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Questions Health Plans Must Ask Before Considering a Laboratory Management or Genetic Prior-Authorization Program

Several start-ups have emerged in the laboratory benefits management and genetic prior authorization space, a direct result of both out-of-control costs and the explosion of genetic testing available. Many are trying to apply the Pharmacy Benefits Manager (PBM) model to labs, which is its own animal and not comparable. Managed care executives are being inundated with marketing about these programs, and they are causing confusion.

We know, because many of our clients are coming to us with questions. We've been providing laboratory benefits management services since 2000, helping health plans maximize benefits for members, while saving 20 percent, on average, which translates into tens of millions of dollars annually, depending on the size of the plan. Kentmere Healthcare Consulting is independent and not affiliated with a laboratory.

> *"It wasn't until working with Kentmere Healthcare that I realized I don't know enough about laboratory management and the technical knowledge it requires."*
>
> *- Ronald S. Mornelli, Senior Vice President and Chief Network Officer at HealthNow New York, Inc. (BCBS Western and Blue Shield Eastern NY).*

In response to these questions from clients, we began outlining the questions we recommend managed care executives ask themselves before choosing a lab benefits management partner.

1. Is their business model viable and does it actually work?

Have you reviewed their audited financials? Has the company demonstrated it is operationally profitable or does it require ongoing funding from its parent company or investors to survive? We all have seen in recent years the collapse of medical technology companies when they cannot fund their own operations even after hundreds of millions of dollars of investment.

2. Does the company have documented experience and validated results with independent client health plans that are not financially or operationally partnered with them?

One hundred percent independence from all clients and laboratories is critical in making sure the health plan receives accurate references and savings data.

Many companies are owned or partially owned by venture capitalists, other health plans or labs, all of which have different investment interests than your plan.

"I have been working in healthcare for 30 years, and have negotiated several lab contracts," said Ronald S. Mornelli, Senior Vice President and Chief Network Officer at HealthNow New York, Inc. (BCBS Western and Blue Shield Eastern NY). "It wasn't until working with Kentmere Healthcare that I realized I don't know enough about laboratory management and the technical knowledge it requires."

3. What are the long-term business goals of the firm?

The goal of venture capital firms is to exit within six years. This is done by a sale to an unknown third party or by trying to go public. In both cases, revenues and profit margins become increasingly more important each year. This all comes out of the health plan's pocket. In the meantime, the ROI for health plan is minimal compared to better proven options. These firms are learning at the health plan's expense.

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4. **Are any of their client's stockholders, investors or providing services for a fee to your company?**
Some companies only have clients who are investors. Will your company get the same level of attention and savings as the investor/client?

5. **Many times, most savings come from laboratory contracting to obtain more favorable pricing – how much savings is your health plan giving away to the company acting as an intermediary?**

PBMs add cost to the health plan and laboratories will not give their best prices to third parties. As utilization and prices trend downward, why should a health plan lose that ROI? A shared savings model can make a plan overpay significantly.

"After working with Kentmere Healthcare to negotiate our laboratory contract, we initially saved more than 25 percent on our core laboratory testing," said Mornelli.

6. **How does their program guarantee your members access?**

Many of these programs allow multiple laboratories in the network, claiming better access for members. In fact, because of the open network, you cannot require labs to open access locations in remote or low-volume areas that may be crucial for your health plan now or in the future.

Do they guarantee stat, testing and turnaround time?

7. **What performance standards and guarantees are provided to your health plan for service and quality?**

What are the financial penalties and who receives them? Are they general to the company or specific to your health plan?

8. **Genetic test prices are dropping rapidly due to competition and new technologies – Is your health plan getting savings credit for industry changes or is that part of the profit driver for the company?**

Genetic spend analyses more than one year old are outdated and meaningless.

Laboratory contract pricing has very little to do with the size of the health plan.

9. **Does their program claim that non-national health plans cannot maximize volume discounts?**

This is not true. Laboratory contract pricing has very little to do with the size of the health plan. It is related to the knowledge the plan has of its market and the labs competitive positions. Using a Lab SME, many small plans have received better pricing or equal pricing to the nationals. Percentage of Medicare is an inaccurate reference benchmark as price, utilization and test mix determines your real negotiating strength.

10. **Is your health plan paying for reductions that are independent of the management company?**

For example, overall laboratory test utilization and costs are going down. Genetic testing utilization is increasing; however, pricing is decreasing. When the data is analyzed correctly you will see genetic testing accounts for less than 5-6 percent of most health plan's cost.

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11. Whose medical policies are the physician providers required to use?

Do they conflict with your health plan's polices? Are they different for physicians using the hospitals or in-office laboratories?

12. What is the cost of the program?

Not only on a PMPM basis but also for the time required by your health plan to start up and maintain the ongoing relationship to manage the program. Also, many of these companies have massive overhead and have to overcharge to make ends meet.

13. What about appeals on laboratory issues?

Is your health plan legally responsible for them and are you required to respond to them?

About Kentmere Healthcare Consulting Corporation

Since 2000, Kentmere Healthcare Consulting Corporation has provided its proprietary outpatient Kentmere Laboratory Benefit Management Program™ for the managed care industry. Kentmere Healthcare Consulting – an independent firm – serves national and regional health plans; is not a laboratory; and does not work for or with laboratory providers. Based in Wilmington, Del., Kentmere Healthcare Consulting delivers a thorough claims analysis that paints a clear picture for health plan executives of where their issues are and how they can save tens of millions of dollars annually, while maximizing benefits. In every instance, Kentmere Healthcare's Laboratory Benefit Management Program reduces its clients' actual total yearly cost of laboratory testing by 10-20 percent (this does not include trend reduction or downstream cost savings), while still delivering the same level of service – or better. Kentmere Healthcare Consulting's client ROI is greater than 20:1.

For more information, visit www.KentmereHealth.com.

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