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Assessing the impact of state “opt-out” policy on access to and costs of surgeries and other procedures requiring anesthesia services

Overall, the results consistently show no improvement in access to inpatient surgical care associated with the opt-out indicator. In other words, opt out was not associated with increase (or decrease) in access; the opt-out rules had no measurable effect on access. Interestingly, states choosing to opt out were associated with subsequent higher costs per inpatient —about $1,800 higher per surgery, or about 8.7%.

On the surface, the inpatient cost result seems counterintuitive, as opt-out provisions in theory allow lower-priced nurse anesthetists to perform the same services as physician anesthesiologists. However, as some recent research has shown, nurse anesthetists take longer to perform the same services. [11] As a result, despite the lower payment per unit for nurse anesthetists, the greater number of units provided may translate into higher anesthesia costs overall. Moreover, recent research suggests that surgery procedures with nurse anesthesia providers working without physician supervision have worse surgery outcomes in terms of complications requiring additional treatment. [6–8] Clearly, surgical procedures with these complications are likely to entail higher overall costs than procedures without complications. [9] Thus, the observed higher costs in opt-out states could be a result of the combined effects of these two issues.

Our results do not support the hypothesis that opt-out laws improve access to inpatient surgical care or reduce its costs. Across a number of specifications for our inpatient discharges models, we find a consistent pattern of point estimates of increased costs with no discernable impact on access.