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Report to Congressional Committees

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MEDICARE

Payments for Clinical Laboratory Test Services Are Too High

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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

Section 4064 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, P.L. 100-203) required us to review the appropriateness of Medicare's fee schedule payments for clinical laboratory test services, considering both laboratory costs and revenues. To measure appropriateness, we compared laboratories' profit rates from Medicare with their overall profit rates. Comparable profit rates would mean that Medicare was carrying its own weight, neither subsidizing all other payers nor being subsidized by them. We found, however, that profits from Medicare business substantially exceeded laboratories' overall profit rates, and we conclude that Medicare's fee schedules are too high.

Our results are based on operations of the five largest independent laboratory companies in the nation, which account for over 40 percent of Medicare payments to independent laboratories. Medicare fee schedule payments to those laboratories produced average profits in 1988-89 of 32 percent of sales, while their overall profit rates averaged 15 percent. Taking into account the Medicare payment reductions effective in January 1990 and 1991, Medicare profit rates would have been 11 percentage points higher than the companies' overall profit rates. Thus, Medicare's clinical laboratory service fee schedule is subsidizing other payers at the larger laboratories. We also reviewed operations at 11 smaller companies, and those that served a mix of payers similar to the large laboratories had profit patterns similar to those laboratories.

Background

Medicare pays for clinical laboratory services performed in independent clinical laboratories, hospital outpatient departments, and physicians'

offices on the basis of fee schedules.[1] This fee schedule payment method was established by section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369), and it replaced a reasonable charge reimbursement method. Each Medicare carrier[2] computed its fee schedule for clinical laboratory services, primarily on what had been paid for services of independent clinical laboratories[3] under the former reasonable charge payment method. Thus, the initial fee schedules included an upper payment limit for each laboratory procedure in each of the 56 Medicare carrier areas in the country.

When billing for laboratory services, the provider is required to bill the Medicare program directly, not the beneficiary. Medicare pays 100 percent of the fee schedule amount or the actual charge for the service (whichever is lower), and the provider must accept this amount as payment in full.[4]

The fee schedule method was intended to save money for both the program, through lower payment rates, and the beneficiary, by eliminating application of deductible and coinsurance requirements. We reported[5] that the original payment system had saved beneficiaries money, but that the Medicare program achieved little or no savings from the initial fee payment rates.

Since 1984, several actions have been taken to reduce fee schedule payment rates. Effective July 1, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) established national limits on Medicare payment rates for each test procedure. The initial caps were set at 115 percent of the median of all carriers' rates. Effective April 1, 1988, OBRA 1987 reduced the cap to the national median rate for each test procedure and reduced, by an additional 8.3 percent, the fee rates for selected frequently performed test procedures. OBRA 1989 (P.L. 101-

[1]Laboratory services furnished as part of inpatient hospital care are covered by Medicare's hospital prospective payment system. Those services received by an inpatient of a skilled nursing facility are generally paid on a reasonable cost basis.

[2]Carriers are Blue Shield plans and commercial insurance companies that contract to process and pay claims on behalf of Medicare.

[3]Payments to physicians for services performed in their offices were not used to compute the fee schedule amounts.

[4]Medicare's usual deductible and coinsurance requirements do not apply to clinical laboratory services paid for under the fee schedule.

[5]Medicare: Laboratory Fee Schedules Produced Large Beneficiary Savings but No Program Savings (GAO/HRD-88-32, Dec. 22, 1987).

239) capped fee payment rates at 93 percent of the national median fee rates, effective January 1, 1990. We estimate that this cap reduced Medicare payments by 5 percent. Most recently, OBRA 1990 (P.L. 101-508) reduced the cap to 88 percent of the national median, effective January 1, 1991. We estimate this lower cap will reduce Medicare payments an additional 4 percent.

About 4,500 independent clinical laboratories are certified to provide services to Medicare beneficiaries. These laboratories are dependent primarily on referrals from physicians and hospitals[6] for their work load.

Independent laboratories generally maintain two price lists, charging retail prices to private paying customers and those whose insurance program, such as Medicare, pays the laboratory directly and discounting their charges to physicians and hospitals. Independent laboratories defend this dual pricing system on the basis of their continuing business relationship with the hospitals and physicians, which allows them to bill these accounts on a periodic "statement" basis, summarizing the charges for many test procedures performed over a time period, such as a month. For these accounts, the laboratories only need to obtain billing information for the physician or hospital and enter that information into their data systems one time—at the time the account is opened. Also, laboratories claim their bad debt expenses from their hospital and physician accounts are lower than from their patient or third-party payer accounts.

In contrast, laboratories generally bill their self-paying patients and third-party payers on a "transaction basis"; that is, the laboratory generates a bill each time it performs test services for a customer. For these customers, patient or insurance billing information must be obtained and entered into the companies' billing records each time services are performed. This increases the laboratory's work load and adds to its expenses. Laboratories claim they also incur additional expenses in billing and recording collections on a transaction basis versus billing on a periodic statement. For example, billing on a transaction basis requires preparing and mailing separate bills for each patient plus recording and depositing payments. Laboratory officials cite these administrative

[6]Beneficiaries may also obtain outpatient laboratory tests from about 6,000 hospital laboratories and 100,000 physician offices that have their own laboratory equipment.

expenses, plus higher bad debt expenses associated with direct billed customers,[7] as justification for the dual pricing system.

Although the system is defended primarily on the basis of cost differentials, laboratory company officials also acknowledge that business competition influences their pricing policies. This competition primarily affects the laboratories' charges to their hospital and physician customers because laboratories compete with one another to obtain a physician's or hospital's work. The premise within the industry is that if a laboratory can obtain a physician's or hospital's account for those services for which it pays the laboratory, the laboratory will receive the testing work from that customer's business that is billed to patients and insurers. Thus, the laboratories tend to discount their charges to hospitals and physicians to attract and retain them.

Objectives, Scope, and Methodology

Section 4064 of OBRA 1987 required us to study the appropriateness of the clinical laboratory service fee schedule amounts, considering the laboratories' costs of these services and the revenues received for furnishing them. Ideally, to accomplish this objective, we would compare the costs of conducting particular tests with the Medicare payment level for them; however, laboratories do not accumulate costs in a manner that would enable such a comparison. Establishing a system to collect, and actually collecting, the necessary cost data would have been prohibitively expensive for the laboratories.

In consultation with your staffs, we decided to allocate laboratories' costs to their three major lines of business—discount (generally hospital and physician) customers, Medicare, and other retail payers—and compare pretax profit rates based on revenues from each payer type to determine whether Medicare was contributing more or less to profits than other payers. If Medicare fee schedule payments were resulting in comparable profit rates with other payers, the program would be paying appropriately.

To allocate costs among laboratories' lines of business, we modified Medicare's hospital cost allocation process to fit the circumstances. Under our method, most laboratory costs are allocated to lines of business based on standardized charges for the tests. Costs that are attributable to specific payers are allocated to those payers. Profit rates are

[7]Laboratories incur no bad debts on Medicare business because the program pays 100 percent of the allowed amount. Beneficiaries are not liable for any payment.

then computed by subtracting allocated costs from the actual revenues received from the payer type and dividing the result by revenues. This yields profits as a percentage of sales. While it is normally preferable to express profits as a return on investment, data were not available to do so for some laboratories, so for consistency we computed return on sales for all laboratories reviewed.

We decided, again in consultation with your staffs, to concentrate on independent laboratories with particular emphasis on large laboratory companies because they offered the greatest economies of scale and thus offered us an opportunity to assess the appropriateness of Medicare's fee rates in an economical service delivery environment. We excluded hospital and physician office laboratories from our analysis.

We chose the five largest independent laboratory companies in the country for our review. Each company had annual net revenues in excess of $150 million. Collectively, these companies had annual net laboratory service sales of about $2 billion. In addition, each company operates multiple testing locations throughout the United States, and we estimate that they perform about 40 percent of all Medicare laboratory test services billed by independent laboratories.

For comparison, we reviewed a sample of smaller laboratories. We selected 11 companies whose annual net revenues ranged from about $200,000 to about $17 million. Five of these companies were recommended to us by the American Association of Bioanalysts, an industry association representing mostly smaller laboratories. We selected the remaining six companies to achieve geographic and size mix. These laboratories had operations in six states.

Additional information on our objectives, scope, and methodology, including a listing of the laboratory companies reviewed and a detailed discussion of the methodology we used to apportion operating costs, is contained in appendix I. We conducted field work between June 1988 and October 1990. Our work was conducted in accordance with generally accepted government auditing standards.

We requested and obtained comments on a draft of this report from the Department of Health and Human Services (HHS). Our response to those comments appears after our recommendation, and a copy of HHS's comments is included in appendix II.

Large Laboratories' Average Return on Sales to Medicare Exceeds Their Overall Rate of Return

Four of the five large laboratory companies suffered losses on business with their discount customers, but all five had substantial returns on sales for Medicare and other retail customers. The overall annualized rate of return on sales for the five companies was 15 percent. Table 1 compares profit rates by customer group for the five companies.

Table 1: Comparison of Annualized Pretax Rates of Return on Sales for Large Laboratory Companies

Figures in percent

Laboratory company	Discount customers	Retail customers		Overall
		Medicare	Other retail	
A	−20	28	33	•
B	−6	22	11	•
C	−8	21	44	•
D	−3	46	41	•
E	5	18	26	•
Weighted average	**−1**	**32**	**31**	**15**

The laboratories' average return on Medicare sales exceeds their overall rate of return because, like other retail customers, Medicare pays substantially more for test services than do the laboratories' discount customers. While the laboratory companies we reviewed did incur higher costs performing work for retail customers, including Medicare, the higher costs were more than offset by higher payments.

The cost of doing an analysis within a laboratory is the same regardless of who pays for it; however, other cost elements, including specimen collection, data entry and processing, billing, and accounts receivable management and collection do vary by customer group. Thus, the allocated cost of performing test services and collecting payment varies also.

Table 2 shows the results of our relative cost comparison for each of the five large laboratories. As a group, discount customers are the least costly to serve. Therefore, for comparison purposes, we have expressed discount customer costs in terms of a $1.00 base cost and have shown Medicare and other retail customer costs relative to that base.

Table 2: Large Laboratories' Costs of Serving Medicare and Other Retail Customers Indexed to Their Costs of Serving Discount Customers

Laboratory company	Discount customers	Retail customers	
		Medicare	Other retail
A	$1.00	$1.28	$1.52
B	1.00	1.12	1.53
C	1.00	1.29	1.36
D	1.00	1.17	1.64
E	1.00	1.30	1.68
Weighted average	**$1.00**	**$1.19**	**$1.55**

During our review period, we estimate that large laboratories' costs were, on average, 19 percent higher for Medicare work and 55 percent higher for other retail customer work than their costs to do the same work for discount customers.

Fee Schedule Payments More Than Offset Higher Costs of Serving Medicare Beneficiaries

While laboratories incur higher costs serving Medicare than their discount customers, these higher costs are more than offset by Medicare fee schedule payments. Table 3 shows a relative revenue comparison for each of the five large laboratories. As with costs, we have expressed discount customer revenues in terms of a $1.00 base revenue for each laboratory and have shown Medicare and other retail customer revenues relative to that base.

Table 3: Large Laboratories' Revenues From Medicare and Other Retail Customers Indexed to Their Revenues From Discount Customers

Laboratory company	Discount customers	Retail customers	
		Medicare	Other retail
A	$1.00	$1.51	$2.17
B	1.00	1.60	1.96
C	1.00	2.14	2.71
D	1.00	2.16	2.67
E	1.00	1.76	2.63
Weighted average	**$1.00**	**$1.72**	**$2.21**

During the period of our analysis, we estimate that Medicare paid 72 percent more and other retail customers paid 121 percent more than discount customers paid for equivalent units of work. Medicare's payments are relatively lower than other retail customers', even though both groups are often billed at the same rates. This results because Medicare pays the lesser of the amount billed or the fee schedule rate, whereas other retail customers generally pay the full amount, or a higher percentage of billed charges than does Medicare.

Medicare Fee Schedule Payments Subsidize Discount Customer Sales

Even considering the January 1990 reduction in the fee schedule cap from 100 percent of the median to 93 percent and the January 1991 reduction to 88 percent, the large laboratory companies would have earned substantially higher rates of return from Medicare and other retail customers than from discount customers. In effect, Medicare and the other retail customers are subsidizing sales to discount customers.

We estimate that the 1990 and 1991 reductions lowered Medicare clinical laboratory service payments by 9 percent. Table 4 shows the effect we estimate these two reductions in the caps would have had on Medicare payments and laboratory profits had they been imposed during our review period.

Table 4: Effect of Fee Schedule Caps on Medicare Payments and Profits From Medicare for Large Clinical Laboratories

Effective date of cap	Median fee cap rate (percent)	Reduction in Medicare payments due to lowering of cap[a] (millions)	Major laboratories' profit rate on Medicare (percent)
April 1, 1988	100.0	•	32.4
January 1, 1990	93.0	$14.0	28.9
January 1, 1991	88.0	25.4	25.7

[a]The reduction is calculated from a base of 100 percent of the median. This is based on our estimate of nationwide reductions in Medicare payments that would occur for 76 high-volume clinical laboratory procedures subject to the fee schedule. The five laboratories operate throughout the United States, and we assumed aggregate payments to them would decline in proportion to our estimate of nationwide reductions.

OBRA 1987 instructed us to consider both costs and revenues in evaluating the appropriateness of Medicare's fee schedule payments. The law did not define appropriateness; however, section 1861 of the Social Security Act provides that payment rates for cost-reimbursed providers should be set so that:

". . . the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] . . . will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare] . . ."

Clinical laboratories are not cost-reimbursed providers, but we believe that the principle that Medicare should pay for its costs, as expressed above, is sound. Under that principle, Medicare and other providers would pay their own way. This is not the case here because the overall profit margins of the laboratories we reviewed averaged about 15 percent and Medicare profit margins averaged about 32 percent. We believe

it is inappropriate for laboratories to realize higher profits from their sales to Medicare than their overall profit margin.

After adjusting for the 5-percent reduction in Medicare payments achieved by the January 1990 cap and the 4-percent reduction resulting from lowering the cap in January 1991, an additional payment reduction of 11 percent would have been needed to lower the Medicare profit margin of the large laboratories to near their overall profit rate of 15 percent. To achieve this reduction by means of the fee rate caps, the existing rates would have to be capped at 76 percent of the median rates. Had they been capped at this rate in 1988, the Medicare program would have paid about $173 million less to independent laboratories and about $106 million less to other laboratory service suppliers (primarily physicians) for a reduction of about $279 million from the approximately $1.4 billion paid for laboratory services with rates capped at 100 percent of the median. In OBRA 1989 and 1990, the Congress reduced fee schedule rates (in two steps) to 88 percent of the median. We estimate these reductions would have saved about $78 million in payments to independent laboratories and about $48 million in payments to other laboratory service suppliers had those caps been in effect in 1988.

Capping Medicare fee rates at the 76 percent of median level would produce payment amounts for some tests that are below what discount customers are paying on average for the same tests. Nevertheless, Medicare will still be paying more for many test procedures and, considering the relative frequency at which Medicare purchases the different test procedures, the Medicare program will continue to pay sufficiently higher amounts than discount customers to cover the higher cost of performing the work for Medicare.

We compared the amount Medicare would pay at 76 percent of the median for 40 frequently purchased tests[8] with the average amounts discount customers of the large laboratory companies paid for the same services. For the five companies combined, if rates were capped at 76 percent of the median, Medicare would continue to pay more than discount customers for 28 of the 40 procedures and would pay less than discount customers for the other 12 procedures. Weighting these average discounted charges and fee schedule amounts by Medicare-purchase volumes, we estimate that Medicare would pay about 37 percent more for these test services than discount customers paid; however,

[8]These procedures accounted for about 46 percent of all Medicare-allowed charges for procedures subject to the fee schedule cap in 1988.

this is substantially less than the 72 percent differential during the period of our review (see table 3).

Smaller Laboratory Companies Had Profit Margins Similar to the Large Laboratories

We concentrated our review on the large laboratory companies because their economies of scale should reflect the costs of efficiently providing services. For comparative purposes, we also reviewed the performance of 11 smaller laboratory companies. Collectively, these companies made an 11-percent profit on sales of $63 million; however, they earned a 17-percent return on their Medicare sales.[9]

We categorized the 11 smaller laboratory companies in two groups—those that served (1) discount and retail customers, including Medicare, and (2) primarily retail customers.

Six of the 11 companies were in the first group. Like the large companies we reviewed, they were earning substantially higher rates of return on services for Medicare and other retail customers than on services for their discount customers. Collectively, the six laboratories made a 23-percent profit on Medicare sales, a 27-percent profit on other retail customer sales, and a loss of 4 percent on sales to discount customers.

The six companies exhibited other characteristics similar to the large companies we reviewed. For example, they practiced a dual pricing policy, billing Medicare and other retail customers at retail prices and billing discount customers from a discount price list. Collectively, they also showed a similar pattern to the large laboratories in their mix of discount, Medicare, and other retail revenue, as shown in table 5.

Table 5: Comparison of Revenue Sources for Five Large Laboratories With Six Small Laboratories

Figures in percent

Laboratories	Discount customers	Retail customers	
		Medicare	Other retail
Large	50	20	30
Small	51	19	30

[9]Some of these companies were closely held corporations, and salaries paid to the principals comprised a substantial portion of total operating costs. For example, two owners of one company paid themselves salaries totaling $474,000 and a year-end bonus totaling $60,000, which together made up almost 28 percent of the laboratory's total operating costs. In computing profit rates for the smaller laboratory companies, we reclassified expenses specifically identified as owner salaries or compensation as a distribution of profits rather than an expense.

The remaining five companies served primarily retail customers.[10] These laboratories collectively made a 7-percent profit on Medicare sales compared to 29 percent on sales to other retail customers, primarily because the Medicare fee schedule rate was lower than the companies' charges. These laboratory companies were also much more reliant on Medicare revenues than were the other company groups, collecting about 75 percent of their revenue from Medicare and 25 percent from other retail customers. This heavier reliance on Medicare would likely make this subset of the independent laboratory industry the most significantly affected by any fee schedule payment reductions.

Table 6 shows for each of the 11 smaller laboratory companies their relative profit rates on sales to each of the customer groups they serve.

Table 6: Comparison of Pretax Rates of Return on Sales for Smaller Laboratory Companies

Figures in percent

		Retail customers		
Laboratory company	**Discount**	**Medicare**	**Other retail**	**Overall**
Companies with discount customers				
F	−13	42	69	•
G	18	14	36	•
H	26	28	28	•
I	2	19	33	•
J	13	16	13	•
K	−51	21	27	•
Group average	−4	23	27	10
Companies primarily with retail customers				
L	•	−11	39	•
M	•	7	9	•
N	•	−11	28	•
O	•	3	5	•
P	•	22	48	•
Group average	•	7	29	12
Overall average	**−4**	**17**	**27**	**11**

Conclusions

Although the large laboratories incurred more costs in performing work for Medicare beneficiaries than for comparable work performed for discount customers, Medicare fee schedule revenues more than offset the

[10]One company had a few wholesale customers. Because about 90 percent of this company's revenues were from retail sales, we grouped this laboratory with others that relied on retail customers for their business.

cost differences, making Medicare one of the laboratories' more profitable customers. Medicare and other retail customers are essentially subsidizing laboratory sales to discount customers. Based on the principle that Medicare should pay its own way but not subsidize services for other customer groups, we believe that Medicare's fee schedule payment rates are, on average, too high.

Even for smaller laboratories that provide services to discount as well as retail customers, their combined return on sales to Medicare beneficiaries is substantially above their rate of return on sales to discount customers, and each laboratory's return on sales to Medicare beneficiaries is higher than the combined rate of return on sales to all customers. Only those smaller laboratories that have essentially no discount customers had a rate of return on Medicare sales below the laboratory's overall return on sales.

The large laboratory companies we reviewed offer the greatest opportunities for economical operations. Had the fee cap reductions of January 1990 and 1991 been in effect during our review period, aggregate Medicare payments to these suppliers would have resulted in profits about 11 percentage points higher than their overall profit rate. If Medicare's fee schedule rates were capped at 76 percent of the median of all fees, the large laboratories would have received a return on sales to their Medicare customers approximately equal to their overall return on sales. To maintain their profit levels under reduced Medicare caps, the laboratories would need to increase revenues from other payers.

If laboratory fee schedules were capped as discussed above, some smaller laboratories would face losses. They would have to take action to improve their level of efficiency by reducing costs or leave the business.

If rates are capped at 76 percent of the median, Medicare would pay more than discount customers for some procedures and less for other procedures. While in the aggregate Medicare would pay more than discount customers, there would likely be some inequities between the Medicare fee schedule and typical charges to discount customers in some Medicare carrier areas. To address and correct any inequities that may exist, the Secretary of HHS would need authority to adjust the fee schedule rates.

Recommendations

We recommend that the Committees propose legislation capping Medicare payments for clinical laboratory test services at a level that will reduce those payments so that Medicare's contribution to laboratories' profits do not exceed their overall profit rate. Our data indicate that capping fees at 76 percent of the median of all fee schedules would accomplish this goal. The Committees also should propose legislation giving the Secretary of HHS authority to adjust the cap rates for individual test procedures where relative rate inequities are apparent.

Agency Comments

HHS agreed that fee schedule payments for clinical laboratory services should be reduced and the Secretary be given authority to adjust rates for individual tests where relative rate inequities are apparent.

HHS raised a concern about setting Medicare payments based on laboratories' profit margins. We considered that when designing our methodology. As stated earlier, although the ideal way to evaluate the appropriateness of Medicare payments would be to compare a particular test's costs with its Medicare payment level, laboratories do not collect the needed cost data and to do so would be prohibitively expensive. We devised the methodology used in this report as a workable alternative, taking no position on whether the laboratories' profit margins are reasonable. Our position is that Medicare should not be subsidizing other customers, but the program is subsidizing the laboratories' discount customers.

HHS suggested and we agree that the appropriateness of Medicare payment levels may need to be reviewed in the future because of changes in the regulatory environment, such as new requirements under the Clinical Laboratory Improvement Act of 1988, and advances in technology.

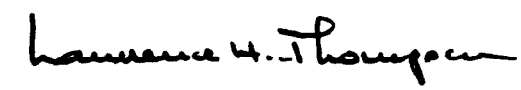
HHS also suggested that because laboratories' costs of providing services to Medicare customers exceeded by an average of 19 percent their costs of equivalent services for discount customers, legislation may be appropriate to limit laboratories' charges to Medicare to about 19 percent over their charges to discount customers for the same services. Overall, laboratories lost money on their business with discount customers. Thus, if Medicare payments had been limited to 19 percent above what laboratories charge discount customers, the laboratories would also have lost money on their Medicare business. This could result in laboratories increasing charges to discount customers to maintain Medicare profits with an overall net increase to society in laboratory costs.

In our view, using fee schedule caps to reduce Medicare payments has certain advantages over the percentage limit suggested by HHS. Those advantages include that caps are easy to implement and have the effect of lowering high payment rates while not affecting low rates.

There is ample precedent for using the capping mechanism, as shown by the Congress' use of caps in the Consolidated Omnibus Budget Reconciliation Act of 1985 and its adjustments to the caps in OBRA 1987, OBRA 1989, and OBRA 1990.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of HHS; the HHS Inspector General; and other interested congressional committees. We will also make copies available to other interested parties on request.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 275-5451. Other major contributors are listed in appendix III.



Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act

Objectives, Scope, and Methodology

This report summarizes the results of our evaluation of the appropriateness of Medicare's fee schedule payment system for clinical diagnostic laboratory services. The requirement and objective of our study are contained in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), section 4064, which directed us to:

"... conduct a study of the level of the fee schedules established for clinical diagnostic laboratory services under section 1833(h)(2) of the Social Security Act to determine, based on the costs of, and revenues received for, such tests the appropriateness of such schedules."

Clinical laboratory test services may be performed in hospitals, doctors' offices, or independent laboratories. In consultation with the congressional committees having oversight of the Medicare program, we decided to concentrate our evaluation on independent laboratories, with special emphasis on the large laboratory companies. The Congress has established the costs of efficiently and economically operated providers as the payment standard for a number of services under both Medicare and Medicaid. We believe these large laboratories offer the opportunity for economies of scale and efficient operation. Thus, their cost and revenue experience are an appropriate basis for evaluating the Medicare fee schedule payment rates in relation to the costs of efficiently furnishing services.

Laboratory Company Selection

Five large laboratory companies account for more than 40 percent of all Medicare test services performed in independent laboratories. These laboratories and their approximate total net revenues during annual periods between April 1988 and December 1989 are shown in table I.1.

Table I.1: Large Laboratory Companies Reviewed

Dollars in millions

Company	Annualized net revenues
SmithKline Beecham Clinical Laboratories	$675
National Health Laboratories	402
Roche Biomedical Laboratories	387
MetPath	352
Damon Clinical Laboratories	152
Total	**$1,968**

We included all or major segments of these large laboratory companies in our audit. Our evaluations of National Health Laboratories and Roche

Biomedical Laboratories covered the entire companies. We included all of SmithKline Beecham Clinical Laboratories, except International Clinical Laboratories, another major laboratory company which was acquired by SmithKline during our review period. We excluded that company because it had not been fully integrated into SmithKline's financial accounting system during this time. We included 1 of 5 MetPath regions and 3 of Damon Clinical Laboratory's 11 regional laboratories in our study. Both MetPath and Damon officials considered the company components we reviewed to be reasonably typical of their operations, and they did not wish to expend the resources needed to assist us in collecting the information to include additional company components.

Laboratory company officials told us that the financial data they furnished for our analyses were proprietary. Therefore, to prevent the inadvertent identification of financial data with a particular supplier, the same designator is not used for the same company each time designators are used. For example, supplier A in one table of this report may be supplier B, C, D, or E in other tables.

We also included 11 smaller laboratory companies in our review for comparative purposes. Five of the 11 laboratory companies were recommended for our review by the American Association of Bioanalysts, an industry association representing primarily smaller independent laboratory companies. We selected the other six laboratories judgmentally from Medicare payment records, giving consideration to selecting laboratories from several areas of the country and from different size strata, based on revenues. These companies, their locations, and their approximate revenues during annual periods between April 1988 and December 1989 are shown in table I.2.

Table I.2: Smaller Laboratory Companies Reviewed

Dollars in thousands

Company and location	Annualized revenues
Companies with discount customers	
Associated Pathologist Laboratories, Las Vegas, Nevada	$16,926
Sierra Nevada Laboratories, Inc., Reno, Nevada	16,880
Physicians Clinical Laboratory, Sacramento, California	13,711
Metromed Laboratories, Inc., Chicago, Illinois	2,665
Suburban Medical Laboratory, Inc., Cuyahoga Falls, Ohio	2,004
Biological Technology Laboratory, Inc., St. Louis, Missouri	1,981
Companies primarily with retail customers	
Norsom Medical Laboratory, Harwood Heights, Illinois	4,535
Schaffer Laboratories, Inc., San Ramon, California	2,293
Allied Medical Laboratories, Inc., East St. Louis, Illinois	1,213
Community Medical Laboratory of Metuchen, Inc., Metuchen, New Jersey	547
Highland Laboratory, Inc., Templeton, California	219
Total	**$62,974**

Time Periods Analyzed

We reached agreement with each laboratory company on the operating period we would examine. These periods ranged from 1 to 12 months and took into consideration company officials' time, resources, and data availability. In each case, however, company officials assured us the selected period was reasonably typical of their operations and that a different period would not produce substantially different results. In all cases where our evaluation covered less than 12 months, we annualized the data.

In all instances, the financial operating period we examined was between April 1, 1988, and December 31, 1989. During this period, Medicare fee rates were capped at 100 percent of the median of all carrier rates. Effective January 1, 1990, Medicare fee rates were capped at 93 percent of the median rates. Also, effective January 1, 1991, rate caps were reduced to 88 percent of the national median. We estimated the effect of these two reductions in the caps on Medicare payments and laboratory profit rates.

Cost Allocation Methodology

The basic methodology we used to assess the appropriateness of Medicare's fee schedules was to compare the selected laboratory companies' profits on the work they performed for Medicare to their profits on work performed for other retail customers and for discount customers.

As discussed below, we allocated each company's total operating costs to the different customer groups. After these allocations, we computed the net pretax profits and profit rates on sales to each group.

Laboratory company officials stated that some of their operating costs vary depending on the customer (or paying entity). Factors they frequently mentioned that caused these variations included the cost of collecting specimens, test order data entry and processing, and billing and collection. They also acknowledged that some costs—such as the costs of analyzing specimens in the laboratory—would not vary by customer. Recognizing these differences, we asked laboratory company officials to identify and separate their total operating costs into two major cost pools—costs that did and did not substantially vary by customer type.

For the costs that did not vary substantially, we adapted an allocation formula that the Health Care Financing Administration (HCFA) uses in its hospital cost reports to allocate ancillary service department costs. This formula allocates costs to the Medicare program in the same ratio as charges to Medicare bear to total charges. To make the allocation formula equitable, Medicare's cost report process requires hospitals to accumulate charges as if all customers are billed at the same rate for the same services. Therefore, to make the allocation formula work in the independent laboratory environment, we standardized revenues by recomputing revenues assuming the companies had billed all customers at the same rates for the same procedures. We used the ratio of each customer group's standardized revenues to the total company standardized revenues to allocate costs that did not vary substantially by customer type.

For costs that did vary substantially, we asked laboratory officials to propose equitable bases for allocations. We accepted or reached agreement on most of the allocations proposed by company officials. Examples of these allocation bases are shown in table I.3.

Table I.3: Examples of Costs That Vary by Customer Group and Bases for Allocating Those Costs Among Customer Groups

Cost element	Allocation basis
Specimen collection costs	Number of specimens collected
Test order data entry	Number of orders entered
Billing and collection	Counts of employees or time used to perform this function

We did not reach agreement with laboratory company officials on all cost allocation bases. The most significant area of disagreement concerned several laboratories' proposals to allocate general and administrative (overhead) expenses and sales expenses on the ratio of customer group net revenue to total net revenues. The laboratories' rationale was that net revenues are an accepted method of allocating these expenses between geographic or organizational units of their companies and, thus, should be an acceptable basis for allocating expenses among the various groups of purchasers.

We disagreed, believing that using net revenue to allocate these expenses would inequitably assign more costs to those customers who pay higher prices, regardless of the resources required to perform the service. For example, if Medicare pays $6 for a routine urinalysis and a discount customer pays $3 for the same test, allocating costs on the basis of net revenue would allocate twice as much expense to the Medicare purchase as to the discount purchase without regard to the relative resources consumed to provide the service.

Where we were unable to reach agreement with laboratory company officials on the basis for cost allocation, we used the basis we judged appropriate. We allocated sales department revenues using the ratio of standardized revenues rather than net revenues. We allocated general and administrative (overhead) expenses using the ratio of accumulated costs—that is, the ratio of costs allocated to each customer group using all other bases to the total costs allocated using all other bases. This accumulated cost ratio is also the basis HCFA uses to allocate general and administrative costs in its hospital cost reports. We discussed this issue with HCFA program officials, and they agreed with our reasoning.

Although this report is based on cost allocations we judged appropriate, for comparison purposes we computed profit rates by customer group assuming that we had agreed with the laboratories' final proposed cost allocations. The results of the analysis did not differ markedly from those we used, as shown in table I.4.

Table I.4: Comparison of Pretax Rates of Return on Sales for Large Laboratory Companies Using GAO's and Laboratory Companies' Cost Allocations

Figures in percent

Basis for estimates	Discount customers	Retail customers		Overall
		Medicare	Other retail	
Allocations per GAO	−1	32	31	15
Allocations per laboratory companies	2	29	28	15

Estimates of Fee Cap Savings

We estimated the Medicare program savings that resulted from imposition of the 93 percent of median fee rate cap, and the savings that would result from the 88-percent cap effective in January 1991 and additional cap levels, using data we obtained from HCFA.

We obtained data files showing each Medicare carrier's fee rate and test volume for 72 frequently performed clinical laboratory test procedures. We also obtained the national median fee rate for each of these procedures. These procedures account for about 60 percent of the total Medicare-allowed charges that are subject to the fee rate caps.

Using this information, we computed the total amount Medicare would pay for the 72 test procedures assuming payment was made at the lesser of each carrier's fee rate or the fee rate cap. We computed these estimated payments assuming that fee rates were capped progressively from the national median rates down to 76 percent of median rates. We then computed the percentage decline in total payments as the cap was progressively lowered. For our computations, we used Medicare fee rates and cap amounts as they existed on April 1, 1988.

In conducting our review, we interviewed laboratory, trade association, and HCFA officials. We also obtained and reviewed laboratory company financial reports and supporting records and automated computer tape files of test services performed. We performed such tests and verifications of these data as we deemed appropriate to assure ourselves of their reliability.

The laboratory companies included in our evaluation agreed to cooperate provided that our report not present information in a manner that would disclose proprietary financial information. That is the reason this report presents financial information in the form of comparative ratios and percentages rather than actual dollar amounts. Also, the companies are listed in random sequence in each report table (that is, company A in table 1 is not necessarily company A in table 2) to preclude association of revenues, expenses, and profits by company.

We conducted fieldwork between June 1988 and October 1990. Our work was conducted in accordance with generally accepted government auditing standards.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: Payments for Clinical Laboratory Test Services Are Too High." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare: Payments for Clinical Laboratory Test Services Are Too High"

Overview

GAO found that laboratories' profit margins are significantly greater on testing performed for Medicare beneficiaries than for other testing performed for physicians and hospitals. As a result, Medicare is essentially subsidizing the lab work of laboratories' other customers. This finding confirms our general suspicion that labs have been overcharging Medicare. GAO goes on, then, to recommend capping Medicare payments at 76 percent of the median of the fee schedules so that Medicare's contribution to laboratories' profits do not exceed their overall profit rate.

GAO Recommendation

We recommend that the Committees propose legislation capping Medicare payments for clinical laboratory test services at a level that will reduce Medicare payments so that Medicare's contribution to laboratories' profits do not exceed their overall profit rate. Our data indicate that capping fees at 76 percent of the median of all fee schedules would accomplish this goal. The Committees also should propose legislation giving the Secretary of Health and Human Services authority to adjust the cap rates for individual test procedures where relative rate inequities are apparent.

Department Comment

We strongly agree with GAO that there is still opportunity for further reductions in the national limit for the lab fee schedule. We agree that Medicare should not be subsidizing discounts to physicians and providers. The GAO conclusion that Medicare is paying too much for clinical laboratory tests is consistent with the OIG's findings as reported in its audit report titled "Changes Are Needed In the Way Medicare Pays for Clinical Laboratory Tests" dated January 24, 1990. This report examined charges to physicians and to Medicare and concluded that profiles, or groups of tests, are billed differently to "discount purchasers" than to Medicare.

However, we are concerned about determining the level at which the national limit should be set based on profit margins. We are not in the business of guaranteeing any particular profit margin to entities providing services to Medicare beneficiaries, nor of determining what is an appropriate level of profit on either all or a portion of private providers' businesses. Such a policy could also have the effect of eliminating incentives for entities to be efficient.

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While we support making further reductions in the national limit, we are concerned about the impact of taking the recommended reduction in 1 year.

- It is not clear what impact such a reduction would have on access to lab services. The report indicates that smaller labs may not be able to absorb the recommended reduction.

- In addition, new requirements under the Clinical Laboratory Improvement Act of 1988 (CLIA) will increase the cost of doing business. Thus, part of our current overpayment will be eliminated as labs fully comply with CLIA.

In summary, we would support reducing partially the national limit to the level recommended by GAO. Subsequent to the implementation of CLIA, the appropriateness of this level could be reevaluated.

In addition, GAO proposes that the Secretary be given authority to adjust rates for individual tests where relative rate inequities are apparent. We concur with this recommendation. While the statute does give the Secretary the authority to make adjustments to fees that are "justified by technological changes", it does not give the Secretary the authority to adjust fees to account for other factors which may have affected the relative costs of individual tests.

Finally, we believe that since GAO has determined that laboratory costs for Medicare testing are 19 percent higher than for discount customers due to higher administrative and bad debt costs associated with Medicare work, GAO should address (in the same legislative recommendations) the question of how HCFA could maintain long-term balance in relative pricing. We suggest that GAO examine this issue and make a legislative recommendation regarding the appropriate parameters for applying section 1128(b)(6)(A) of the Social Security Act. This section provides sanctions for suppliers that charge Medicare significantly in excess of their usual charge. Defining "significant" and "usual" have been stumbling blocks to effectively implementing this provision.

GAO could recommend a legislative definition that any charge to Medicare by a laboratory greater than a certain percentage of the lowest charge by that laboratory to any other customer is significantly in excess of its usual charge for the purposes of section 1128. On page 9 of the draft report, GAO notes that laboratories' costs were, on average, 19 percent higher for Medicare work than laboratories' costs for discount customers. The 19 percent figure is based on the average charge to discount customers while we suggest that GAO identify an equivalent percentage based on the lowest charge to discount customers.

Now on p. 7

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The GAO data would appear to lend itself to this calculation. In this way, Medicare would be assured that future efficiencies in the production of tests would be passed through to the benefit of the program. We believe this is a particularly important concern in the case of the laboratory market because of the constant advances in technology.

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