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From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE BUSINESS INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs / COOs / CFOs / PATHOLOGISTs

Restricted information, see page 2

Commentary & Opinion by...

R Lewis Dark

Founder & Publisher

Diversifying Lab Management's "Gene Pool" of Methods

I ENCOURAGE OUR CLIENTS AND REGULAR READERS to give careful thought to the intelligence findings provided by our editor about the unfolding laboratory joint venture in Cincinnati between **Lab*One*, Inc.** and **The Health Alliance**. *(See pages 2-7.)*

He contends that Lab*One* will bring additional management skills and experience to this established multi-hospital laboratory venture. Those skills, in combination with the skills of the existing laboratory management team, can be expected to generate faster growth in outreach revenues and ongoing, substantial reductions in laboratory costs.

In one respect, I have to admire his boldness in making this assertion. Within the hospital laboratory segment of our industry, there is certainly a widespread feeling that commercial laboratories don't have much to offer hospital laboratories and should "mind their own affairs." Commercial labs earned this skepticism, because over the past 20 years there have been many examples of hospital lab/commercial lab collaborations that went poorly and did not survive beyond the term of the first contract.

However, our editor makes an essential distinction. He observes that commercial laboratory managers develop management skills and have experiences which are different from hospital laboratories. Yet some of those skills, when applied in hospital laboratories, have great value. Effectively, he recognizes that, as companies, commercial laboratories haven't demonstrated a good track record in many hospital laboratory ventures. But in the area of lab management methods, individuals with commercial lab management experience can make important contributions to the success of hospital laboratories.

In effect, management skills and experience gained in commercial laboratory operations, when imported and blended with existing hospital laboratory management skills, is like an infusion of fresh genes into the hospital lab management gene pool. It adds diversity and expands the options and tools used to achieve the goals of the hospital laboratory. The arrival of ISO-9000, Six Sigma, and Lean management represents a similar infusion of "new genes" into lab management's gene pool. As early-adopter hospital labs are proving, diversifying their lab's gene pool of management tools is leading to significant progress and improvement in all dimensions of their laboratory's performance. TDR

Lab*One* in Cincinnati: Watch Events Unfold

It's a case study in real time about achieving ambitious goals

CEO SUMMARY: It's another example of a commercial laboratory taking over the laboratory assets of a multi-hospital consolidated laboratory. Will LabOne manage these assets and get more growth, more cost savings, and more profit? If this happens, it will mark the third time in recent years that leadership by individuals with commercial laboratory skills and experience has "turbo-charged" this type of lab organization.

FOR AT LEAST THE THIRD TIME in recent years, a consolidated hospital laboratory with an extensive outreach program is coming under the management of individuals with commercial laboratory experience.

As reported last month, **Lab*One*, Inc.** of Lenexa, Kansas has acquired certain laboratory assets of **The Health Alliance of Cincinnati**. It also signed contracts to manage six rapid response laboratories based in hospitals owned by the Alliance.

Hospital laboratory directors and pathologists should closely watch the changes that Lab*One* will implement to the Health Alliance laboratory operations. If the experience of two similar consolidated hospital lab organizations is any guide, Lab*One*'s management expertise will trigger a significant and sustained period of growth in both outreach revenues and net profits.

If this happens, it will be the third example THE DARK REPORT can identify where managers with commercial laboratory experience have "jump started" a relatively moribund, multi-hospital laboratory outreach testing program. If this particular "lightening" strikes for the third consecutive time, it might make a persuasive and specific argument for hospital laboratory administrators and pathologists.

The argument would be this: commercial lab managers have certain management tools and methods which hospital outreach program directors should identify, acquire, and deploy within their own laboratory. By using

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R. Lewis Dark, Founder & Publisher. Robert L. Michel, Editor.

SUBSCRIPTION TO THE DARK REPORT INTELLIGENCE SERVICE, which includes THE DARK REPORT plus timely briefings and private teleconferences, is $11.90 per week in the US, $12.50 per week in Canada, $13.55 per week elsewhere (billed semi-annually).

these management tools, their hospital outreach programs can grow at a faster rate, net profit margins can improve, and the average cost-per-test can decline for both inpatient and outpatient testing.

Two Similar Hospital Deals

The two earlier examples similar to the Health Alliance/Lab*One* arrangement are familiar to many in the laboratory industry. The first example is **Sonora Quest Diagnostics**, based in Phoenix, Arizona. The second is **Spectrum Laboratory Network**, located in Greensboro, North Carolina.

It was in 1999 that a deal was struck between the eight-hospital **Samaritan Health System** in Phoenix and Quest Diagnostics Incorporated. Both parties contributed their outreach (physicians' office) laboratory testing business into the joint venture. Laboratory operations were consolidated and a new laboratory facility was built near the Phoenix Airport.

Only one half of the story about why this joint venture was created has ever been revealed. Quest Diagnostics Incorporated had determined that its existing laboratory operation in Phoenix was unlikely to be the source of either significant volume growth or greater profitability. Thus, merging this laboratory with another local player would allow it to realize the benefits of consolidation.

Sonora's Untold Story

What has never been publicly revealed until now is the reason why Samaritan Health System was willing to fold **Sonora Laboratory Services** into a joint venture with a competing commercial laboratory. Lab industry presentations given by Sonora laboratory executives in the late 1990s generally painted a picture of basic success, with the hoped-for goal of eventually consolidating Sonora's outreach testing volume with Samaritan's inpatient lab specimens.

The financial reality at Sonora Laboratory Services was actually much different. In the years leading up to the creation of the joint venture with Quest Diagnostics, Sonora Lab Services had lost as much as $6 million. Samaritan needed to stem the ongoing financial losses and the joint venture with Quest Diagnostics was a way to accomplish that.

Not surprisingly, some months after the two laboratory businesses were combined, a lack of clear, sustained operational and financial improvement resulted in a management change at the top. The existing CEO, with a strong hospital laboratory background, was assigned other responsibilities. The new CEO, an employee of Quest Diagnostics, was someone with 20 years of experience in commercial laboratory operations.

Spectacular Turnaround

What happened in the next two or three years may be one of the most spectacular laboratory turnaround stories of the past two decades. THE DARK REPORT is under confidence and cannot reveal details. But it can be said that operating profits were restored within six months of the management change. More spectacularly, in a 24-month period, outreach revenues doubled, from a base of around the mid-$20 million range to over $60 million!

THE DARK REPORT was privileged to have a full tour of this laboratory. Its revenue growth continues on a sustained basis. The morale and operating environment are exceptional when compared to similar types of consolidated laboratory operations. Six Sigma projects are contributing to service enhancements and the entire laboratory staff is motivated, focused, and accomplishing goals considered unat-

tainable under earlier management regimes.

The second example of a multi-hospital laboratory organization coming under the leadership of an executive with commercial laboratory management experience is Spectrum Laboratory Network. In a separate story which follows, THE DARK REPORT provides a more complete picture of the progress made at this laboratory. *(See pages 5-7.)*

Certainly the speedy, 180-degree turnaround in both cases suggests that a vital ingredient was missing prior to the arrival of the new CEOs.

Spectrum was formed in 1997 by three health systems in North Carolina. The goal was to consolidate laboratory testing to harvest economies of scale and pursue outreach opportunities. Unfortunately, for the first three years of its life, Spectrum Laboratory Network was a financial disappointment.

The turnaround came when Spectrum hired a new CEO, an individual who had been CEO of a publicly-traded laboratory company and had decades of commercial laboratory experience. In the four years since his arrival, outreach revenues have jumped from about $18 million per year (net collections, not gross billings) to more than $60 million. Profit margins for a hospital-based laboratory are on par with that of the two blood brothers.

Many Similarities

THE DARK REPORT observes that both the Sonora and the Spectrum stories share significant similarities: 1) a consolidated, multi-hospital laboratory organization offering outreach testing; 2) sustained financial difficulties; 3) following the arrival of a CEO with commercial laboratory experience, both Sonora and Spectrum were quickly restored to profitability; and 4) both Sonora, and Spectrum then started a multi-year period of aggressive growth in revenues and sustained increases in profit margins and net profit.

Is this a coincidence? Did lightening strike twice in the same fashion? Or did the commercial laboratory executives possess skills and experience which were not known to the hospital lab administrators they replaced? Certainly the speedy, 180-degree turnaround in both cases suggests that a vital skill or talent was missing prior to the arrival of the new CEOs.

THE DARK REPORT suggests that the financial and service outcomes from the Sonora and Spectrum stories are too powerful to be ignored by thoughtful hospital lab directors and pathologists. There are useful management lessons to be learned from these two examples.

Watch Events In Cincinnati

If this assumption is correct, then the Health Alliance/Lab*One* relationship provides an opportunity to watch, in real time, whether Lab*One*'s commercial laboratory expertise stimulates significant, rapid, and sustained growth in lab outreach revenues, while at the same time operational improvements boost overall margins.

It may be time for hospital laboratory managers to be less skeptical about the management skills of their commercial laboratory counterparts. Notwithstanding the failure of commercial laboratories to be more successful in their collaborations with hospital laboratories, the Sonora and Spectrum examples demonstrate, at a minimum, that leadership does make a difference. TDR

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Spectrum Lab Network Expands Into Tennessee

Laboratory joint venture claims service is major reason for its sustained growth

CEO SUMMARY: During the past four years, this energized hospital laboratory joint venture has posted significant growth in its laboratory outreach program. One notable accomplishment has been the effective deployment and use of Web browser-based lab test orders and results reporting with its client physicians. The operational and service benefits from this strategy have been significant.

STARTING IN JANUARY, TENNESSEE had a new laboratory competitor. **Spectrum Laboratory Network** activated its new branch in Knoxville, Tennessee and has sales representatives in the field soliciting new clients.

But there is more to the story of Spectrum's success than its expansion into new territory. It is an example of two management philosophies—and two radically different outcomes.

In the first three years of its life, Spectrum Laboratory Network was managed by veteran hospital laboratory administrators. Regardless of the reasons, a succession of administrative leadership could not work through the issues and bring the laboratory to profitability.

With the arrival of a new CEO four years ago, the situation changed. Within months, profitability was restored. In the years since, Spectrum has attracted national attention for its ability to capture market share. It demonstrates the potential every well-managed hospital laboratory outreach program has to become a dominant player in its regional service area.

The numbers speak for themselves. After three years of operation, outreach net revenues were $18 million per year. By 2003, that number had climbed to $60 million. In 2004, revenue is projected to exceed $70 million. Cost and productivity measures advanced in comparable ways.

Same Story, Different Results

The story of Spectrum's creation is similar to other hospital laboratory consolidation projects launched during the 1990s. "Spectrum Laboratory Network was established in 1997 by three local hospital systems," stated Nate Headley, CEO at Spectrum. "**Moses Cone Health System**, **High Point Regional Health System**, and **Novant Health System** were the original owners.

"Back then, the goals were to consolidate testing across all the hospitals to lower overall costs and develop an effective outreach program," explained Headley. "The original investment by the three health systems was almost $6 million."

However, the effort to create an integrated laboratory organization did not go well. During the next three years, the three health systems poured additional capital into the foundering laboratory. Headley arrived four years ago, when Spectrum's CEO slot was vacant.

"From my perspective, Spectrum was an unusual opportunity," observed Headley. "First, the three health systems are respected in their communities and physicians can be very loyal in their support of their hospitals' lab outreach programs.

Potential for Profit

"Second, managed care is a relatively minor factor in this region. This means physicians still have freedom to choose their laboratory provider. Third, average revenue per accession in this area remains relatively high, thus providing the profit margins necessary to sustain a dynamic outreach program and still deliver profits to the health system owners," noted Headley.

"Fifth, this was a market that had not seen much competition in the past five or six years," he added. "That's because **Laboratory Corporation of America's** headquarters and big national laboratory are just down the road. It was the major laboratory provider, but in the absence of significant lab competitors, it had thinned down its service network over the years.

Emphasizing Service

Starting four years ago, once the financial stability had been restored to Spectrum, emphasis turned to its outreach program. "Our goal was to offer physicians laboratory testing services comparable to what they experienced through the mid-1990s," stated Headley. "That was a time when local labs, owned by local pathologists, were proud to provide high quality laboratory test services. That type of service gives any laboratory the capability to compete effectively with the national laboratories."

Spectrum Laboratory Network At-A-Glance

A for-profit laboratory joint venture owned by High Point Regional Health System and Moses Cone Health System.

Formed: 1997
Headquarters: ..... Greensboro, NC
2004 Outreach Revenues: ..... $72 mil (est.)
2003 Outreach Revenues: ..... $60 mil (est.)
Service Area: ..... NC, SC, VA, TN
FTEs: 850
Physician Clients: 2,500
Sales Reps: 20
Executive Team: .....
Nate Headley, CEO
Robert M. Gay, Medical Director
Jeff Downs, Chief Financial Officer
Karen Yoemans, V.P., Sales & Marketing
Taylor McKeeman, V.P., Operations

Spectrum's ability to capture market share from its big neighbor to the east has given LabCorp more than a few fits. *(See TDR, December 9, 2002.)* Its management strategy has been simple: 1) execute well; 2) offer services that differentiate it from competing laboratories (like Web browser-based lab test ordering and results reporting); support a professional and aggressive sales effort; and, 3) set ambitious goals and hold people accountable for accomplishing them on time and on budget.

"We are proud of the accomplishments here," noted Headley. "Our team shows that it is possible to provide high quality testing for the hospitals' inpatients even while building a fully-competitive and profitable outreach program.

"We do inpatient testing at cost for our owners," he added. "During the span of Spectrum's lab operations, our

Web-Based Lab Test Orders & Results Plays a Key Role in Spectrum's Strategy

WIDESPREAD USE of a Web-based lab test ordering and lab test reporting system by physician clients of Spectrum Laboratory Network is the source of both competitive advantage and lower costs in the laboratory.

"Currently 30% of our 2,500 clients are connected to our laboratory electronically," stated Nate Headley. "One of our strategic goals is to maximize the number of clients which use this system.

"As a result of this high conversion to electronic ordering, 55% of our daily accessions are 'automated' in the field. When they arrive in our laboratory, they are simply wanded into our system," explained Headley.

The financial benefit to Spectrum is substantial. "We staff 35% fewer people in accessioning than is typical for our daily test volume," he said. "We also have 40% fewer data entry people than laboratories of equal size.

"But the real payoff is in customer service," noted Headley. "The error rate common to most laboratories has been greatly reduced here. We attribute some of this to a higher ratio of test requisitions which come to us with information which is complete and accurate. Physician clients notice our consistent service. It has been a source of competitive advantage in winning and keeping new business."

Good management execution lies behind this high rate of client conversion to electronic ordering. "Along with sales reps and customer service reps in the field, we have 'automation' installers," explained Headley. "It takes us just 72 hours from the time a physician tells us to start his account until his office is electronically connected to our laboratory."

Not only is this impressive service to the new customer, but the speed with which a new account is converted makes it tough for the laboratory losing the business to respond.

Spectrum Laboratory Network uses AtlasLabworks, from **Atlas Medical Systems**, for its Web browser-based lab test ordering and lab test resulting system. Spectrum's success with electronic ordering and resulting has been mirrored by **Memphis Pathology Laboratory** (MPL) of Memphis, Tennessee.

Like Spectrum, MPL is using Web test ordering and resulting as a winning doubleplay. Its deployment in physician offices generates competitive advantage and new outreach accounts. At the same time, the increased number of complete, accurate, and legible electronic requisitions is reducing errors, cutting costs, and boosting customer service. All of these benefits translate into additional competitive advantage for MPL's outreach sales effort.

At the upcoming *Executive War College* in New Orleans on April 27-28, John Mazzei, MPL's Executive Director, will discuss how his lab's effective deployment of browser-based lab test ordering and lab test resulting has accelerated growth in new accounts and net revenues.

owners have seen cost savings of $31 million for inpatient testing.

The ongoing success of Spectrum Laboratory Network and its thriving outreach program, taken together with the performance of **Sonora Quest Laboratories** in Phoenix *(see pages 2-4.)* provide examples of how management leadership can make a huge difference in the performance of a multihospital laboratory organization. The similarity in their real-world accomplishments demonstrates that something more than luck or coincidence is responsible for their success. **TDR**

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Billing & Collections Update

Catholic Hospital in Illinois Loses Tax-Exempt Status

Hospital industry concerned that other charitable hospitals will face same challenge

HOW HOSPITALS BILL and collect from uninsured patients is becoming a national issue.

The latest shot fired is a ruling by the **Illinois Department of Revenue** revoking the state property tax exemption of **Provena Covenant Medical Center**, located in Urbana, Illinois. The hospital site and another 20 parcels of land owned by the hospital were declared "not in exempt use."

The Champaign County Board of Review had earlier determined that the 199-bed hospital was not a charitable institution. This was based, in part, on its policies toward needy patients. The hospital was filing lawsuits and taking other aggressive actions to collect debts owed by patients.

Charities Do Not Sue

"Based on the fact that they sue people—and we had been told by the Department of Revenue that if you sue people you are not charitable—there was not a lot of room for ambiguity [in our decision]," observed Stan Jenkins, member of the Champaign Board of Review.

Another dimension in the Board's ruling was the fact that Provena Covenant Hospital facilities were using external, for-profit entities to provide key hospital functions (outsourcing of services).

The ruling means Provena Covenant Hospital, subject to appeal, will need to pay $1 million in back property taxes, as well as future taxes. The hospital lost $700,000 in 2003.

As many lab directors and pathologists know, the entire hospital industry is coming under attack for charging uninsured patients "full price" for services, then filing collection lawsuits and attaching assets to get at the money. Consumer advocates argue that uninsured patients should be charged no more than hospitals are willing to accept from managed care plans and Medicare.

Because many hospital laboratory outreach programs have their hospital do the billing and collections, this trend will likely have direct impact at some future point. Watch for these two key points. First, will hospitals adopt a policy to bill uninsured patients at discounted rates which are comparable to those paid by managed care plans?

Second, as in the case of Provena Covenant Hospital, will for-profit activities, including laboratory outreach programs and laboratory joint ventures, be viewed by tax authorities as signs of non-charitable business practices when they include not-for-profit hospital settings?

Provena Covenant Hospital is appealing, so the end to this story is still unknown. Hospital industry observers predict that scrutiny of not-for-profit hospital billing practices will increase. TDR

Will Laboratory Industry Exert Positive Influence?

New Healthcare Change Cycle Is Opportunity to Fix Problems

CEO SUMMARY: Healthcare's new cycle of change will be greatly influenced by geneomics, proteomics, the Internet, consumer-driven healthcare, and political decisions that affect the Medicare and Medicaid programs. The launch of a such a new cycle of change presents the laboratory industry with an opportunity. Timely input with key decision makers can insure that the long-standing problems concerning test coverage decisions, adequate reimbursement, and patient access to testing services can be corrected.

By Robert L. Michel

HEALTHCARE IN THE UNITED STATES is entering a new cycle of change—one that will radically alter many long-standing institutions and common business practices.

Some healthcare futurists predict this cycle of change will revolutionize every aspect of healthcare, from how health services are funded to the relationship a patient has with his/her physician. Moreover, many experts predict these changes will occur relatively rapidly.

For this reason, laboratory managers and pathologists should begin to track this cycle of change. Strategic planning sessions should include a review of global trends and influences in healthcare, along with trends specific to laboratory management and laboratory medicine.

Managed Care Experiment

The last healthcare change cycle is the "managed care experiment." It demonstrates how specific political themes and business philosophies can frame the debate and push healthcare in a specific direction.

Starting in the mid-1980s, the nation launched an ambitious effort to introduce "managed care" operational models into healthcare. As an experiment, it was a disastrous failure. By the second half of the 1990s, consumers had resoundingly rejected the worst aspects of the primary managed care business model—the closed-panel, gatekeeper HMO. As well, both hospitals and physicians were left in financial turmoil, a consequence of accepting capitated and full-risk contracts with payers.

Consumers rejected the managed care plans offered to them for two reasons. First, this healthcare model actively strove to deny care to consumers who, under fee-for-service insurance plans, were accustomed to getting any and all healthcare services they felt appropriate. Second, consumers resented being forced to accept a limited number of in-network providers, along with restrictions on the ability to obtain second and third opinions.

Neither health insurance companies, employers, nor Medicare/Medicaid could sustain their experiment with managed care in the face of this consumer rebellion. The fallback option became PPO and POS plans (preferred provider organizations and point-of-service).

Ongoing Problems

However, recent years' experience deonstrates that these types of health plans have failed to satisfy anyone. Consumers are still concerned about the cost of care, the quality of care, and access to the doctors they prefer. Employers are struggling to cope with four consecutive years of double-digit increases in their health insurance premiums. And within the Medicare and Medicaid programs, both federal and state governments are failing to provide the funding necessary to allow hospitals and physicians to fully recoup the cost of the care they provide to beneficiaries of these programs.

Consequences Still Remain

Most clients and regular readers of THE DARK REPORT are keenly aware of these events. I've summarized them above to establish agreement on a key point: that between 1985 and 1999 we lived through a distinct and identifiable cycle of change in the healthcare system of the United States. Further, another consequence of the experiment in managed care is that any number of medical procedures are now reimbursed at amounts which fail to adequately cover the full cost of providing those procedures.

Most lab managers and pathologists would agree with me when I say there exists an uneasy status quo in healthcare today. Providers have reservations about the intentions of employers and private payers. Budget constraints within the government cause Medicare and Medicaid program administrators to arbitrarily reduce the money paid to providers, whether through restrictions on when a procedure will be reimbursed, or through reduced levels of reimbursement.

This is a familiar story in the laboratory industry. Medicare takes the collective menu of tests and pays an arbitrary percentage of a "national price." It has also failed to provide

cost-of-living increases to the fee schedule in most of the past 15 years.

Glum View For Improvement

Are lab managers and pathologists frustrated with the Medicare and private pay situation that exists in healthcare today? You bet! Is there a popular belief that things will get worse before they get better? Definitely!

Simply put, every laboratory administrator and every pathologist has a vested interest to see that this cycle of change in healthcare generates positive improvements in today's status quo. Existing problems can be solved. Medicine can again become a satisfying profession that provides adequate compensation to its providers.

Seeking Objective Solutions

I suggest that, with healthcare entering a new cycle of change, it is both appropriate and timely for the laboratory industry to become a voice for positive change. It is at the start of such a cycle that our industry has the maximum potential to influence events toward the right outcomes.

In the early days of the managed care experiment, laboratories failed to understand the ways this business model would fail, both in providing adequate recompense to providers and in meeting the needs and expectations of consumers. The consequences were devastating throughout the laboratory industry. That is why it is timely for our industry to have an influential voice in the current debate about "where do we go from here."

What is the right starting point? In my view, there are four main drivers in the healthcare system today. The first is Medicare. In many ways, what Medicare does directly influences the decisions of private payers. Second would be employers. They pay for the largest portion of healthcare in this country. Third are the state Medicaid programs, which directly reflect unique attributes of each state. Fourth are the state health insurance regulators.

Each of these vested interests has its economic and political agenda. It is not for me to sort out the merits of each position. I would like to focus on one aspect of the debate on which I believe most laboratory executives and pathologists concur: Whatever the next shape and form the American healthcare system takes, laboratories will do best if both physicians and consumers are allowed to choose the laboratory—and lab testing services—that best meet their needs.

I've already noted how consumers want choice in healthcare. Both employers and politicians are sensitive to that concern. It is also acknowledged that physicians don't like to be forced, by contract or other means, to use a specific laboratory that might not meet their needs and preferences.

The Right To Chose

For the laboratory industry, these are two important constituencies which support choice. However, buyers of healthcare (read: government, payers, and employers) often want to restrict choice for a variety of reasons. To help clients and readers of THE DARK REPORT understand some other dimensions of this situation, we are reproducing an essay written by Regina Herzlinger, the distinguished professor of business administration at **Harvard University**.

Herzliner brings out additional perspectives in the debate about how to reform our healthcare system which seldom get much attention. Her comments about the need for choice do mirror the laboratory industry's interest in this subject. As well, the overall perspective in her essay is sure to stimulate energized discussions for any laboratory which includes this in their strategic planning sessions. **TDR**

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Regina Herzlinger's Observations About U.S. Healthcare System

By Regina E. Herzlinger

WITH THE EFFECTIVE PASSAGE of the Medicare drug bill, we have just vastly enlarged the health-care sector. This is the one-seventh of our GNP that is run Soviet-style: where the doctors who are uniquely qualified to create and manage health-service businesses are prohibited from owning more of them; where entrepreneurs often must pass a local government smell "test" before they are permitted to build new facilities; and worst of all, where government dictates the prices and exact characteristics of the insurance benefits for which it will pay. Most private health insurers follow Medicare's lead.

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Small wonder that health-care costs rise at double-digit rates, while the rest of our economy perks right along. Back in the U.S.S.R.

The U.S. economy has boomed because brilliant entrepreneurs can enter it freely. If they succeed, they are appropriately lionized. A McKinsey report claims that the retailing industry was No. l in enhancing productivity, and credits Sam Walton's **WalMart** for much of that increase. No. 2 was the finance sector, whose productivity was greatly enhanced by John Bogle's dogged insistence on the wisdom of indexed, consumer-driven mutual funds. Yet, had Messrs. Bogle and Walton been forced to rely on government approvals to start their businesses and on government-dictated products and prices to earn their revenues, we might not have benefited from the productivity-enhancing innovations they created. Indeed, they would have been chopped off at the knees if they were in the health-care sector: It prohibits physicians, the health-care equivalent of Messrs. Bogle and Walton, from owning their own facilities. The unattractiveness of these conditions explains why few of the 100 Harvard MBA students enrolled in my "Innovating Health Care" course plan to enter the trillion-dollar health-services sector.

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Further, because Medicare prices are dictated by government and do not reflect marginal costs, capital is misallocated. Among other things, this has produced vast temples to cardiology, a service Medicare has overpriced; and shreds of services for emergency care, a service that Medicare has underpriced. And because Medicare dictates product specifications, it penalizes innovations. For example, **Duke University's Medical Center** improved the health of victims of congestive heart failure and vastly reduced costly hospitalizations by integrating into one team the many different providers required for appropriate care for this disease—who normally do not communicate with each other—saving $8,600

The unattractiveness of these conditions explains why few of the 100 Harvard MRA students enrolled in my "Innovating Health Care" course plan to enter the trillion-dollar health services sector.

per person. But Medicare pays Duke primarily for hospital-based care. There is no standard payment code for integrated care. In Medicare's straitjacket, the more Duke's innovation improved health and lowered costs, the more money the center lost.

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Technology innovators also are penalized by delays and mispricing. For example, Medicare waited for a full year to cover the implantable defibrillators that caused a 31% reduction in deaths, when compared to patients treated only with drugs. These high-tech, $25,000 devices can prolong lives for up to seven years. Without Medicare's coverage, some of those who could not afford to pay out of pocket surely died prematurely. Yet positive coverage decisions still do not assure access. If Medicare sets inadequate prices, providers lose money. Its price for implanting the drug-eluting stents that prevent reclogging of an artery, for example, eliminates hospital profits. Providers who implant do it as a charitable act.

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Sure, it is great that seniors will now have expanded access to drug benefits. After all, the purpose of health insurance is to enable people to use services that they could otherwise not afford. But, can we have our cake and eat it too? Yes! With an American Revolution that replaces the Medicare entrepreneur-strangling apparatus with a market-based system of determining supply and demand. Consider the following example of how it would work for victims of congestive heart failure:

· An innovative provider like Duke could offer its program at 20% lower prices—the savings it achieved. Innovators in drugs and devices could freely market them to these providers, who would determine their value for the money.

· Enrollees could then select from different programs that offer complete, integrated treatment of their disease. Healthcare clones of *Consumer Reports* would help them, just as people now get help buying computers and cars. Enrollees who opt for more cost-effective packages, such as Duke"s, could use some of the savings for costly, uninsured needs, such as long-term care.

· As for government, in a consumer-driven health-care system, such as Switzerland's, its role is to risk-adjust payments, so insurers and providers are rewarded for caring for the sick. Governments also prosecute incompetent, fraudulent providers and help the infirm and indigent.

Some economists believe that the health-care sector is optimally efficient: You can't make this orchestra play any faster. To them, only a single-payer system that eliminates redundant insurers and rations care can control costs. But a growing number of consumer-driven entrepreneurial insurance plans, intermediaries and health-care providers disprove such views the old-fashioned American way—by increasing productivity. Such plans could be offered as options under the Medicare program.

In Medicare's straitjacket, the more Duke's innovation improved health and lowered costs, the more money the center lost.

In our traditional healthcare system, a typical corporation limits the choice of

health insurance plans to a single, one-size-fits-all plan. But consumer-driven insurance plans are designed for individual needs. The Minneapolis-based Vivius program lets enrollees choose the plan that best fits their budget from an a la carte menu of doctors, hospitals, deductibles and co-payments.

Other plans let enrollees set aside funds in tax-free savings accounts for uninsured, important and costly benefits, such as drugs or long-term care expenses. The Illinois-based Destiny plan rewards health-promoting enrollees with lower costs. Some plans are relatively cheap; one provides insurance against catastrophic medical events for $1,500 for a single mom and two kids, unlike the typical $5,000 to $8,000 cost for such coverage. Sure, the plan has a $2,000 deductible, but it 's a lot better than no insurance at all! Entrepreneurial firms help consumers sort through their options with the aid of skilled personnel, computer programs and hard data about the quality of doctors and hospitals.

Under the Medicare regime, however, the money is spent cruelly because it restricts care; and wastefully, because it shackles the innovators who represent the best promise for controlling costs, improving quality, and increasing the access to our healthcare system.

Then there are the productive providers. A Minneapolis-based employers' consortium, BHCAG, permits doctors and hospitals to organize themselves into care systems, quote their own prices and determine for themselves how to best provide services. Innovative regimens like these reduce treatment costs by improving overall health.

Many people who favor centralized control defend the current state of affairs by scoffing at consumers' abilities. Health care is "too complex" for the likes of us to negotiate on our own. Without their savvy help, we would get lost. But somehow, we consumers have steadily improved the quality and beaten down the price of computers, cars and other complex products without their limiting of choice.

Others ask where governments could find the money for sick people who would favor plans that give them freer access to care. Hello?! Medicare expends that money right now! Under the Medicare regime, however, the money is spent cruelly because it restricts care; and wastefully, because it shackles the innovators who represent the best promise for controlling costs, improving quality, and increasing the access to our health-care system. The competitive features of the new bill are a step in the right direction. But, if it went further, ending Medicare's pricing and benefit stranglehold and recognizing physicians' right to own facilities, we could replicate in our health care system the productivity gains we enjoy elsewhere in our economy. TDR

Ms. Herzlinger is a professor of business administration at ***Harvard Business School*** *and a senior fellow at the* ***Manhattan Institute****. She is the author of "Consumer-Driven Healthcare," a new book soon to be published by Jose-Bass. This essay is appeared in the* Wall Street Journal*, which holds the copyright.*

Price Discount Practices May Prove Troublesome

One lab industry executive is surprised at how deeply test prices are discounted to payers

CEO SUMMARY: Some laboratories continue to offer deeply-discounted prices to the nation's largest managed care plans as a way to maintain provider status and keep market share. In one case, these deep discounts surprised a long-time lab executive, who decided to share the information, along with his comments. Among his concerns is how such situations argue in favor of Medicare's desire to initiate competive bidding.

DURING THE PAST DECADE, there's been plenty of debate and discussion about Medicare reimbursement for laboratory testing and whether existing fee schedules adequately reimburse laboratories for the cost of such testing.

This debate took an an added dimension last fall when the **Office of the Investigator General** (OIG) published rules that would amend regulations related to Medicare/Medicaid's prohibition against discriminatory billing practices. The proposed rules would establish a more specific formula for laboratories to use when calculating "usual charges."

Medicare Pays More

Timing of the OIG's action indicates it believes providers are failing to extend to Medicare the lower, discounted prices they customarily charge other healthcare consumers. That is a reasonable assumption, because it is common knowledge that hospitals, physicians, and laboratories, for most of the past decade, have accepted capitated and highly-discounted fee-for-service arrangements with many private payers and IPAs. Reimbursement rates for these arrangements, when compared to Medicare reimbursement levels, frequently are much less.

"This is an important situation for the laboratory industry," stated Joseph Plandowski, President of the **Lakewood Consulting Group**, located in Lake Forest, Illinois. "Many laboratories operate on razor-thin profit margins. This is particularly true of hospital outreach testing programs. So any substantial reduction to existing Medicare lab test reimbursement schedules represents a potentially devastating financial blow.

"The scale of this potential hit was made obvious to me recently," he noted. "As part of my periodic medical checkup, routine clinical chemistry tests were performed. The specimens were drawn at a local patient service center operated by **Quest Diagnostics Incorporated** and the tests were done at their regional laboratory. My physician also did a few tests in his office. *(See table, page 16.)*

How UnitedHealthcare Enjoys 90% Discount in Contracted Fees for Laboratory Testing

Here's the analysis done by Joseph Plandowski of Lakewood Consulting Partners for the laboratory testing done as part of a periodic medical checkup. The table shows the amount billed by the national laboratory and his physician to UnitedHealthcare, the amount reimbursed by UnitedHealthcare, and reimbursement that Medicare would pay in Illinois for the same tests.

	Billed by Quest or M.D.	Paid by UnitedHealth	Discount to UnitedHealth	Medicare Fees (Illinois)
Phlebotomy	$14.90	$0.00	100%	$3.00
Metabolic Panel	$53.10	$7.82	85%	$14.77
Lipid Panel	$96.95	$7.02	93%	$18.72
Uric Acid	$34.95	$3.59	90%	$6.31
Occult Blood	$15.00	$3.15	79%	$4.54
Urinalysis	$25.00	$3.15	87%	$4.43
Total	**$239.90**	**$24.73**	**90%**	**$51.77**

As part of a periodic medical checkup, tests ordered included a comprehensive metabolic panel, a lipid panel, uric acid, occult blood, and non-automated urinalysis with micro. Occult blood and urinalysis tests were done at the physician's office. Specimens were drawn at a patient service center operated by Quest Diagnostics, which performed the two panels and uric acid assay. Results reported in the metabolic panel included: glucose, sodium, potassium, chloride, carbon dioxide, urea nitrogen, creatinine, Bun/Creatinine ratio, calcium, total protein, albumin, calculated globulin, A/G ratio, total bilirubin, alkaline phosphatase, AST and ALT. Lipid panel results included: total cholesterol, HDL cholesterol, cholesterol percentile, triglycerides, LDL calculated cholesterol, and cholesterol/HDL ratio.

Note: This table originally appeared in the "American Pathology Review", a publication of the American Pathology Foundation (APF), in the summer of 2003.

"UnitedHealthcare is my health insurer. Both Quest Diagnostics and my physician are providers and both accepted UnitedHealthcare's payments as full reimbursement," explained Plandowski. "Moreover, as a patient, I was not required to pay anything. Although that may be good for me financially, the amount reimbursed for laboratory testing and services was appallingly low!

United Gets 90% Discount

"As billed by either Quest Diagnostics or my physician, the total charge for phlebotomy and all testing was $239.90. United Healthcare paid a total of $24.73. That's a 90% discount," exclaimed Plandowski.

"As a point of comparison, based on Medicare fees for Illinois, Medicare would have reimbursed $51.77 for these same laboratory tests and services," he added. "That's more than double the amount the national laboratory and my doctor accept from United Healthcare for reimbursement.

"These discounts are huge," said Plandowski. "However, it is the payment amounts which deserve the most attention. The absolute dollars accepted by Quest Diagnostics and my doctor are staggeringly low.

"This highlights two concerns. First, can any small laboratory or hospital lab outreach program compete at these fees and survive?" questioned Plandowski. "This certainly explains why Quest Diagnostics and **Laboratory Corporation of America** con-

stantly tell Wall Street their future lies in such higher-margin testing as genetics, infectious disease, prognostic cancer markers, and the like. To the nation's largest health insurers, these national lab companies have priced routine, high-volume testing so low that it now generates inadequate margins, even at the low cost-per-test generated by their economies of scale.

"Second, Medicare is still a big elephant in the room. Assume that insurance companies like **Aetna**, **UnitedHealthGroup**, **Oxford Health**, **Cigna**, and **Humana** get prices like the example provided here, and collectively this represents laboratory testing for upwards of 50 million American. Isn't it reasonable to expect that Medicare would want these same price levels for the laboratory tests provided to Medicare and Medicaid beneficiaries by the two blood brothers?" asked Plandowski.

"No one should be surprised if the Medicare program takes more aggressive steps to address this pricing inequity," he added. "One way to do that is to be more detailed in defining 'usual and customary charges,' which is reflected in the proposed language the OIG published last September.

Competitive Bidding

"The second way is to institute a demonstration project for competitive bidding in laboratory testing services," observed Plandowski. "With examples like the pricing offered to UnitedHealthcare by Quest Diagnostics and my doctor, Medicare can certainly go to Congress and defend the need for this step.

"Further, does the uninsured or self-pay patient deserve to pay an artificial 'patient test price' that is disconnected from the actual prices negotiated between large laboratory companies and large payers?" he continued. "Probably not. Hospitals are already under pressure by policy makers, consumer groups, and attorneys to cease charging uninsured patients prices which are double and triple the amount they accept from major payers.

"It is not a stretch to see consumer groups attack the laboratory industry for 'overcharging' uninsured patients," said Plandowski. "They can use the same arguments now being made against hospital billing and collection practices."

Potential For Change

Plandowski raises several interesting questions that strike at the heart of the lab industry's status quo with the Medicare and Medicaid programs. Would government healthcare administrators make different reimbursement decisions for laboratory tests if they understood the full scale of price discounting that seems to exist between the nation's big insurance companies and the largest regional and national laboratory companies?

Plandowski believes situations like this will prove problematic for the laboratory industry. "For pathologists, hospital administrators, uninsured patients, and the federal government, this raises a host of interesting questions," he said. "Not the least is the question of inequity in access to lab testing services. Should uninsured patients and those of government-funded programs like Medicare and Medicaid pay more than a patient covered by a private insurance plan–one that uses the sound business practice of competitive bidding to achieve the lowest price offered in the market?"

At a minimum, the pricing dichotomy for lab testing services that developed in the 1990s between private and public payers may be a ticking time bomb. When it explodes, there will probably be more losers than winners in the laboratory industry. TDR

Contact Joe Plandowski at 847-295-8805 or plan1340@comcast.net.

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

There's a new player offering clinical diagnostic services in oncology. **Genomic Health, Inc.**, based in Redwood City, California, is now accepting specimens. Last month, its laboratory received all the regulatory clearances required to conduct business. The company's proprietary technology is incorporated in a test it calls Oncotype DX™. This clinically-validated diagnostic assay provides a quantitative assessment of the likelihood of distant breast cancer recurrence. The test analyzes RNA using a technique called real-time RT-PCR.

There's consolidation activity among the group purchasing organizations (GPOs). **Healthcare Purchasing Partners International** (HPPI) of Irving, Texas agreed to purchase the group purchasing assets of **Healthcare Services of New England**, based in Quincy, Massachusetts. HPPI is owned by **VHA** and **University HealthSystem Consortium**, which also jointly own **Novation**.

C-REACTIVE PROTEIN MAY HAVE VALUE IN COLON CANCER TESTING

High levels of C-reactive Protein (CRP) are considered a sign of increased risk of heart attacks. Now comes a new study that says elevated levels of CRP in blood may also be an early warning sign of colon cancer. Researchers at **Johns Hopkins Medical Institute** in Baltimore, Maryland studied 22,887 adults. They determined that those with the highest levels of CRP were twice as likely to develop colon cancer as those with the lowest levels of CRP. This was true even when other risk factors, such as family history, age, smoking, and being overweight were considered. The records examined were mostly white adults in Washington County, Maryland, who were participating in another clinical study.

ADD TO: *Colon Cancer*

In the study, 131 people were diagnosed with colon cancer. Fifty of those diagnosed had CRP levels in the highest range while 20 of the diagnosed patients had CRP in the lowest range. Researchers noted that more study is needed before CRP might be used to improve current screening methods. It is unclear whether high CRP levels result from early colon cancer or represent a risk factor for later development of cancer. For laboratory directors and pathologists, the results of this new study demonstrate how the still-nascent field of proteomics may generate new markers for either early detection of cancer or increased risk of cancer.

P.S. ON PROTEOMICS:

Protein chip developer **Ciphergen Biosystems, Inc.** announced that long-time lab industry executive Gail Page has joined the company. She is President of its newly-formed Protein Molecular Diagnostics division. Page held executive positions at **Luminex Corporation**, **Laboratory Corporation of America**, and **Roche Bio-Medical Laboratories**. Ciphergen, based in Fremont, California, is developing diagnostic tests which use multiple markers.

That's all the insider intelligence for this report.
Look for the next briefing on Monday, March 15, 2004

PREVIEW #4

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