

# Educating Patients Critical to Controlling Out-of-Pocket Clinical Laboratory Test Costs

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**AS HEALTHCARE COSTS CONTINUE TO ESCALATE** in Rhode Island and nationwide, an important but often overlooked portion of those costs—along with insurance coverage issues—deserves to be examined: fees for clinical laboratory tests.

The basic facts of the situation are as follows:

- All of the above services, when provided by accredited facilities—whether hospital-affiliated or not—are essentially the same.
- Regardless, there is a wide disparity in costs between services delivered by independent providers—and those delivered by hospital-affiliated facilities. For example, an independent clinical lab would charge \$33 for a Complete Blood Count—vs. a hospital-affiliated lab's charge of \$45; \$53 for a **Comprehensive Metabolic Panel (CMP)**, which includes 14 basic chemistry tests consisting of glucose, BUN, Creatinine, Calcium, Total bilirubin, AST, ALT, Alk. Phosphatase, Total Protein, Albumin, and electrolytes—vs. \$474; \$52 for a TSH test—vs. \$87, \$21 for a U/A vs. \$40, and \$52 for a PSA vs. \$65.81
- Consequently, the hospital-affiliated facilities receive higher per-service reimbursements from insurance companies. Moreover, hospitals receive their reimbursements at higher rates on charges than independents—an average of 70% vs. an average of just 40%. This means that of the full charges submitted to the commercial insurers, such as BCBSRI and United, hospitals are generally reimbursed closer to 70 % of their charges vs. 40% of charges for independents. Since hospital charges are substantially higher than those of independent providers, the resulting reim-

bursement (cost to the insurer) is much higher. If a patient has insurance, s/he does not have to pay anything for covered services unless the plan is subject to a deductible, in which case s/he would be responsible to pay whatever the insurer would have paid the provider of the services.

- Increasingly higher insurance reimbursements contribute to steadily higher premiums that individuals and employers must pay—with increases of 7% to 12% for company plans approved by the RI Insurance Commissioner for 2011. Moreover, these increases are for policies that typically offer lower coverage levels, and require higher deductibles.
- Higher deductibles—resulting from the proliferation of more affordable, lower-premium insurance plans—mean that patients are paying, *out of their own pockets*, increasingly larger portions of the costs of their clinical lab tests. Exact reimbursement information for the hospitals is unavailable; however, based upon the five tests listed above, the *highest* reimbursement an independent lab would receive for these tests would be \$79.70. If we assume the 70% reimbursement level for the hospital, the same five tests would reimburse \$498.27. Even if we assumed they were reimbursed at only 25% of a charge, they would receive \$177.95, which is more than twice what the independent lab would receive from its best payer. This amount would be applied to the deductible and result in an out-of-pocket expense to the patient.

This is an inherently complicated, confusing, and exasperating situation for many patients, but one which can be

improved through education. Insurance companies are not generally providing this education. Nor are benefits managers at many companies. To its credit, the **Rhode Island Department of Health (RIDOH)** attempted to help by requesting that all clinical laboratories submit their charge lists for publication on the RIDOH website, and thus make this comparative information available to the public. Unfortunately, most of the hospitals did not reply, and the effort consequently failed. In light of these challenges, it is critically important that healthcare professionals and institutions take up the slack and assume some responsibility for this worthy mission.

The goal of this educational effort would be to ensure that individual consumers of healthcare services understand the way insurance coverage works—and possess the knowledge and tools to take greater control over the cost of their clinical lab and other ancillary services while also, collectively, making a contribution to the slowing of the overall cost of healthcare.

Specifically, patients need to understand:

- Why, fundamentally, there is a disparity between the cost of services provided by independent facilities vs. the cost of comparable services provided by hospital-owned or -affiliated facilities—because hospitals have higher overhead or operating costs (at least when services are provided under the hospital's roof, and not at a separate, commercial, "outreach" site in the community).
- How those costs are passed on to insurance companies—in the form of higher reimbursement payments.
- That those costs are ultimately passed on to the individual—in the form of higher premiums, co-payments, and deductibles.

In specific regard to deductibles, it is noteworthy that in April 2011, Blue Cross/Blue Shield of Rhode Island ceased offering a policy without a deductible when sold to groups of 50 or less, which constitute the majority of group plans in the state.

- How lower reimbursement payments to independent providers will help the bottom line of insurance companies—and ideally help rein in the increases of individual and employer premiums, as well as of deductibles.
- The fact that using lower-cost healthcare service providers reduces the individual's deductible expenses—by ensuring that the individual pays less out of pocket, and possibly never has to “work off” the entire deductible amount in a given year.
- That patients can, at any time, exercise their right to choose their providers of clinical lab services

(as well as imaging, PT, and other services)—by reviewing the options, comparing them, and discussing them with their physicians and other healthcare providers.

- How personal cost-efficiencies—beginning with the selection of lower-cost independent service providers—can reduce not only personal healthcare costs, but also overall healthcare costs, with potential system-wide savings of millions of dollars annually.

Communications vehicles for conveying this vital information to patients could include: pamphlets—especially from leading organizations devoted to the diagnosis and treatment of specific diseases—on display in waiting rooms; postings on physicians', clinics', and hospitals' websites, with links to other useful sites; community outreach and education forums at community hospitals; and, of course, one-on-one discussions between patients and their primary care doctors.

This is a logical, straightforward, and eminently achievable educational

program that healthcare providers and institutions can easily undertake, individually or in concert with their professional associations. It is a program they *should* undertake—in fact, to expedite—in the best interests of the physical, emotional, and financial well-being of the patients who depend on them.

#### **Disclosure of Financial Interest**

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