REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF THE IMPACT OF MANAGED HEALTH CARE SYSTEM PRACTICES ON MEDICAL LABORATORY SERVICES PURSUANT TO HJR 233 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 20

COMMONWEALTH OF VIRGINIA
RICHMOND
1995

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Preface

House Joint Resolution (HJR) 233 of the 1994 Session requested the Joint Commission on Health Care to study the impact of managed care system practices on the quality and competitiveness of medical laboratory services.

While not specifically stated in HJR 233, the contracting methods used by managed care companies to secure medical laboratory services for their enrollees was the focus of this study. Most managed care companies (e.g. Health Maintenance Organizations and preferred provider organizations) contract with one large regional laboratory, often on a capitated basis, to provide laboratory services to their participating physicians and enrollees. In return for a high volume of services, managed care organizations are able to negotiate discounts which lower the cost of services to physicians and patients.

Some smaller laboratories have voiced concern that the contracting practices of managed care organizations result in lower quality services, and eliminate physicians and patients' choice of where to have their testing performed. They also contend that these contracting practices are causing smaller labs to close down, leaving a few dominant labs to control the market. Lastly, the smaller laboratories argue that in order to survive in the marketplace, the reimbursement provided to medical laboratories should be on a discounted fee-for-service basis, rather than a capitated basis.

While four national/regional labs hold a substantial share of the market, we were not able to find any research that analyzed the differences in cost and quality between large and small labs. The smaller laboratories were not able to provide any research, studies or data to support their claim regarding quality of services. The managed care organizations interviewed as part of this study stated that they receive few if any complaints from physicians or patients regarding the quality of laboratory services. Moreover, several of these organizations stated that the discounts negotiated through their contracting practices reduced their costs by 50% or more.

An issue which directly impacts medical laboratories is the passage of House Bill (HB) 840 by the 1994 General Assembly. This legislation provides that managed care organizations and other insurers cannot deny or limit benefits for enrollees who receive services from any pharmacist or "ancillary service provider" so long as the provider accepts the managed care organization or insurer's level of reimbursement that is paid to network providers. HB 840 did not specifically define "ancillary service provider." However, subsequent to the completion of this study, the Bureau of Insurance issued Administrative

Letter 1994-8, in which it stated its position that the statutory definition of "ancillary service provider," as provided in HB 840, is extremely broad, and that unless and until the statutory definition is made more restrictive, any person or class of persons that provides services that support, facilitate or otherwise enhance medical care and treatment meets the definition of "ancillary service provider." Thus, medical laboratories currently are considered ancillary service providers, and managed care organizations may not prohibit persons from receiving services from a laboratory as long as the laboratory accepts the level of reimbursement the managed care organization provides to network providers.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

December 30, 1994

TABLE OF CONTENTS

Authority for Study

House Joint Resolution (HJR) 233, which was passed by the 1994 Session of the General Assembly, directs the Joint Commission on Health Care, in cooperation with other appropriate state agencies and private groups, to study the impact of managed care system practices on the quality and competitiveness of medical laboratory services. Specifically, the resolution requests the Joint Commission to assess the impact of managed care systems' practices on (i) the Commonwealth's efforts to contain costs while assuring quality health care, and (ii) competition in the marketplace among medical laboratories.

Background

Medical Laboratories Provide a Wide Range of Services in a Variety of Settings

Medical laboratory services include a wide range of diagnostic services such as testing of blood, urine, and tissue samples. Medical laboratories conduct these tests in support of routine chemical analyses, microbiology, hematology, and pathology.

These services are provided in a number of different settings. However, the primary settings in which laboratory services are provided are: hospitals, physicians' offices, nursing facilities, home health agencies, and independent laboratories. Figure 1 provides information on the various types of laboratories currently operating in Virginia.

Medical Laboratories Are Not Licensed or Regulated by the Commonwealth

Like nearly all other states, the Commonwealth neither licenses nor regulates medical laboratories. The Virginia Department of Health's (DOH) Office of Health Facilities Regulation works in cooperation with the U.S. Health Care Financing Administration (HCFA) to ensure that laboratories meet federal guidelines for the proper handling and testing of human specimens.

Figure 1

Medical Laboratories in Virginia
(June, 1994)

Type of Laboratory	Number in Operation
Physicians' Offices	2,428
Skilled Nursing/Nursing Facilities	206
Hospital	195
Independent Laboratories	119
Home Health Agencies	114
Other	655
TOTAL	**3,717**

Source: Department of Health, Office of Health Facilities Regulation

Laboratories Must Follow Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Act was enacted by Congress in 1967 in an effort to improve the quality of laboratory services. The provisions of this act remained in place without any revisions until 1988. In 1988, Congress passed the Clinical Laboratory Improvement Amendments (CLIA) which updated various provisions of the original act. The amendments were passed, at least in part, as a response to a number of highly publicized studies in the mid-1980s which indicated that medical laboratories were producing inaccurate, and in many cases, fraudulent test results.

As an example of the kinds of serious shortcomings uncovered during the mid-1980s, a 1985 study of 5,000 laboratories conducted by the College of American Pathologists found that more than one half of the laboratories misread the level of cholesterol in blood samples by at least five percent, some by as much as 15 percent. Pap smear tests also came under tremendous scrutiny during 1987 and 1988. A 1987 study by the American College of Obstetricians and Gynecologists found that poor quality lab work failed to catch between 15 and 40 percent of cervical cancers or pre-cancerous conditions. The most

egregious errors were found in so called "pap-mills," which were high volume labs where some technicians' daily workload was more than six times greater than that recommended by the American Society of Cytology.

The CLIA guidelines require every facility that tests human specimens for the purpose of providing diagnosis, preventing or treating disease, or assessing the health of a human being to meet certain federal requirements. The CLIA guidelines include requirements regarding minimum qualifications of certain staff members, laboratory control procedures, and testing protocols.

Laboratories which perform only basic, routine types of tests are granted a waiver from the Health Care Financing Administration. Laboratories which perform other types of tests are classified as either a "moderately complex" laboratory or a "highly complex" laboratory, depending on the complexity of the tests that they perform. However, all laboratories including those granted a waiver must register with the Health Care Financing Administration (HCFA).

The Virginia DOH acts as an intermediary between HCFA and medical laboratories and assists laboratories through HCFA's certification process. DOH staff also conduct inspections of laboratories on behalf of HCFA as part of the ongoing CLIA certification process.

Joint Subcommittee of General Assembly Studied Medical Laboratories in 1988

As previously noted, the medical laboratory industry became mired in a major scandal during the mid 1980s. In response to the serious concerns raised about the quality of medical laboratory services, the General Assembly established a Joint Subcommittee (Senate Joint Resolution 62, 1988) to review a number of issues regarding the quality of laboratory services in Virginia. As reported in Senate Document 32 of the 1989 Session, the Joint Subcommittee examined: (i) the training and qualifications of laboratory technicians, (ii) the conduct of laboratory testing, (iii) the requisite standards for obtaining and preparing cell specimens for analysis, and (iv) the need to regulate laboratory technicians.

The Joint Subcommittee made a number of recommendations regarding medical laboratories. However, because the recommendations did not address the issue of how managed care system practices affect medical laboratories, the recommendations of the Joint Subcommittee are not presented in this issue brief.

Managed Care Practices Affecting Medical Laboratories

House Joint Resolution (HJR) 233 directs the Joint Commission on Health Care to examine the impact of managed care system practices on the costs and quality of medical laboratory services, and on competition among medical laboratories.

The term "managed care" has many different meanings. "Managed care" can refer to specific practices such as an insurance company requiring utilization review for certain medical procedures or pre-certification of hospital admissions. "Managed care" also is used in a much broader context to describe certain health care delivery systems such as Health Maintenance Organizations (HMOs) and some Preferred Provider Organizations (PPOs).

Managed Care Organizations' Contracting Practices With Medical Laboratories Are Questioned by Some Community-Based Laboratories

Based on interviews with representatives of several smaller, community-based medical laboratories who requested that HJR 233 be introduced, it was learned that the managed care practices to be evaluated in terms of their impact on the cost and quality of laboratory services and competition in the marketplace are the contracting practices of managed care organizations. More specifically, some of the smaller, community-based laboratories in Virginia have called into question the practices that managed care organizations employ when contracting with medical laboratories.

To obtain information regarding the contracting practices of managed care organizations, interviews were conducted with the following organizations which operate HMO and/or PPO health benefit plans in Virginia:

* Aetna,
* Trigon, Blue Cross Blue Shield,
* Blue Cross and Blue Shield of the National Capital Area,
* Metropolitan,
* Prudential,
* Travelers,
* MD IPA (an HMO operating in northern Virginia), and
* New York Life (which administers Health Plus HMO).

Most Managed Care Organizations Contract With One Primary Medical Laboratory In Each Geographic Area

With respect to HMO benefit programs, all of the managed care organizations identified above contract with one primary medical laboratory per geographic area to provide nearly all of the laboratory services for the physicians who participate in their HMO provider networks and the patients enrolled in their respective HMO plans. With the exception of Trigon, Blue Cross Blue Shield (Trigon), each of these managed care organizations also utilize the same contracting practices and the same medical laboratory for their PPO physicians and enrollees. Trigon utilizes a broader network of medical laboratories for its PPO benefit plans.

The laboratories utilized by these managed care organizations for their managed care benefit plans (HMOs and PPOs) include: Smith-Kline Laboratories, MetPath Laboratories, Roche Laboratories, National Health Laboratories, American Medical Laboratories, and Maryland Medical Laboratories. Smith-Kline, MetPath, Roche, and National Health Laboratories are large national companies, while American Medical and Maryland Medical are regional laboratories. Because some managed care organizations' service areas cover multiple states or regions, some contract with two or more of these laboratories. However, only one laboratory typically is used as the primary laboratory in a given geographic area.

Each insurer indicated that while one laboratory performs the vast majority of laboratory services in a given geographic area, there are instances in which other laboratories are used. For instance, other laboratories are used when the primary laboratory does not have a location nearby or when there is an "overflow" of work that cannot be handled in a timely fashion by the primary laboratory. Another instance in which other laboratories are used is when PPO enrollees receive laboratory services "out-of-network."

HMOs Pay Medical Laboratories on a Capitated Basis; PPOs Pay Laboratories on a Capitated or Discounted Fee-For-Service Basis

As with most services, HMOs reimburse medical laboratories on a capitated basis. As such, HMOs negotiate a set payment amount that is made on a monthly basis to their respective medical laboratory(ies). Similar to other types of "capitated" providers, the laboratory receives a payment amount based on the number of enrollees regardless of the number of procedures or tests performed. This capitated payment arrangement eliminates any incentive for the laboratory to conduct additional tests not ordered by the referring physician, which helps to hold costs down.

With respect to PPO benefit plans, some of the managed care organizations indicated that medical laboratories are paid on a capitated basis, while others stated that their laboratories are paid on a discounted fee-for-service basis.

Impact of Managed Care Organizations' Contracting Practices on Cost and Quality of Laboratory Services

Representatives of Several Small Laboratories Contend Managed Care Organizations' Contracting Practices Result in Lower Quality Services

As previously noted, interviews were conducted with representatives of several smaller community-based laboratories. These individuals indicated that the larger regional and national laboratories with which many managed care organizations are contracting for laboratory services do not provide the same level of quality services provided by smaller laboratories. Specifically, these individuals contend that larger laboratories operate in a "factory-like" environment in which laboratory technicians are required to perform too many tests in a given period of time. As a result of this environment, representatives of the smaller laboratories assert that the tests performed by the larger laboratories are not as accurate as those performed by smaller laboratories where the technicians are able to provide more "personal service" for physicians and patients.

According to the smaller laboratories, another consequence of this "factory-like" environment is that the larger laboratories have incorrectly billed health plans and patients. They indicate that most physicians are not satisfied with services provided by the larger, regional or national laboratories.

The smaller laboratories also contend that the larger laboratories are not able to provide the same quick "turnaround time" for certain tests that the smaller laboratories are able to provide. Lastly, these individuals believe the managed care organizations' practice of contracting with one regional or national laboratory eliminates physicians and enrollees' choice of where to have their testing performed. By limiting the laboratories from which physicians and patients can receive services, they believe the quality of service is reduced.

Little, If Any, Evidence Has Been Found Which Shows Larger Laboratories Produce Lower Quality Results than Smaller, Community-Based Laboratories

While the representatives of the smaller laboratories believe that the contracting practices of managed care organizations result in lower quality services, they were not able to provide any specific research, studies, data, or

literature to support their argument. Instead, they referred to two studies completed in 1993 regarding managed care in general. One study, which was published in the Journal of the American Medical Association, concluded that patients prefer small-scale, fee-based services to managed care delivery systems. The other study, which was completed by two Harvard physicians, calls into question the overall quality of care provided by HMOs. While these studies are related to managed care in general, neither focused on the quality of services provided by large, national medical laboratories as opposed to the services available through smaller, community-based laboratories.

Representatives of the smaller, community-based laboratories also point to an incident involving National Health Laboratories as evidence of the poor quality of services that can result from contracting only with larger, national laboratories. In 1992, National Health Laboratories pleaded guilty to two felony counts of defrauding the federal government, and agreed to pay $110 million to settle a separate civil suit alleging that the firm billed federal health agencies (Medicaid and Medicare) for millions of dollars of unnecessary blood tests. While this lawsuit shows that a national laboratory clearly violated the law and was engaged in fraudulent practices, the findings in this case cannot be generalized to the issue of whether regional and national laboratories, as a group, provide lower quality services than smaller community-based laboratories.

Managed Care Organizations Defend Contracting Practices as Providing High Quality, Low Cost Laboratory Services

The managed care organizations that were interviewed as part of this study state that their contracting practices are producing high quality, low cost services to physicians and patients.

Cost Savings: The managed care organizations state that the medical laboratory market is highly competitive, and that as a result of this competition they have been able to negotiate very favorable prices with the larger laboratories. The managed care organizations indicated that by directing their entire volume of laboratory services to one primary laboratory per geographic area, they have been able to negotiate deep discounts with their respective laboratories. Several of the managed care organizations stated that these discounts reduced their costs for medical laboratory services by 50% or more, which, in turn, reduced the cost of providing health insurance to their customers. They indicated that, for proprietary reasons, they were unable to provide specific contract figures to verify their savings estimates.

The managed care organizations stated that paying their laboratories on a capitated basis also helps to hold down costs by removing any incentive for a laboratory to perform additional unnecessary tests. Another advantage of capitation is that the administrative costs of processing payments are much lower than in a fee-for-service environment. By paying the laboratory a set fee each month for all laboratory services, the managed care organizations do not have to expend resources paying numerous individual claims, adjusting claims, and auditing claims.

Quality Services: The managed care organizations state that by directing a high volume of work to one laboratory, they can be more effective in monitoring the quality of services that the laboratory provides to their physicians and patients, and can respond to any concerns more quickly than would be possible if they contracted with a number of laboratories. Moreover, directing a high volume of business to one laboratory gives the managed care organization more "clout" to demand quality services for their physicians and patients.

Managed Care Organizations Report Very Few Complaints from Physicians and Patients

Each of the managed care organizations indicated that they receive very few complaints from physicians or patients regarding the quality or cost of laboratory services. One indicated that it has received some complaints, but not enough to warrant any change in its procedures. Two of the managed care organizations stated that they had received one complaint in the past year regarding their respective medical laboratories. The others were unable to identify a specific number of complaints, but indicated that "laboratory services simply have not been an issue."

No Pertinent Research Has Been Found Which Evaluates Managed Care Organizations' Contracting Practices with Medical Laboratories or Analyzes the Differences in Cost and Quality between Large and Small Laboratories

To assess the impact that managed care organizations' contracting practices are having on the cost and quality of medical laboratory services, computerized literature searches of medical journals, government publications, and general interest magazines and journals were conducted. While several articles and studies regarding various aspects of laboratory services were found, no research or studies regarding the impact of managed care organizations' contracting practices on the cost or quality of laboratory services were found.

As noted earlier in this issue brief, several articles and studies were published on the quality of laboratory services during the mid and late 1980s. While these published reports focused on the quality and accuracy of certain laboratory testing procedures (e.g. cholesterol testing and pap smears), none of the research included any analysis as to whether the quality of testing conducted by larger laboratories was any different from that performed by smaller laboratories.

The Health Care Financing Administration and State Health Departments Conduct Laboratory Inspections to Ensure Quality and Safety

The Clinical Laboratory Improvement Amendments (CLIA) apply equally to large and small laboratories. As such, all laboratories that seek certification as either a "moderately complex" or "highly complex" laboratory must adhere to federal guidelines for safety and quality. All states assist the Health Care Financing Administration in conducting inspections of medical laboratories. Laboratories which fail to meet federal regulations are not permitted to operate. Thus, the CLIA guidelines and the enforcement of these guidelines help to ensure quality laboratory services.

Impact of Managed Care Organizations' Contracting Practices on Competition Among Medical Laboratories

Smaller Laboratories Argue That Managed Care Organizations Are Reducing Competition in the Marketplace

The smaller, community-based laboratories contend that managed care organizations' practice of contracting with one large laboratory per geographic area is reducing the medical laboratory market to a few large companies that are dominating the market. As a result, the smaller community-based laboratories are having to close, resulting in a loss of jobs.

The laboratories were unable to provide any data to support their claim that the number of community-based laboratories are decreasing, and that there has been a reduction in laboratory jobs. Because medical laboratories are neither licensed nor regulated by the Commonwealth, there is no data to determine the number of community-based laboratories that have closed in the last few years. The Virginia Department of Health began collecting information on Virginia laboratories in 1992 as a result of the Clinical Laboratory Improvement Amendments (CLIA) that became effective in 1992. Thus, it cannot provide

historical data on the number of community-based laboratories which may have closed.

Enrollment in HMOs is Increasing

Based on information provided by Virginia HMOs to the State Corporation Commission's Bureau of Insurance, enrollment in Virginia's HMOs has grown 67% between 1988 and 1993, from approximately 360,000 enrollees to approximately 602,000. While there is no empirical data to determine if the number of community-based laboratories has decreased, it is reasonable to assume that as enrollment in HMO and PPO benefit plans continues to grow, the market share of the smaller community-based laboratories may erode as more and more patients receive their laboratory services from regional and national laboratories.

The Four Largest Laboratories Hold a Substantial Share of the Independent Laboratory Market

Based on information regarding clinical laboratories obtained from Blue Cross and Blue Shield National Association documents, there were approximately 5,000 independent laboratories (i.e. laboratories not associated with a physician's office or hospital) in the United States in 1988. At that time, the five largest laboratories were MetPath, Damon, National Health Laboratories, Roche, and SmithKline.

According to data published by the Blue Cross and Blue Shield National Association, these five laboratories held 29% of the independent medical laboratory market in 1988, and approximately 5% of the total laboratory market (including hospitals, physicians' offices and others). In a 1991 study of Medicare laboratory fee schedules, the General Accounting Office (GAO) found that these five laboratories accounted for more than 40% of the Medicare test services performed by independent laboratories. While the GAO study pertained only to Medicare enrollees, it is reasonable to assume that this data is somewhat illustrative of other third-party payors. More recent data regarding the market share of these laboratories were not available.

MetPath recently purchased Damon Clinical Laboratories. As such, there now are four laboratories which likely hold somewhere between 29 and 40% of the independent medical laboratory market. Managed care organizations contract with large regional or national laboratories other than the four identified above. Nonetheless, the data regarding the four largest laboratories indicate that a substantial share of the independent laboratory market is held by these companies.

Managed Care Organizations Argue That Their Customers are Benefiting from a Highly Competitive Laboratory Market

Managed care organizations indicate that the medical laboratory market is highly competitive, and that their customers are reaping the benefits of this competition. They argue that their contracting practices are not "driving" the market; rather, their practices are taking advantage of the cost savings that results from the competition taking place within the market.

The managed care organizations which utilize the larger, regional/national laboratories indicate that the smaller, community-based laboratories simply are not able to provide the level of service at the same cost that is available in other sectors of the market. They contend that if they did not take advantage of the efficiencies available in the market, their products would be more expensive and less marketable to employers.

Impact of House Bill 840 on Medical Laboratories Is Unclear

House Bill (HB) 840, which was passed by the 1994 Session of the General Assembly, is a "freedom of choice" law affecting pharmacies and ancillary service providers. This legislation provides that persons receiving pharmacy or ancillary service benefits may receive these benefits from any pharmacy or ancillary service provider as long as the provider agrees to accept reimbursement for their services at rates applicable to the preferred providers that participate in the network. The legislation affects both PPO and HMO provider networks.

> As provided in HB 840, ancillary services refer to:
> *"...those services required to support, facilitate or otherwise enhance medical care and treatment. Such services include, but are not limited to, the furnishing of medical equipment required for therapeutic purposes or life support."*

However, the law does not identify specifically which providers are considered "ancillary service providers." The representatives of the smaller, community-based laboratories contend that their services are "ancillary services," and that the provisions of HB 840 apply to medical laboratories. Accordingly, they believe that PPOs and HMOs no longer will be able to prohibit patients from receiving services at their laboratories or charge patients a higher copayment or fee as long as they agree to accept the PPO and HMO reimbursement amounts.

While the smaller, community-based laboratories believe that HB 840 resolves their concerns regarding access to managed care patients, they believe that in order to survive in the marketplace, the reimbursement provided to medical laboratories needs to be on a fee-for-service basis, rather than on a capitated basis. They argue that the volume of work performed by smaller community-based laboratories is not large enough to support a capitated reimbursement system.

Managed care organizations do not consider medical laboratories to be "ancillary service providers." Regarding the method of reimbursement for laboratory services, managed care organizations which capitate their laboratories believe this to be the most cost-effective reimbursement system, and that consumers benefit from capitation. Accordingly, they do not envision any changes in their contracting practices or method of reimbursement.

Bureau of Insurance Reviewing Impact of HB 840

The Bureau of Insurance has received several inquiries from insurers and others seeking to determine which providers are considered "ancillary service providers." The Bureau is researching this issue, and is in the process of responding to these inquiries. However, the provisions of HB 840 state that the State Corporation Commission shall have no jurisdiction to adjudicate controversies arising out of this section. Thus, it appears that legislative action may be necessary to resolve this issue.

Policy Options

There appear to be two options for addressing the issues presented in this paper. The first option is to take no action and maintain the status quo. The second option would be to amend §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 of the Code of Virginia to include medical laboratories as an "ancillary service provider."

Option I: Status Quo

This option recognizes that while the contracting practices of managed care organizations may be reducing the market share held by smaller, community-based laboratories, these practices have been effective in reducing the cost of health care, with no apparent reduction in the quality of services.

This option also recognizes that the contracting practices of managed care organizations are the result of a highly competitive marketplace, and that the

cost savings generated by these practices inure to the benefit of employers and others paying health insurance premiums.

Option II: Amend §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 to Include Medical Laboratories as an "Ancillary Service Provider"

This option recognizes that while the current contracting practices of managed care organizations have reduced the cost of laboratory services for managed care customers, patients should be allowed to receive services from smaller, community-based laboratories with no reduction in benefits, as long as the laboratory accepts the managed care organizations' reimbursement rate. By including medical laboratories in the definition of "ancillary service provider," managed care organizations will not be able to prohibit persons from receiving services from any laboratory as long as it is willing to accept the network's reimbursement rate. Moreover, managed care organizations will not be able to impose any higher copayment or fee on patients who receive services from laboratories who are not "preferred providers."

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA -- 1994 SESSION

HOUSE JOINT RESOLUTION NO. 233

Requesting the Joint Commission on Health Care to study the impact of managed health care system practices on the quality and competitiveness of medical laboratory services.

Agreed to by the House of Delegates, February 14, 1994

Agreed to by the Senate, March 8, 1994

WHEREAS, the rising cost of health care in the United States and in the Commonwealth of Virginia is of concern to the General Assembly and to all citizens of the Commonwealth; and

WHEREAS, the need to identify ways to control medical costs, including the cost of medical laboratory work, while assuring access to quality health care is currently the focus of attention in the United States Congress and in numerous states, including the Commonwealth; and

WHEREAS, the General Assembly has previously authorized preferred provider organizations and other forms of managed health care systems; and

WHEREAS, the theory of such managed health care systems is that as a result of the benefit incentives favoring services of contracted providers, providers included in such networks will experience increased business volume and thus be willing to accept discounted rates as well as to participate in insurers' utilization management programs; and

WHEREAS, it is widely reported that some managed health care systems are restricting medical laboratory work to a few large laboratories for all testing needs; and

WHEREAS, such practices eliminate the competitive benefits offered by the inclusion of smaller, independent laboratories; and

WHEREAS, key managed health care system models proposed at the federal level and under examination by the states would offer laboratory contracts to large laboratories which are either controlled by or are the subsidiaries of big business; and

WHEREAS, such a restrictive model would devastate the thousands of community-based laboratories and would ultimately mean the loss of many hundred of thousands of jobs that are currently held by the people who work there; and

WHEREAS, competition at all levels of managed health care systems is essential to assure quality service and to reduce costs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with other appropriate state agencies and private groups, study the impact of managed health care systems' practices concerning the utilization of medical laboratories on (i) the Commonwealth's efforts to contain costs while assuring quality health care and (ii) competition in the marketplace among medical laboratories.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 5:
Impact of Managed Care Practices on Medical Laboratories

Comments regarding the "Impact of Managed Care Practices on Medical Laboratories" Issue Brief were received from the following 6 interested parties:

Secretary of Health and Human Resources, Kay Coles James
Blue Cross and Blue Shield of the National Capital Area
HealthPlus
The Virginia Association of HMOs
Metropolitan Life Insurance Company
George E. Broman, M.D.

Policy Options Presented in Issue Brief

Two policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Maintain status quo.

Option II: Amend Code of Virginia to include medical laboratories as "ancillary service providers."

Summary of Comments

With the exception of Dr. Broman, all those submitting comments supported Option I. Dr. Broman provided general comments, but did not express an opinion regarding either Option I or II.

Summary of Individual Public Comments

Secretary Kay Coles James

Secretary James indicated that the issue of managed care plans' use of medical laboratories is a subset of the discussion of "any willing provider" laws. She also noted that the laboratory issue is one of a changing industry and automation. Secretary James commented that it is unlikely government intervention can reverse this trend.

Secretary James recommended that the Commonwealth not enact any willing provider protection for medical laboratories and that the laboratory industry be permitted to operate as freely as possible in order to ensure the maximum possible levels of quality and affordability.

Blue Cross and Blue Shield of the National Capital Area (BCBSNCA)

Gail M. Thompson, Government Affairs Administrator, indicated that BCBSNCA supports Option I and opposes Option II. Ms. Thompson commented that the contracting practices of managed care organizations as they relate to medical laboratories have not been demonstrated to reduce the accessibility, availability or quality of services to enrollees. She stated that without such evidence, legislation which protects a category of providers from marketplace competition is inappropriate.

HealthPlus

Denise C. Savage, J.D., Manager of Regulatory & Legislative Affairs, indicated that HealthPlus supports Option I. Ms. Savage stated that if the public is desirous of choice as indicated in the report, that choice should be made when the selection of a health care plan is made.

The Virginia Association of HMOs

Mr. Reginald N. Jones of the law firm of Williams, Mullen, Christian & Dobbins submitted comments on behalf of the Virginia Association of HMOs. Mr. Jones indicated that the HMO Association supports Option I. Mr. Jones noted that no evidence has been provided that supports the contention that the contracting practices of managed care organizations, as they relate to medical laboratory services, result in a reduction in the quality of services. He stated that without

such evidence, it is inappropriate to enact legislation which protects a category of providers from competition in the marketplace. Mr. Jones commented that competition in the marketplace should be allowed to determine what medical laboratories are available to providers, patients and managed care organizations.

Metropolitan Life Insurance Company (MetLife)

Gregory M. Redmond, Government Relations Counsel, stated that MetLife supports Option I. He commented that Option II is objectionable as volume discounting of price would be lost and credentialing standards would be forfeited by the plan.

George E. Broman, M.D.

Dr. Broman did not express an opinion regarding Option I or II. He noted that a larger and larger percentage of the market is and will be controlled as "mega" companies grow and acquire each other. He noted that these trends are not healthy and certainly do not promote competition.

JOINT COMMISSION ON HEALTH CARE

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