Health Care Reform and its Impact on the Laboratory Industry
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General Trends

Overview
Reactions abound on the new, historic federal health care reform legislation’s ramifications for patients, providers, and insurers. The law largely addresses the areas of universal coverage and insurance reform but lacks measures to contain costs. Predecessor legislation in Massachusetts had a similar focus, intentionally leaving cost control to be dealt with in a future stage. Now, a couple of years later, Massachusetts has begun to determine systemic approaches for slowing down the brisk pace of insurance premium increases. Similar initiatives are underway nationally and in many other states. Concern is palpable as the rapid rise in health plan premiums threatens to create economic havoc.

Michael A. Sachs, chairman and CEO of the health care intelligence firm Sg2, predicts that there will be three phases to reform as shown in Figure 1 below (1).

![Figure 1: Health Care Reform Phases](source)

The first phase, The Prelude (2010-2013), will be a time of slow growth, deteriorating payer mix, and local battles for market share. It is estimated that 80 percent of physicians will be employed by an integrated delivery network (IDN), hospital consolidation will accelerate, and the strong will get stronger. During Market Expansion (2014-2017), new federal money will expand coverage and fuel rapid market expansion, access problems will develop due to capacity constraints, and further regulation will be applied. In the final stage, Regulation and Restructuring (2018-2020), rate transparency and regulation will increase and new payment structures will dominate. Survival will require the ability to succeed in a more regulated, rate- and quality-driven environment.
In an era when increased life expectancy and the aging of the baby boomer generation have already intensified demand for services, adding 32 million Americans to the ranks of the insured will bring new revenue opportunities in every area of health care. At the same time, intense downward pressure will continue to be exerted on prices and utilization as the portion of the gross national product dedicated to health services trends at an alarming rate and threatens the very foundation of the U.S. economy. To be successful, providers must find ways to win market share while reducing average cost. They must also offer value to caregivers in their efforts to contain costs through better care management, improved quality, and greater efficiency. Positive change will depend on the ability to incorporate information into an electronic medical record and effectively provide the data necessary to manage care under new forms of reimbursement, as there are clear indications of movement away from fee-for-service toward a system of global payments.

This article makes a case that these emerging trends bode well for hospital outreach programs. In fact, failure to seize opportunities at this moment may exclude hospitals from the outreach market for decades.

**Managing with Integrated Information**

The movement to build a community electronic medical record (EMR) is underway. Although progress on merging patient information from all providers within a defined geography has been slow, steady strides have been made toward offering a single record of services supplied within a hospital system, including those of employed physicians. Independent physician groups now have the ability to combine patient information into one office record; however, data on care that does not take place or is not ordered by that practice does not automatically post to that record. Instead, it is mainly exchanged via paper forms that must be typed or scanned into the file. Likewise, the hospital EMR lacks information on services furnished outside its delivery network.

It is doubtful whether a community EMR will be commonplace anytime soon. Electronic compilation of every episode of care taking place in the community seems a near-impossible task in the face of challenges such as interfacing disparate software, coordinating the input of manual records, and resolving differences related to competition and ownership. The most successful efforts currently involve the collection into a single electronic record of every episode of care within an IDN, typically one led by a hospital. Influenced by a number of factors, these endeavors will produce a variety of outcomes that will contribute to the more efficient organization of patient care.

Much has been written on the value of an all-inclusive EMR in achieving quality and cost control. These records promote quality by giving every provider access to comprehensive and precise information at his or her fingertips. Quite simply, a physician no longer has to question patients about interactions with other practitioners or spend valuable time contacting another doctor to get information. Patients do not have to seek out films or CDs or ask other doctors, laboratories, etc., to fax reports and results to their physician. All pertinent data appears in the electronic record, which facilitates a more timely and accurate diagnosis. A lot of single quality indicators are currently tracked that seem relatively simplistic when compared to the importance
of diagnosing a patient quickly and correctly. With regards to cost, EMRs can eliminate repeat
testing that is too often substituted for chasing down information.

**Global Payment System**

A special health care commission in Massachusetts has recommended significant reimbursement
reforms that would end the costly incentives of a fee-for-service system. The proposed solution
is a global payment strategy in which an integrated network of hospitals and physicians would be
paid an actuarially calculated monthly amount for each member. Proponents assert that this
differs from the capitated payment structure of the 1990s because rewards and penalties for
quality would be designed to protect against any inclination to financially benefit from
withholding necessary care. Payment reform of this type has now become part of the national
dialogue in the form of accountable care organizations (ACOs).

Such a system cannot work unless there is full connectivity through an EMR that also contains
the charge against the global payment for each patient. This will not be easily achieved unless
providers are organized as a network; those who are not will not have a seamless interface to the
EMR. Further, the anticipated move toward IDNs’ negotiation of global rates with payers in
response to the new payment approach will drive an increasing number of independent
physicians to join hospital systems. Large physician groups will be able to maintain at least their
employment independence by contracting jointly with hospitals for global payments.
Opportunities to manage these payments through accountable care organizations and virtual
networks will also arise. No matter the form, global payments will result in risk-sharing among
providers and necessitate ease of electronic access to a patient’s entire medical history.

It is important to note that under global payment hospitals and physician groups assume the
insurance risk that previously lay with health plans, essentially becoming re-insurance
companies. Actuarial calculations are made to determine global payment rates, and hospitals and
doctors, not the insurers, either gain or lose depending on their ability to manage quality and
cost. Health plans indicate they will allow for adjustments if patients are more ill than assumed
in the calculations, but there is widespread skepticism on whether these adjustments will be
made easily and in a timely fashion.

One potential negative ramification for patients will be limitation of choice. Since global
payment requires the capture of all care into a single EMR, patients will need to obtain health
care services from an electronically integrated network of hospitals and physicians. Historically,
reimbursement strategies narrowly restricting patient choice have met with formidable
resistance. When HMOs developed and expanded in the 1980s and 1990s, provider networks
were initially limited and exclusionary. This strategy failed as patients demanded a wider range
of options and health plan networks elected to include nearly all providers in any geography.
The time may be coming, however, when the cost of health care to the U.S. economy requires
citizens to confine their choices to those within a common IDN.
Best Practices and Utilization

Hospitals have grappled for years with methodologies to monitor physician utilization by diagnosis as a means to institute best practices through evidence-based protocols. Given the inability to accurately track outpatient data, this effort has been largely focused on inpatient utilization. Over the years, delivery of health care services has increasingly shifted to the outpatient setting, to the point where the rapid growth in outpatient care as a percentage of the health premium dollar now poses great concern. In order to take a thorough approach to best practices in response to this trend, the totality of services must be contained in an EMR. Similarly, the contemplated global payment system will be dependent on the ability to account for every episode in the continuum of care. Due to these requirements, a comprehensive EMR is the clear tool for achieving quality, efficiency, and, as a by-product, cost containment.

Overview of Ramifications for Hospital Laboratories

Being on the cusp of major changes in both payment and the organization of health care delivery itself offers a unique and historic opportunity for hospital outreach programs. In this new environment, a multitude of vendors with different information systems will not, and should not, be tolerated. An integrated delivery network EMR free of numerous, cumbersome interfaces will give a hospital an edge for securing additional outreach business, especially since the information contained in this EMR will drive efforts on utilization and cost containment, quality, and global payment management. Standardization in these systems to eliminate excessive interfaces will be key for hospital laboratories to gain a technological advantage that will better position them to acquire significant new outreach testing revenue. Managing data from many sources will not be acceptable—a global payment strategy will call for a very limited number of sources of laboratory information. The hospital laboratory will be the obvious choice since it already captures so many inpatient and outpatient encounters. In addition, only a hospital laboratory can provide a true continuum of testing among inpatient, outpatient, skilled nursing facility, and home testing.

Beyond this new era of patient information technology innovation driven by control and quality imperatives that are properly incentivized in a new global payment system, several other factors will propel increased outreach volume for hospitals. New business will obviously come from the inherent market growth associated with 32 million newly insured Americans and the swelling of an elderly population with a higher life expectancy by the baby boomers. Volume will also result from the new emphasis on wellness and prevention. As G2 Intelligence notes, “The health care reform law puts a premium on services recommended by the U.S. Preventative Services Task Force (USPSTF). Medicare may decide to cover additional screening tests with an A [strongly recommended] or B [recommended] rating, while group and individual health plans will be required to cover services rated A or B, along with other recommended services and immunizations.” (2) At last, the long-term prospect of a healthier population has gained credibility as a cost containment strategy.

Further, the hospital laboratory, as opposed to a commercial counterpart, will become an essential knowledge center for clinicians as they strive together to achieve quality, efficiency, and diagnostic accuracy. Working with the hospital laboratory, professionals responsible for
testing will facilitate the development of clinical protocols. Laboratorians and pathologists will be a critical part of the care team developing new methods to align cost and quality incentives using the all-inclusive EMR.

**Hospital Laboratory Strategies and Readiness**

**Market Share**

One cannot overemphasize the importance of this moment for hospital laboratory outreach programs. Using the EMR and global payment as its major tools, the national agenda to control costs and improve quality will move forward quickly, and missed opportunities will not present themselves again for a long time. Given the impressive gains expected to accrue for outreach programs, working with outside laboratories to interface their data into hospitals’ EMRs would be a serious misstep. The national laboratories realize this and, in some cases, have supplanted the hospital laboratory as the only interface to the EMR for hospital doctors. Very few, if any, of these incursions should be allowed, since they preclude hospitals from capturing outreach testing business. If a health system is not quick to embrace an outreach program, a commercial competitor will not hesitate to capitalize on the incredible volume available from the new and growing markets mentioned above.

A number of steps are required for expediency and success. Keeping Michael Sachs’ prediction in mind, laboratories will be heavily market-share focused over the next four to seven years. If the hospital laboratory is not operating to the satisfaction of the medical staff, it must aggressively pursue the necessary improvements to build its credibility and expand into the outreach arena. The laboratory must then develop a sound business plan for outreach and build the required infrastructure. Laboratories with a strong reputation and excess testing capacity can accommodate new testing with relatively minor adjustments to infrastructure focused on areas such as information systems, transport capability, patient service center locations, and sales. Outreach has been shown to be a successful business model with average contribution margins of 20 to 30 percent. Some programs have generated over 50 percent of hospital EBITDA. The key to success for the next several years is building market share. With 80 percent of physicians aligning with IDNs over the coming years, hospital outreach programs will be positioned for advantage over national laboratories.

The development of outreach sales capability deserves a special mention, as hospital laboratories often underestimate the specific expertise and training required for this endeavor. Proficiency in outreach-specific sales is not a core competency generally found in hospitals. An outreach program’s success will be highly dependent on its ability to outmatch the sales efforts of commercial competitors that understand how short the time horizon is not just for winning new business but also for protecting their base business. Some may question if this expertise will be needed in the new “normal” of ACOs and dominance of regional IDNs. National laboratories are fearful of these changes, and they are making substantive changes in their sales organization to counteract hospitals. There is a window of opportunity for laboratories to capture enough market share to meet the service requirements for contracting with a local or regional IDN. This can only be accomplished with an aggressive sales effort.
Pricing

There is no doubt that pressure to decrease laboratory test prices will intensify and be driven by payers, consumers, and price transparency. In addition to the general demands already put on pricing by the ever-present need to stem rising insurance premiums, the new health reform law calls for Medicare dollars to be diverted to cover the uninsured. Sg2’s Michael Sachs predicts that by 2016 the government will regulate or control up to 80 percent of health plan premiums. (3) The impact of falling pricings on laboratory outreach can be mitigated by volume increases and the resulting economies of scale, however. Taking a “wait and see” approach to outreach would be catastrophic for hospitals. If they hesitate, large commercial laboratories will achieve the necessary connectivity to the EMR on an exclusive basis, and the business opportunity for hospital outreach will disappear.

Cost

In a global payment model where there is an integrated system of vertically-owned services and employed physicians, price loses importance and cost becomes operative. Profitability of the whole is dependent on cost-effectiveness throughout the continuum of services. The appeal of the hospital laboratory outreach program lies in its ability to provide tests at a comparable or lower cost than commercial laboratories on an incremental cost basis.

Current reimbursement trends for hospital versus independent laboratories help illustrate this point (Table 1). Except for a few national managed care contracts, laboratories do not compete on cost. Reimbursement actually favors high-cost laboratories, just the opposite of what is intended through health care reform. Hospitals have higher costs and are paid at higher rates than independent laboratories.

<table>
<thead>
<tr>
<th>Table 1: Revenue Per Requisition</th>
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<tr>
<td>Outreach Program</td>
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<td>Revenue Per Requisition</td>
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As Table 1 indicates, hospital laboratories enjoy an advantage in reimbursement. Their median net revenue per requisition (assuming an average of 3.0 tests per requisition) is 14 percent higher than Quest and 23 percent higher than LabCorp. In other words, there has been no real incentive for hospital laboratories to compete on cost in the past. How will they fare if price and cost of testing is one of many driving factors for laboratory selection? Surely this will change with increasing transparency and downward pressure on price at a national level. The current reimbursement rates for hospital laboratories are not sustainable.

For an independent physician group that currently does its own testing, the goal becomes contracting for the lowest price for laboratory testing since continuing to perform it in-house at a cost below the price point of an outside vendor is unlikely. The lowest cost laboratory may not be based solely on unit costs. Hospital laboratories have an advantage over independent
laboratories in that less repeat testing is required as care shifts from the hospital to the skilled nursing facility or home. Reform may drive further consolidation of laboratories within and across IDNs. In the end, it all boils down to market expansion for the most cost competitive laboratories. Aside from cost, the independent physician group also faces the expensive and cumbersome process of efficiently incorporating its laboratory data into a comprehensive EMR necessary to manage global payments.

For IDNs with all employed physicians, the term “outreach,” which has long been used to describe the selling of laboratory services to a myriad of independent physicians and other entities such as nursing homes, will fade. As discussed previously, Michael Sachs foresees the vast majority of physicians becoming part of an IDN within the next few years. At this stage, “outreach” will be more aptly defined as the process of competing with other IDNs to employ physicians. With the hospital laboratory and physicians joined organizationally, the laboratory must instead engage in “inreach,” demonstrating to the network as a whole the advantages of keeping testing within the system. This focus on inreach will result in deeper penetration of a local market versus shallow penetration of a broader one. Given a global payment approach, the economics in play center around cost rather than profitability—that is, whether it costs less to “make” testing within the IDN rather than “buy” it from an outside provider. The case in favor of the hospital program is made once its quality and efficiency match or exceed that of the commercial laboratories. Other significant benefits of inreach include the seamless availability of results in the network’s EMR and provision of in-house laboratory expertise to assist physician groups with achieving best diagnostic practices in the context of multi-disciplinary protocol teams.

The current narrow definition of “service” will evolve in this new environment (Figure 2). The choice of laboratory today is largely driven by three factors: patient access, electronic results, and turnaround time. In the future, the definition of service will be broadened to include price, integration of results into an EMR, and serving as part of an IDN team to achieve better quality and efficiency. For hospital laboratories, the most challenging of these criteria is price—they have been able to match or better the national laboratories on every item except price. Driving down costs will therefore become the new imperative for hospital laboratories.

Figure 2: Evolution of Service Definition

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
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<tr>
<td>Narrow Definition of Service</td>
<td>Broad Definition of Service</td>
</tr>
<tr>
<td>• Patient access</td>
<td>• Price*</td>
</tr>
<tr>
<td>• Electronic results</td>
<td>• Patient access</td>
</tr>
<tr>
<td>• Turnaround time</td>
<td>• Results to EMR*</td>
</tr>
<tr>
<td></td>
<td>• Turnaround time</td>
</tr>
<tr>
<td></td>
<td>• Part of IDS team to achieve better quality and efficiency*</td>
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*New requirements in the future.
Capitation Contracting for Laboratory Services

As described previously, the advent of global payment will cause insurance risk to pass from health plans to hospitals and physician groups. As a result, provider networks will be inclined to contract for services in a way that passes portions of this risk on to others. Outreach programs may therefore be compelled to negotiate capitated payments. Without dwelling on all the intricacies this form of payment entails, suffice it to say that hospital laboratories must prepare themselves for this eventuality.

Test Menu

Regardless of what has been said here about hospitals aggressively pursuing outreach despite concerns about downward pressure on prices, there will be some selectivity pertaining to the types of testing offered. For example, hospital laboratories may not be able to achieve economies of scale for esoteric testing in markets that lack sufficient volume potential, leaving this business to their commercial competitors. However, if hospital systems can successfully capture the lion’s share of outreach for the most common laboratory tests, commercial laboratories may find themselves relegated to performing only esoteric reference testing.

The trend of the national laboratories’ increasing focus on esoteric testing appears to be underway. By its own admission, one of LabCorp’s primary strategic goals is to further augment its esoteric capabilities, building on gains it has already made through recent key acquisitions. With its purchase of Genzyme Genetics in December 2010, esoteric testing now comprises approximately 40 percent of LabCorp revenue, and the company intends to increase that to 45 percent within the next three to five years (4). From a volume standpoint, nearly 23 percent of LabCorp’s 2010 total came from esoteric testing, a figure that can be expected to grow with future acquisitions. With the national laboratories turning more attention towards the esoteric market, the door may be open for hospital laboratories to capitalize on the opportunities in the outreach market presented by healthcare reform.

Imaging and Other Diagnostic Services

The preceding discussion of the opportunities presented by and implications of health care reform for the laboratory also applies to imaging and other diagnostic services. As global payment replaces fee-for-service, the incentive for independent physician groups to perform any diagnostic testing in their offices will evaporate. Just as these groups will most likely require outside laboratory providers, they will similarly seek out external entities that offer imaging and other diagnostic services at a lower cost and in a manner that easily combines the results into a comprehensive EMR. Hospitals can offer an all-inclusive, economical solution by expanding their laboratory outreach programs to include imaging and other diagnostic services. A model for this blended diagnostic approach (Future Business Model for Outreach) can be found on the Chi website. Strategically planning, managing, and executing these services together will lead to a more successful and efficient outreach operation.
Summary

Health systems need to develop a sense of urgency regarding the formation and growth of outreach programs. Following several years of competition for market share, the choice of laboratory provider will ultimately be based on a broader definition of service that includes connectivity to the EMR and competitive pricing. There is a window of opportunity for hospitals to position themselves to capture this business. Allowing commercial laboratories to increase their hold on the market now may prevent hospitals from claiming their fair share for a long time to come.

Cited Sources