The Consequences of Not Offering Premium Lenses

The extra steps needed are worth the effort.

BY JOHN F. DOANE, MD; AND JAMES A. DENNING

Demographics are coming into cataract surgeons' favor. The populations that drive cataract surgery and premium lens upgrades are the silent generation and baby boomers. The silent generation represents patients born before 1946. In the United States, this group is composed of approximately 35 million people. Their average age this year will be around 71 years old, which coincides with the average age at which people undergo cataract surgery. Patients choosing toric IOL upgrades are usually 2 years younger than the average cataract patient. Thus, one can assume that the toric IOL market will grow faster than the presbyopia-correcting IOL market (Table 1).

The baby boomers were born between 1946 and 1964. In the United States, they number approximately 78 million, and their average age in 2010 will be around 55 years, with a leading age of 64 years. Patients selecting presbyopia-correcting IOLs are generally 8 years younger than the average cataract patient. Thus, the leading edge of the baby boomers is just entering the presbyopia-correcting IOL market. This market should grow from sheer demographic movements.

CONVERTING TO PREMIUM LENSES

Offering premium IOLs is a technological path. The transition is much like converting from extracapsular cataract extraction to phacoemulsification: surgeons who did not make the change felt the consequences. Premium lenses have raised and accelerated the technological path, which can be compared with the transition from fax machines to voicemail, voicemail to e-mail, e-mail to texting, and texting to instant messaging. Adults who do not text have a hard time communicating with their kids. Similarly, cataract surgeons who do not implant premium IOLs will have a hard time satisfying the wishes of their patients in the future.

EXTRA WORK FOR PREMIUM LENSES

We have been involved with accommodating IOLs since 2000 when the US Food and Drug Administration (FDA) trials of the Crystalens (Bausch + Lomb, Rochester, New York) started. We have used refractive and diffrac-

TABLE 1. TORIC LENS CONVERSION FACTOR

	2009 Volume	2010 Volume	2011 Volume	2012 Volume
Cataract volume	300	300	300	300
Cataract reimbursement (USD)	$628.00	$628.00	$628.00	$628.00
Cataract annual reimbursement (USD)	$188,400	$188,400	$188,400	$188,400
Medical inflation @ 6% (USD)		$11,304.00	$11,982.00	$12,701.00
Additional revenue to stay even (USD)		$199,704.00	$211,686.00	$224,387.00
Toric net upgrade (USD)	$500.00	$500.00	$500.00	$500.00
Toric volume to offset inflaton		23	24	25
Toric conversion rate		7.5%	8.0%	8.5%

TAKE-HOME MESSAGE

- As the silent generation and baby boomers age, patient demographics are coming into cataract surgeons' favor.
- A lot of work is involved with incorporating presbyopia-correcting IOLs into practice; however, the return is a healthy financial balance.

tive multifocal IOLs since their approval in the United States. We therefore well know that there is no perfect presbyopia-correcting IOL with a zero-hassle factor for patients, staff, or doctors. A lot of work is involved. Specifically, patients' astigmatism must be reduced to below 0.50 D postoperatively, either by corneal incisional surgery or laser vision correction. The spherical equivalent refractive error must be within ±0.50 D of the target, or the patient will likely need or request an enhancement in the form of laser vision correction.

Probably at least 25% of all presbyopia-correcting IOL patients require an enhancement. This is a huge issue for the surgeon and his staff to understand and manage. With standard IOLs, we would estimate that the typical percentage of eyes within ±0.50 D from the target is 45%. This means that 55% of eyes will not have an acceptable uncorrected distance vision and that patients will seek spectacles from the optical shop for better visual performance. Patients who pay for presbyopia-correcting IOLs typically do not go to the optical shop, but they do seek laser vision correction. Fortunately, if a surgeon is extremely compulsive, he can increase the percentage of patients within ±0.50 D of the intended target to 75% and thus reduce the number of patients seeking laser vision enhancement.

CONCLUSION

Despite the additional work and skills required for patients' postoperative satisfaction with premium IOLs, we believe the extra steps are necessary. Surgeons and practices have a choice: Either they accept what third-party payers pay, which is only going to decrease, or they offer premium services and are reimbursed for their extra time and effort, which will promote a healthy financial balance. ■

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