Outpatient surgery: helping to contain health care costs

Rising costs are prompting insurers to offer incentives or provisions to guide patients toward less expensive outpatient services

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The price of health care increased 109 percent between 1981 and 1991—more than twice the 50-percent rise in the price of all items in the Bureau of Labor Statistics Consumer Price Index[1]—prompting employers to encourage workers to use less expensive health care services. Health insurers have introduced measures to control costs, offering incentives for seeking a second opinion for surgical procedures and requiring approval by an insurer before hospital admissions. These measures allow health care carriers to evaluate an illness or injury of an enrollee before the prospective patient enters the hospital or undergoes surgery. Carriers can then determine in advance which expenses they will cover.

The cost of hospital care has risen 135 percent in the past decade[2]; this rise affected health care prices significantly because hospital expenses make up approximately 40 percent of all health costs.[3] Health insurance carriers have responded by encouraging participants to shift their health care use from inpatient hospital services to less expensive outpatient services. For example, carriers often offer financial incentives for choosing outpatient, rather than inpatient, surgery.

Approximately 80 percent of full-time employees participated in an employer-provided health care plan during the 1989–90 period; all participants were covered for inpatient and outpatient surgery. Inpatient surgery costs generally were covered on a percentage of usual, customary, and reasonable charges,[4] and subject to an annual deductible and a lifetime maximum benefit. Health care plans covered costs of outpatient surgery at the same rate as inpatient surgery or at a higher percentage in an effort to encourage the use of outpatient services.

This article examines benefits provided by health care plans for inpatient and outpatient surgery, and discusses the plans' incentives for encouraging outpatient surgery. It also explores some reasons for and against choosing outpatient, rather than inpatient, surgery.

Data are from the 1989 and 1990 BLS Employee Benefits Survey, which provides representative data for 77.9 million full-time employees.[5] The survey includes data on many types of employer-provided benefits, including health care, life insurance, retirement and capital accumulation plans, and paid leave.

Surgical procedures and facilities

Although surgery is traditionally associated with emergency rooms and hospital confinements, many procedures are performed without a hospital confinement. Outpatient surgery, also called "same-day" or ambulatory surgery, can be performed in the hospital, a doctor's office, or a "freestanding" ambulatory surgical center.

Despite the differences among the three locations, all are used routinely to perform same-day surgery. A hospital's outpatient services may be provided in the hospital or at a separate but affiliated facility. In contrast, freestanding surgical facilities are not affiliated with a hospital: they may be part of a chain of surgical centers, or they may be independent. A doctor's office may be in an of-

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fice building, a hospital, or the physician's house; it is controlled administratively and financially by one or more physicians, regardless of its location.

From the point of view of health insurance companies, surgery is considered outpatient surgery if it takes place in any of these locations. Fees for surgeons and related personnel are approximately the same at each of these sites, although the charge for use of the facility may differ.

All outpatient surgery locations provide not only operating rooms, but also recovery rooms designed for a relatively short recovery instead of an overnight confinement. Differences among outpatient surgery sites are not related to the type or complexity of surgical procedures that can be performed, but are related more to their administration.

Cost containment measures

Outpatient surgery is more attractive to health insurance carriers who bear most of the costs of surgery. Health insurers, therefore, offer their members financial incentives to have surgery performed on an outpatient basis. These incentives are not the only surgery-related cost containment measures: many plans include provisions designed to guide patients toward the least expensive choice for elective surgery and other procedures not requiring immediate attention.

One such provision is mandatory second opinions for specific surgical procedures. In the 1989–90 period, second surgical opinions were required for 30 percent of participants in medical plans other than health maintenance organizations (HMO's).[6] Participants were required to obtain a second opinion before voluntary surgery for certain procedures—foot surgery, a tonsillectomy, or cataract surgery, for example. Plans generally pay the full cost of the second opinion, or pay at the same rate as for other services; if the participant does not seek a second opinion, the plan reduces its payment for the surgical procedure. For example, the plan might pay 50 percent of the surgical charges for which a second opinion was not obtained instead of 80 percent that would be payable with a second opinion.

For 39 percent of participants in a health care plan, a second opinion before surgery is voluntary and benefits are not reduced if a second opinion is not sought. A second opinion may give the patient two alternatives to inpatient surgery: the second physician might advise against the surgery or recommend that the procedure be performed on an outpatient basis.

Health care plans also may require outpatient surgery for certain less complicated procedures. To reinforce these requirements, the plans may impose penalties, such as reducing reimbursements if these procedures are performed in an inpatient setting.

These cost-containment measures represent some of the strategies health care plans use to reduce costs. Plans also attempt to control costs by encouraging preventive care and requiring approval prior to hospital admissions.

Benefits for surgical procedures

In the 1989–90 period, health care plans covered 83 percent of full-time employees. Nearly all of these workers were enrolled in 1 of 3 types of plans: traditional fee-for-service, preferred provider organizations (PPO's), or health maintenance organizations (HMO's). Most participants, 71 percent, were in traditional fee-for-service plans that reimburse for health costs as they are incurred, and allow the enrollee to choose his or her physician. PPO's also do not restrict the enrollee's choice of providers; however, participants are encouraged to choose from a selected list of doctors and hospitals (preferred providers) and are offered financial rewards if they choose these providers. For instance, a plan may pay all costs for the services of a preferred provider, but only 80 percent of the costs for services other providers offer.

HMO members pay for their health care on a fixed, prepaid basis and are required to receive treatment from specified doctors and hospitals under contract to the HMO. HMO's do not offer incentives for outpatient surgery; they review the medical circumstances and instruct the member on the type of surgery to be performed. For this reason, the following discussion of benefit provisions is limited to plans other than HMO's.

Health care participants in plans other than HMO's numbered 53.7 million over the 1989–90 period, and approximately half had inpatient surgery covered at 80 percent of usual, customary, and reasonable charges. One-eighth were covered at various other percentages, such as 90 percent or 95 percent. These plans commonly require the participant to satisfy an annual deductible before they pay benefits, and they impose a ceiling on the amount of benefits a participant will receive in a lifetime. The average annual deductible for participants subject to a deductible was approximately $200, and the most common lifetime dollar maximum was $1 million.

The remaining participants (slightly more than one-third) had inpatient surgery covered at 100 percent. This includes participants who were not subject to any limits, as well as those who had an annual deductible or a lifetime maximum. A small percentage of participants had inpatient surgery covered at 100 percent up to a maximum dollar amount per procedure, then a percentage of the balance is covered. In this study, these participants

are considered to have inpatient surgery coverage at 100 percent.

Outpatient surgery was covered at the same rate as inpatient surgery for approximately 75 percent of participants. For the remaining 25 percent, the plan generally included an incentive, such as a reimbursement rate for outpatient surgery that was higher than the rate for inpatient surgery. Plans use this strategy to guide patients to less expensive outpatient surgery.

Table 1 shows the percentage of health care participants at various rates of reimbursement levels for inpatient and outpatient surgery, by type of establishment—medium and large establishments, small establishments, and State and local governments. Some striking differences occur among plan participants in these types of establishments. In general, participants in plans in State and local governments were covered for both inpatient and outpatient surgery at a higher percentage than were plan participants in medium and large establishments (those employing 100 workers or more). Plan participants in small establishments (fewer than 100 workers) were covered at a lower rate.

Slightly more than one-half of health care (other than HMO) participants in State and local governments were covered for inpatient surgery at 100 percent, compared with one-third in medium and large establishments, and one-fourth in small establishments. Most of the remaining participants had inpatient surgery covered at 80 percent, and a small percentage (approximately 10 percent) in each type of establishment were covered at 90 percent. In all types of establishments, virtually all participants who were covered for inpatient surgery at 100 percent were similarly covered for outpatient surgery.

Table 1. **Percent of full-time employees with health care benefits, by rate of reimbursement for inpatient and outpatient surgery, 1989–90**

Reimbursement	Inpatient surgery	Outpatient surgery
All establishments, 1989–90	100	100
Less than 80 percent	3	2
80 percent	51	33
81–99 percent	10	10
100 percent	35	55
Medium and large establishments, 1989	100	100
Less than 80 percent	4	3
80 percent	49	32
81–99 percent	12	9
100 percent	35	56
Small establishments, 1990	100	100
Less than 80 percent	3	2
80 percent	62	41
81–99 percent	9	8
100 percent	26	49
State and local governments, 1990	100	100
Less than 80 percent	2	2
80 percent	32	20
81–99 percent	12	12
100 percent	54	67

When the plan offered an incentive for outpatient services, the participant generally was covered for outpatient surgery at 100 percent and inpatient surgery at 80 percent. In small establishments, two-thirds of the participants with inpatient surgery coverage at 80 percent had the same coverage for outpatient surgery, and virtually all remaining participants had outpatient surgery covered at 100 percent. This pattern applied to medium and large establishments and State and local governments. In addition, some participants were not required to satisfy an annual deductible if they chose outpatient surgery. This incentive was offered in addition to a higher reimbursement rate, or by itself.

Cost comparison

As noted earlier, inpatient surgery costs more than outpatient surgery. In both cases, approximately equal charges are incurred for surgeon's fees and anesthesia, but costs for hospital confinement add to the cost of inpatient surgery.

Expenses for hospital confinement are composed of room and board costs (charges for room and meals) and ancillary costs (charges for drugs and medications, nursing services, diagnostic tests, and x-rays). These total hospital costs could average approximately $1,000 daily.[7] For example, a relatively simple procedure that would require a 3-day hospital confinement would cost $3,000 less if performed on an outpatient basis. Health care plans that offer patients incentives to seek outpatient surgery can avoid paying for hospital room and board and ancillary charges.

This large cost difference between inpatient and outpatient surgery is one reason health care insurance carriers may pay a higher reimbursement rate for outpatient surgery. The cost differential is large enough to still save the plan a considerable amount of money, even considering the higher percentage of the costs reimbursed for outpatient surgery.

Potential problems

Many surgical procedures may be too complicated to be performed without a hospital confinement. For complex procedures such as neurosurgery, a hospital setting is imperative, requiring patients to be observed and cared for by physicians and nurses before and after surgery. Surgery for certain

procedures must be performed in a hospital in case of a life-threatening situation.

The reasons for surgery and the condition of the patient, or both, may help determine if outpatient surgery is appropriate. Some analysts argue that outpatient procedures could result in substantial post-surgery costs. For instance, costs may be incurred for after-surgery confinement in a hospital, and physical problems due to complications from outpatient surgery may result in additional costs.

However, data from the *Journal of the American Medical Association* indicate that only 1 percent of outpatient surgery patients have unanticipated admissions to the hospital following surgery.[8] The study specified characteristics of a surgical procedure that could lead to an unanticipated admission. For example, outpatient surgery patients who had received general, rather than local, anesthesia were more likely to be admitted to the hospital.

Conclusion

As health care expenses continue to escalate rapidly, employers and insurance carriers have become more concerned with controlling costs. They have responded by introducing into health care plans cost-containment measures to achieve some control over services their members choose. Hospital costs represent a large percentage of health costs, and are rising faster than health costs as a whole. Therefore, many cost-containment measures used by health insurers are designed to avoid paying for unnecessary hospital confinements.

Some measures may reduce reimbursements to encourage members to choose the least expensive treatment. Some require members to pay an additional portion of the total cost if they do not obtain advance approval for hospital confinement, or if they do not get a second opinion before undergoing surgery.

Approximately 25 percent of health care participants (other than HMO participants) receive an incentive to elect surgery on an outpatient basis. Under this arrangement, both parties save money if outpatient surgery is chosen. The plan, which pays the bulk of the cost of the surgery, avoids reimbursing expensive hospital confinement costs, and the participant pays only a small percentage of the cost, if any. Money the plan saves by avoiding payment for hospital charges far outweighs money the plan may lose by reimbursing the participant at a higher level. □

Footnotes

[1] Information on the price change is from the Bureau of Labor Statistics Consumer Price Index for all Urban Consumers (CPI-U). For more information, see *CPI Detailed Report*, December 1991.

[2] *CPI Detailed Report.*

[3] *Current Trends in Health Care Costs and Utilization* (Mutual of Omaha, 1991), p. 26.

[4] Usual, customary, and reasonable charges are defined as being not more than the physician's usual charge; within the customary range of fees charged in the locality; and reasonable, based on the medical circumstances.

[5] *Employee Benefits in Medium and Large Firms, 1989*, Bulletin 2363 (Bureau of Labor Statistics, June 1990) provides representative data for 32.4 million full-time employees in private establishments with 100 employees or more. *Employee Benefits in Small, Private Establishments, 1990*, Bulletin 2388 (Bureau of Labor Statistics, September 1991) provides representative data for 32.5 million full-time employees in private establishments with fewer than 100 employees. *Employee Benefits in State and Local Governments, 1990*, Bulletin 2398 (Bureau of Labor Statistics, February 1992) provides representative data for 12.9 million full-time employees in State and local governments.

[6] Data on second surgical opinion provisions represents health care participants enrolled in plans other than Health Maintenance Organizations (HMO's) because HMO's do not offer outpatient surgery incentives. This is discussed later in the article.

[7] *Current Trends*, p. 5.

[8] Barbara S. Gold and others, "Unanticipated admission to the hospital following ambulatory surgery," JAMA, *The Journal of the American Medical Association*, Dec. 1, 1989, pp. 3008–10.