Health Policy: Current Issues and Orthopaedic Surgeon Involvement

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In any game, the agreed-upon rules are of prime importance in the play and final outcome. In Monopoly, for example, will you get an extra $500 bill for landing on free parking, or just the taxes that have collected? Life is but a game. In healthcare, the agreed-upon rules come from our government, our payers (both federal payers and the private payors that manage the vast majority of payment transactions), medical interest groups deciding on codes and coding packages, hospitals, and providers.

Before dice are rolled in a board game, presumably, all players agree to specific rules. But when starting a medical career, surgeons assume that because they are entering the game late, the rules are set in stone, and they must be followed without question or modification. They are wrong, notwithstanding the reality that there are a trillion other important things competing for a young surgeon's focus, including actual patient care

Health policy is the perpetual discussion of the rules. Nothing is set in stone. Other superfluous stakeholders chronically debate and change the rules. Without surprise, the participants in those discussions benefit. And that benefit comes at the expense of the players absent to that discussion.

Perhaps you have remained absent from health policy discussions. If so, you are playing in a game that is designed for you to lose, to become burned-out, to not shine in the craft you invested 10+ years to hone. Voting is not enough; we have seen broken promises and failure of relief from both major political parties. A quiet wheel will not get greased.

But the fix can be easy. Involvement can be as simple as financially supporting your representatives to these discussions. Contributing to the Orthopaedic Political Action Committee (PAC) is a bare minimum (stop reading this and do it now!). The trial lawyers mobilize PAC support at nearly 100% participation; hospitals and insurance companies do as well. Orthopaedic surgeon participation hovers between 20-30%.

Deeper involvement in health policy generates even deeper effects. Surgeons should meet and support their elected officials and share stories of the incredible improvements in patients' lives. Encourage patients to champion the treatments that keep them mobile. Go to Congressional fundraisers (the PAC will pay your way) and build meaningful relationships that you can call upon later. Join your surgical society trips to Washington DC to deliver clear and simple asks of your representatives. We are the experts in musculoskeletal care and elected officials need access to our expertise.

Today's health policy discussions, like yesterday's and tomorrow's, revolve around money, either directly or indirectly. Top on the minds in Washington, DC lives the persistent and now predictable *annual* assault on payments for our work. Year-on-year, the complexity and challenges of orthopaedic surgery are consistent. If anything, the work gets harder as we raise the bar incrementally and accept fewer complications, fewer dissatisfied patients, and fewer outliers. Despite this, and despite being successful at reducing complications and dissatisfaction, and while dramatically improving the quality of life and functional productivity of patients, we get paid less today than yesterday.

Surgeon fees account for about 5% of the total episode cost in total joint arthroplasty, but the bullseye remains on our backs. For example, the 2021 Medicare Physician Fee Schedule (PFS) reduced wRVU for THA and TKA by 5.3% from 20.72 to 19.6 units. This was explained by the fewer number of post-op visits documented with modern arthroplasty (i.e., less work over the 90 days). This may not even be true, but if it is, it is a result of improved outcomes and pre-surgical optimization efforts that were stimulated by earlier bundle models. On top of that, there is a PFS conversion factor that multiplies the overall RVU to determine surgeon payment. In 2022, we faced a proposed cut in the PFS conversion factor from 34.89 to 33.59 (3.7%); ultimately the cut was "only" to 34.60 in the final rule. These cuts in wRVU and conversion factor combine to decrease payments from around $1,415 to $1,270 for a joint replacement.

For years, the recurrent strategy from payers has been to propose deep cuts and then compromise on a smaller cut. We sigh in relief from a smaller cut, but let's not forget that we are still worse off than the year before. Advocacy and our collective involvement can be thanked for the smaller cut. Greater bargaining power, from universal involvement (imagine our clout if we enjoyed 100% participation in our PAC), meaningful relationships with elected officials, and a clearer narrative focusing on patients and surgeons, might stop these recurrent cuts. To really dream big, an increase to match inflation could occur one day. Or—gasp!—an increase, like a raise, even after paying for higher annual labor and other expenses of a practice.

In the Budget Control Act of 2011, Congress passed a 2% sequestration clause in Medicare payments. The CARES Act in 2020 provided relief from that cut to help cover costs from the pandemic. As of April 1, 2022, 1% of that sequestration has returned, with the remaining 1% reduction planned to start

on June 1, 2022. The downward pressure on payments is ever present.

Stronger participants in the health policy discussions have not fared the same as surgeons. Hospitals have enjoyed annual increases in payments for DRG 470 (lower extremity arthroplasty without major medical complications or co-morbidities) since 2019. The 2022 payment is $11,675, which is $252 (2.2%) more than in 2021 and $265 more than in 2020. Recall that surgeons are paid around $145 less per case compared to 2020. Sitting on the sidelines of this game is not working out for us.

Private payers are in the game. Surgeons accustomed to reading financial reports should read the most recent UnitedHealth Group (UNH) quarterly report ending March 2022. An easy way to understand profitability is to look at how $80 billion in *quarterly* revenue trickles down to individual shares. By law, at least 80% of revenues have to pay for actual health care, so that leaves $16 billion for salaries, costs, and shareholders. In the full year, UNH expects to profit around $20 per share. They have almost a billion shares "floating" out there. Though we love capitalism, it is hard to cheer for this $20 billion drainage from the healthcare system. Adding the profits of Anthem, Aetna, CVS, and other private insurers, even a capitalistic society must ask whether scarce healthcare dollars really ought to end up in investment accounts.

Health policy agendas go beyond perennial payment concerns. A major contemporary issue, and one that undoubtedly contributes to the profitability of UNH and others, is the impediment to patient care known as "prior authorization." This is the modern implementation of private payer oversight of medical decision making. An insurance representative, often lead by a medical director, reviews submitted documentation to determine if the indication for a surgical procedure is met. This is a cost-control tactic, and its use has increased significantly in recent years. Congress and the Department of Health and Human Services are aware of the problems of prior authorization, in particular because patient care is disrupted and delayed, but also because of the burdens placed on medical practices.

One major concern from hip and knee surgeons is the lack of evidence for some of the criteria used by insurance companies and third-party reviewers like eviCore. An internal AAHKS membership survey found that prior authorization denials never or rarely followed clinical practice guidelines and evidence-based medicine 55% of the time. For example, eviCore requires a documented range of motion spanning greater than 50 degrees before approving knee replacement. On the contrary, when performed by experienced hands, arthroplasty restores function and improves the lives of patients with such severe motion limitations.

Other health policy agenda items are wide ranging, including restoring surgeon discretion for site of service, namely performing surgery as a hospital in-patient versus hospital outpatient or ambulatory care center, shaping bundle payment models, and advocating for federal research support for orthopaedic diseases.

As the foremost experts in musculoskeletal care, orthopaedic surgeons have a duty to patients that expands beyond the clinic and into the halls of Congress and several agencies in Washington. At a minimum, participation in the PAC is as easy as setting up auto-pay for your cell phone bill. Going further, attending fundraisers and engaging with elected representatives helps patients and our profession.