Association
American Medical Technologists
American Society for Clinical Laboratory Science
American Society for Microbiology
Becton, Dickenson and Company
Clinical Laboratory Management Association
Laboratory Corporation of America Holdings
National Independent Laboratory Association
Quest Diagnostics Incorporated
Roche Diagnostics
Sonic Healthcare USA