Pricing Orthopedic Implants

"I'll Take the Mink....."

Peter D. McCann, MD

Continuum Health Partners, comprising New York institutions Beth Israel Medical Center, St. Luke's–Roosevelt Hospital Center, and Long Island College Hospital, recently concluded prolonged negotiations with several manufacturers and agreed to the pricing of hip, knee, and shoulder implants. As Chair, Department of Orthopaedic Surgery at Beth Israel Medical Center, I was intimately involved in this process and, hence, feel qualified to say that there could hardly be a more Byzantine and tedious exercise. Nevertheless, my experience has brought into sharp focus a concern of which most orthopedic surgeons are unaware: how do we afford orthopedic implants?

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To my mind, the problem stems from the peculiar financial relationships among the 3 principal players: the implant manufacturer (the producer), the insurance company (the payer), and the hospital (the middle man). As a for-profit entity, the implant manufacturer seeks the highest price for its product. Similarly, in an effort to maximize profits (or, in the case of government insurers, avoid losses), the insurance company seeks the lowest price for the implant. The hospital (ours is a nonprofit institution) seeks simply to bridge the gap and break even, which is extremely difficult since there is no communication between the producer and the payer at any point in this transaction, and the hospital has little or no leverage over either party.

Further complicating this process is that the consumers—surgeons and patients—have little concern about the price of the implant since neither pays directly for the product (of course, we ALL pay indirectly). Demand for the newest (and most expensive) implant remains extremely high, driven by industry advertising as well as by surgeons' and patients' assumptions that "newer is better." Consequently, the hospital administration is thrown into this morass of, on the one hand, conflicting parties (industry and insurers) and, on the other hand, disinterested parties (surgeons and patients) and is expected to arrive at "the right price."

I recently shared my frustration with this process with my family at dinnertime, which is the one opportunity during the day where we all have a chance to sit together and talk about the events of our day. Our 13-year-old daughter described swimming practice that day and complained about the unreasonable expectations of a demanding teacher. My wife, principal in an architectural firm she founded 25 years ago, discussed an intriguing new building design and the frustrations of dealing with a particular contractor. As I reviewed, in turn, the confusing financial relationships of the various parties involved in implant pricing as described above, I could see that I was losing my daughter's attention as she rolled her eyes in that teenage manner that conveys total boredom.

In an effort to salvage the conversation (a challenge with any 13-year-old), I asked her to imagine that her mother is in her favorite New York department store, Bergdorf Goodman (great product, great service, and priced accordingly), shopping for a winter coat. Price is of no concern and she can get any coat she wishes. Someone else (not me!) will pay for it. She tries on a beautiful Italian woolen coat ($10,000) that will keep her perfectly warm during the New York winter, and then she tries on a stunning Russian mink coat ($50,000) that also will keep her perfectly warm but is unimaginably soft and luxurious. I reminded her again that the cost of the coat did not matter, since someone else would be paying for it. She could make her selection based solely on her own set of criteria for a desirable winter coat. I also asked her to assume that her mother had no objection to wearing fur (she does).

Dr. McCann is Chair, Department of Orthopaedic Surgery at Beth Israel Medical Center, New York, New York.

Mommy interjected, "I'll take the mink."

What have I learned through this process? Of course, factors other than the lack of consumer restraint (ie, the Bergdorf's analogy) play a role in the complicated process of pricing implants. However, I believe hospitals are placed in the untenable position of being the intermediary without leverage over the other parties but with maximum exposure to downside risk. Nevertheless, I can offer 3 points worth considering.

First, surgeons, I believe, need to know the cost of implants and how these costs are covered (or not), and take the time to educate patients on matching an implant with the patient's needs. Second, patients, the ultimate consumer, need to understand that "standard implants" with a proven record for reliability and durability can provide predictable pain relief and improved function and that the assumption that "newer is better" may not always apply. If, after a discussion with the surgeon, a patient requests use of the more expensive "latest implant," regardless of the lack of proven clinical benefit, the patient should be obligated to help defray that increased cost. Finally, there must be some dialogue between implant manufacturers and third party payers. Producers must understand what the payer can afford and, conversely, the payers must understand the production and R&D costs inherent in bringing implants to market.

I realize that my recent experience with implant price negotiations is only a small component of the enormous health care financing crisis facing this country, but it has brought into sharp relief for me the urgent need to address this issue on many fronts: industry, insurers, hospitals, surgeons, and patients. The process would benefit from direct communication, full disclosure, and transparency. With that, let the market forces play.