



The ECONOMIC IMPACT OF AMBULATORY SURGERY CENTERS in WASHINGTON




**Washington
Ambulatory Surgery
Center Association**
Our Patients Come First



THE ECONOMIC IMPACT OF AMBULATORY SURGERY CENTERS IN WASHINGTON

JOHN E. SCHNEIDER, PHD^{1,2} AMANDA DUMVILLE¹

¹Oxford Outcomes, Inc.

²Department of Economics, Drew University

MARCH 4, 2010



ABOVE: GIG HARBOR BUSTLING WITH BOATS BELOW MT. RAINIER, NEAR TACOMA WASHINGTON *PHOTO COURTESY TACOMA REGIONAL CONVENTION + VISITOR BUREAU

COVER: TOP—WASHINGTON STATE CAPITOL GROUNDS, OLYMPIA, WASHINGTON *PHOTO COURTESY VISITOLYMPIA.COM;

LEFT—SEATTLE'S SKYLINE FEATURING THE SPACE NEEDLE AND MT. RAINIER IN THE DISTANCE;

RIGHT—A COMBINE HARVESTER COMBS OVER A HILL OF GOLDEN WHEAT IN EASTERN WASHINGTON

DEAR ASCs, LEGISLATORS,
REGULATORS, INSURANCE PROVIDERS,
LOCAL BUSINESSES, ADMINISTRATORS,
PHYSICIANS, AND INTERESTED PARTIES—

Over the past several years, health care and its economic impact have pushed their way to the forefront of business, politics, and the lives of everyday Americans.

To increase awareness of the significant role that ambulatory surgery centers have in our country's health care system, the Washington Ambulatory Surgery Center Association ("WASCA") has commissioned an economic impact study. Conducted by Health Economics Consulting Group, this study gives a non-partisan picture of how integral ambulatory surgery centers are to Washington's economy.

Beyond a well-documented record of providing superb patient care, ambulatory surgery centers have steadily

grown into one of the largest stakeholders in Washington's economy. Creating nearly \$1.87 billion in economic activity and over \$76 million in tax revenues, Washington's ambulatory surgery centers attract and employ thousands of highly skilled employees in our metropolitan and rural areas. By providing top-notch health care services and labor, ambulatory surgery centers play a crucial role in both the literal and figurative health of Washington's economy.

Today, as much as any other time in recent history, the breadth of the

problems, dilemmas, and the task of improving such a large industry have become clear. The trajectory of the partnerships between government, business, and health care providers is still unclear, but the importance of these relationships to Americans and our economy are apparent. WASCA and its members look forward to continuing their commitment to excellent health care services, and forging new alliances to build and strengthen Washington's economy.

SINCERELY,



WILLIAM A. PORTUESE, MD
PRESIDENT, WASCA



SUSAN L. SIMONS
VICE PRESIDENT, WASCA



INGENUITY

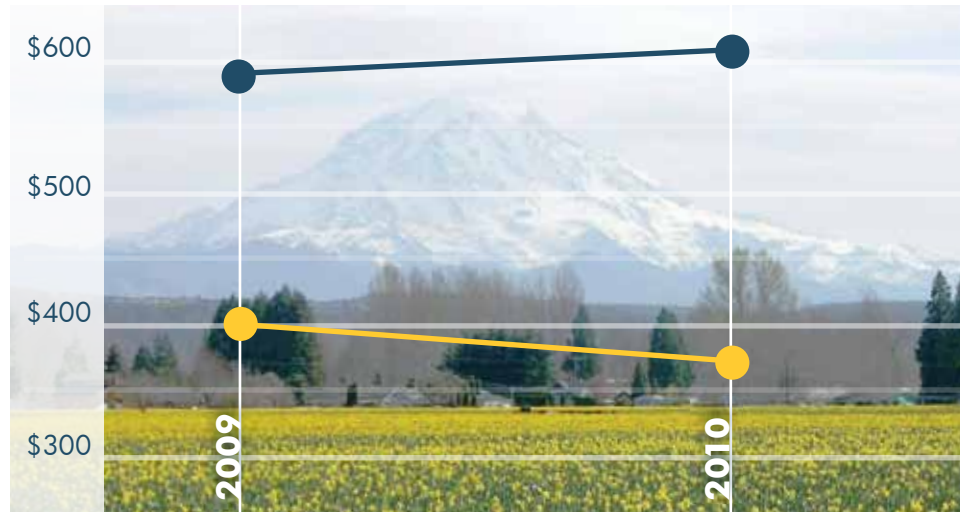
As the health care industry has come under increased scrutiny, new questions are being asked on how to provide better care while also providing cost savings. Americans are divided on how to answer these questions, but nonetheless they are calling for a restructuring of our health care system, and in response the federal government has passed and signed into law the most expansive changes to the health care industry ever.

Leaders in parts of the government and industry are condemning the plans on ideological and fiscal grounds while others celebrate it as an end to predatory insurance practices and a proliferation of basic care to all Americans. It is obvious how divisive this legislation is, but it is clear that certain forms of health delivery are saving money while delivering quality care.

In this discussion, President Obama has called for a “uniquely American” solution that will utilize America’s ingenuity while fixing the problems of an outdated system.

This ingenuity has been showcased over the past few decades by the rise and success of ambulatory surgery centers in Washington and around the country. Providing another option besides going to a hospital, ASCs have bolstered competition by providing the same, and often better, care at significantly lower costs.

Studies from around the country have independently confirmed that the average cost of a procedure, such as a colonoscopy, is less expensive when performed at an ASC than at a hospital. Ironically, while ASCs are clearly a



In 2009, the Medicare reimbursement rate for a diagnostic colonoscopy performed at an ASC is \$398.95 (shown here in yellow), compared to hospitals, which receive \$593.76 for the same procedure (shown here in blue). In 2010, the ASC rate will decrease to \$376.55, and hospitals will see an increase to \$614.11.

MT. RAINIER SITS IN THE FOG BEHIND A FIELD OF DAFFODILS IN PUYALLUP VALLEY NEAR TACOMA, WASHINGTON
*PHOTO COURTESY TACOMA REGIONAL CONVENTION + VISITOR BUREAU

more economical option for outpatient services, Medicare reimbursement rates are declining as hospital reimbursement rates are on the rise.

The 2009 Medicare reimbursement rate for a diagnostic colonoscopy performed at an ASC is \$398.95. Meanwhile hospitals receive \$593.76 for the same procedure. In 2010, the same rates will decrease to \$376.55 for ambulatory surgery centers, as hospitals will see an increase to \$614.11.

The disparity in reimbursement rates is putting ASCs at a disadvantage, but more importantly it is depriving consumers of equitable choices. By limiting administrative and other overhead expenses, ASCs are taking advantage of American entrepreneurial spirit and consumer-driven choices.

It is more important than ever that the success ASCs have had is incorporated into the broader delivery of health care.

ASCs HAVE BOLSTERED COMPETITION BY PROVIDING THE SAME, AND OFTEN BETTER, CARE AT SIGNIFICANTLY LOWER COSTS.

EMBRACING THE RECOVERY

When caught in the middle of a violent and destructive storm, it is tough to remember that even the most blustery tornado or wettest flood will eventually pass, albeit the scars left behind will remind those quick to forget.

Similarly, the latest recession has left a stabilizing American economy with visible reminders of what went wrong. But besides the direct effects of irresponsible homeowners and bankers, it appears that the more agile and forward-thinking companies, rather than those thought too-big-to-fail, are making it through in the best shape.

As Americans were forced to cut their personal costs and look at the best value for their dollar, ASCs stood by their communities and offered premium health care services far less expensively than hospitals at a time of increased constraints.

Washington's ASCs are a shining example of how a new and revitalized American economy might look. Companies which relied on the status quo and that became rigid and brittle from several

years of prosperous times were not well served by the sudden hemorrhaging of the economy. But through adapting to what consumers need and how they need it, ASCs were able to quickly stabilize, diagnose, and treat areas that needed improvement.

With a decentralized model, ASCs can more easily adapt to the specific needs of a community. This not only

brings essential health care services, but also the high skilled and high paying jobs, along with tax revenues, to communities that support these ASCs.

It is unclear where the recovery will take business, but it is obvious that the core principles of service to the community have made ASCs indispensable to the health care system and the people who use it.

ASCs CAN MORE EASILY ADAPT TO THE SPECIFIC NEEDS OF A COMMUNITY.



A ROW OF GRAPE VINES IN THE SAINT LAURENT WINERY NEAR WENATCHEE, WASHINGTON *PHOTO BY MARCIA JANKE

HEALTH CARE COSTS

Between 2000 and 2006, the cost of family coverage has risen 87%, while consumer prices are up 18% and wages up only 20%.

Some of the rise in costs can be attributed to more advanced procedures and newer, more expensive, drugs. Other aspects of the rising cost can be explained by the complexity of the system physicians, insurance providers, health care providers, and patients work in. For instance, hospitals charge and receive payments from Medicare, insurance companies, and uninsured patients using three different scales.

According to Uwe E. Reinhardt, an economics professor at Princeton, the pricing of hospital services is described as “chaos behind a veil of secrecy.” Medicare’s flat fee payments are recalibrated by the federal government using the advice of Congress’s Medicare Payment Advisory Committee, a permanent group of private stakeholders who are not immune from the influence of private interest groups.

Insurance companies are left to negotiate the cost of procedures annually between each hospital and each insurance carrier. This allows for large variance in payments for the same procedure depending on the hospital and insurance carrier. Unfortunately for the uninsured, they are left to pay the listed amount from a hospital’s “charge master,” the hospital’s asking price from which insurance companies negotiate a lesser sum.

What does this all mean for the patients/consumers? In short, we pay for more than just medical treatment. Patients pick up the tab for not only the cost of

treatment, but also all the backroom negotiations and the myriad administrative issues that accompany them.

While Medicare is by no means a shining example of how a universal coverage system ought to work, Medicare operates with overhead expenses around 3%. Due to the complexity and inefficient process that insurance carriers go through, they operate with up to 30% overhead and pass the costs on to the consumer.

A natural counterbalance to the high cost of doing business and always receiving care at a hospital is a greater utilization of the services ASCs provide.

With a proven record of exemplary care, ASCs also operate with less administrative costs, and usually perform the same procedure for much less than federally subsidized hospitals. There is no doubt that hospitals provide a variety of much needed services to the community, yet it does not make much sense to continue exclusively providing them with federal subsidies while ASCs provide the quality care more economically and deliver it with more comfort, convenience, and accessibility.

INSURANCE AVAILABILITY

Washingtonians, along with the rest of the country, are ravenously trying to get their hands on every morsel of information to interpret what these changes mean for their family.

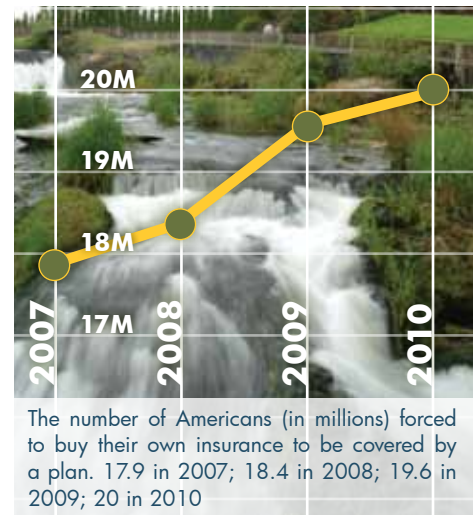
It is important to remember that the sweeping initial changes, and revisions guaranteed to follow, were a product of a system that put little, if any, premium on efficiency and lower costs. The rising cost of

health insurance has forced difficult decisions upon employers and individuals.

Many employers are reducing benefits or cutting them altogether, leaving individuals to fend for themselves.

In 2007, 17.9 million people were forced to buy their own insurance in order to be covered by a plan. This number increased to 18.4 million in 2008, and is estimated to reach 19.6 million and 20 million in 2009 and 2010 respectively.

Many people in this predicament become underinsured and some visit the emergency room for routine illnesses,



which is significantly more expensive than an office visit.

Washington is acutely aware of the rising number of uninsured with 12% of its population without any health insurance. This number includes the 118,200 children ages 0–18 years old who have no coverage at all. Interestingly, 67.8% of Washington’s uninsured families have at least one full-time worker in the family, indicating that health insurance is becoming prohibitively expensive for small and medium sized businesses to continue coverage.

The ECONOMIC IMPACT OF AMBULATORY SURGERY CENTERS in WASHINGTON

SUMMARY

We measure the net economic impact of ambulatory surgery centers (ASCs) on the statewide economy in Washington.

We use an economic method referred to as “input-output” analysis. These models describe each state’s economy as a series of inter-linked industries and sectors. A stimulus to one sector, such as a new firm or cluster of firms, impacts all other sectors in the economy, to varying degrees, through a “multiplier effect.”

We use survey data on ASC employment and operating expenditures verified by two external data sources to calculate the economic impact of Washington’s ASCs on the statewide economy.



THE PAVILION PEAKS OUT OF THE TREES IN THE HEART OF RIVER FRONT PARK AND THE SPOKANE CLOCK TOWER STANDS TALL ON THE SHORE OF THE SPOKANE RIVER IN SPOKANE, WASHINGTON

We find that ambulatory surgery centers add considerable value to the Washington economy, with a 2009 total statewide economic impact of **\$1.87 BILLION**, including more than **\$76 million** in tax payments and the employment of about **5,850 full-time equivalent workers**.

INTRODUCTION

Ambulatory surgery centers (ASCs) have become a very important part of the U.S. health care system.

Nationally, there are more than 5,300 freestanding ASCs, and the number continues to grow at approximately 3% per year.¹ An estimated 57.1 million surgical and non-surgical procedures were performed during 34.7 million ambulatory surgery visits in 2006. Of the 34.7 million visits, 19.9 million occurred in hospitals and 14.9 million occurred in freestanding ASCs.²

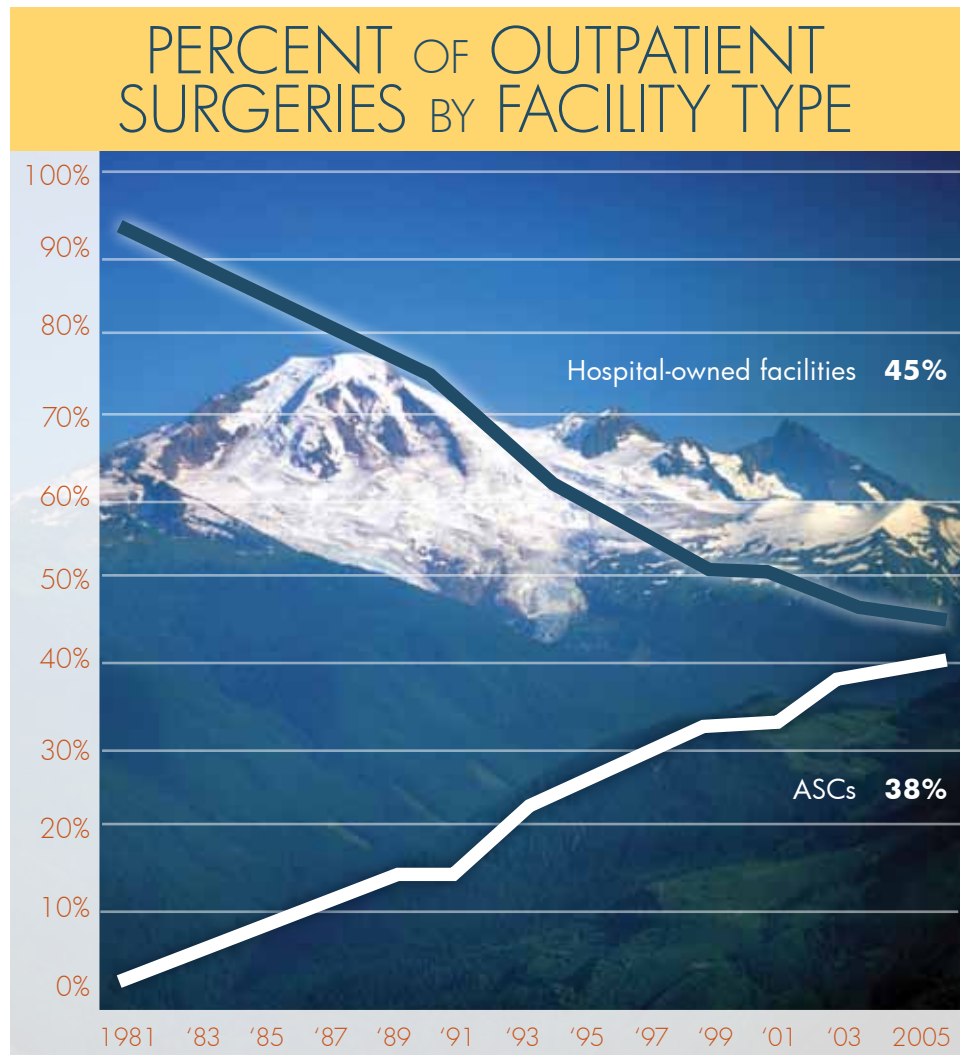
The rate of visits to ASCs increased three-fold from 1996 to 2006, whereas the rate of visits to hospital-based surgery centers has remained essentially unchanged during that time period.³

Frequently performed ambulatory procedures include endoscopy of large intestine (5.8 million), endoscopy of small intestine (3.5 million), extraction of lens (3.1 million), injection of agent into spinal canal (2.7 million), and insertion of prosthetic lens (2.6 million). The leading diagnoses at ambulatory surgery visits included cataract (3.0 million); benign neoplasms (2.0 million), malignant neoplasms (1.2 million), diseases of the esophagus (1.1 million), and diverticula of the intestine (1.1 million).

1 Trendwatch Chartbook, American Hospital Association, 2008. Also see Cullen, Hall, and Golosinskiy (2009)

2 Cullen, Hall, and Golosinskiy (2009) The estimates are based on data collected through the 2006 National Survey of Ambulatory Surgery by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). The survey was conducted from 1994-1996 and again in 2006. Diagnoses and procedures presented are coded using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

3 Cullen, Hall, and Golosinskiy (2009)



Ambulatory surgery centers in general provide high-quality medical care at lower costs than their hospital counterparts.

For example, in one of the earlier studies of ambulatory surgery quality, Warner et al. (1993)⁴ studied 38,598 patients undergoing 45,090 ambulatory procedures and were “surprised by the low incidence of overall major morbidity and mortality in [the study] patient population” and that

morbidity rates in the ambulatory setting “occurred less often than we would have expected in [the study] patient population” (p.1140).

Similarly, Fleisher et al. (2004) examined patients undergoing 16 different surgical procedures using a nationally representative sample of Medicare beneficiaries. They found that surgery at various outpatient settings in the high-risk elderly population was associated with similar rates of inpatient hospital admission and death, though

4 Warner, Shields, and Chute (1993)

*GRAPH SOURCE AHA, TRENDWATCH CHARTBOOK, 2008, SUPPLEMENTARY DATA TABLES, ORGANIZATIONAL TRENDS MOUNT BAKER NEAR BELLINGHAM, WASHINGTON *PHOTO COURTESY BELLINGHAM WHATCOM COUNTY TOURISM



mortality rates were lowest in ASCs.⁵ Seven-day mortality rates were 25 per 100,000 outpatient procedures at ASCs, compared to 50 per 100,000 in hospital outpatient departments.

In addition to the well-documented quality advantages, ASCs are economical surgical settings;⁶ according

⁵ Fleisher et al. (2004)

⁶ Freestanding ambulatory surgery centers cost less to run than in-hospital ORs (1999); Balicki, Kelly, and Miller (1995); Castells et al. (2000); Healy, Cromwell, and Thomas (2007); Jacobs and Morrison (2008); Joshi (2008); Marcinko and Hetic (1996)

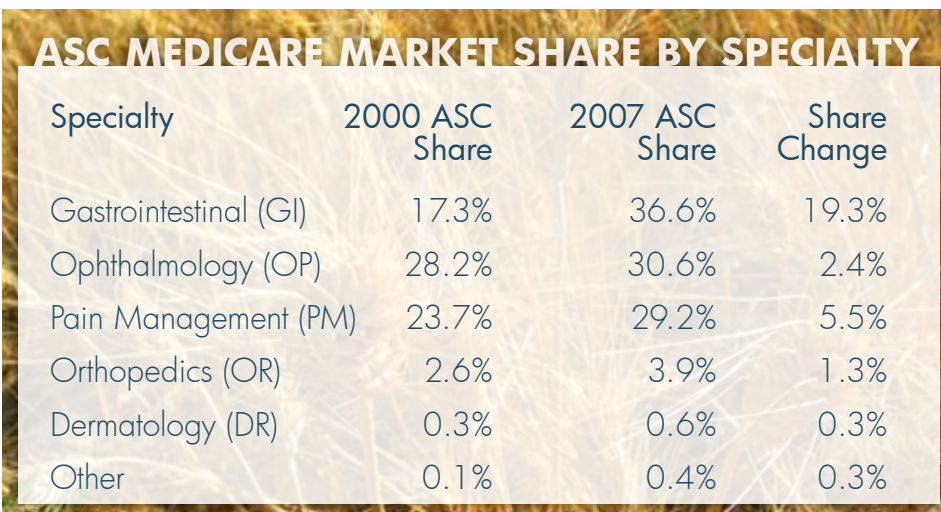
to a large number of ASC studies, even when differences in patient acuity is taken into account, ASCs can perform the same procedures at lower cost than their community hospital counterparts.

The costs of medical care are driven in large part by technology and labor. Medical care is a “high touch” service, which means that it is very labor-intensive. Medical care is also a “high tech” service, meaning that in order to deliver high-quality care to their patients providers make use of many valuable

technological advances in medicine.

Both of these “inputs” in the medical care delivery process are costly, which means that the typical health care facility spends a lot of money in order to continue providing high-quality medical care. The vast majority of these expenditures end up staying within the state in which the facility is located. This is particularly true for ASCs, where labor costs take up a proportionally larger share of total operating expenses due to lower facility overhead (compared to larger general hospitals).

In this study, we calculate the statewide economic impact of the ASCs in Washington, using a variety of data sources and the application of economic multipliers. In sum, we find that ambulatory surgery centers add considerable value to the Washington economy, with a 2009 total statewide economic impact of \$1.87 billion, including more than \$76 million in tax payments and the employment of about 5,850 full-time equivalent workers.



*GRAPH SOURCE: KNG HEALTH ANALYSIS OF MEDICARE PPSFS FILE. MAPPING OF PROCEDURE CODES TO SPECIALTY PROVIDED BY THE ASC ASSOCIATION
WHEAT FIELD NEAR RITZVILLE, WASHINGTON

METHODS

To obtain a measure of the total impact that a policy might have on an economy, several components of that total impact need to be measured.

The first component is the “direct” effect. This is the initial effect that a business or policy has on an economy. In this case, the direct effect is the added payroll, trade payables, and capital expenditures generated by ASCs in the state. The remaining effects are referred to as the “indirect” and “induced” effects.



To measure these effects, an Input/Output (IO) model of a local economy is employed. An IO model describes an economy as a series of inter-linked industries or sectors. A stimulus to one sector, say a tax on a particular sector, then impacts all other sectors in the economy, to varying degrees, through a “multiplier effect.”

The multiplier effect measures the indirect and induced impact of a direct injection. As a matter of technical exposition, indirect effects are those “re-spending” effects that filter through other industries in an economy as a result of the direct injection. For instance, suppose a direct impact on hotel expenditures boosts demand for cleaning services at these hotels (an initial indirect effect).

This stimulates demand for those sectors that supply cleaning capital and cleaning products (a secondary indirect effect). This secondary indirect effect stimulates demand in other sectors, and so on. The sum of all these effects on other industries is the indirect effect. The induced effect is the effect on final demand in an economy. Final demand can

be characterized in the following way.

All of these sectors employ people locally. Increased demand for output from these sectors induces additional labor inputs, paid for via wages and salaries. The resulting increase in employee incomes *induces* additional spending locally. This additional spending is the induced effect. The continual “re-spending” of the original direct injection accumulates through to the local economy.¹

The total effect is then the sum of the direct, indirect, and induced effects. From these figures, we obtain economic multipliers, which can be thought of as measures of the impact of one dollar’s worth of direct injections. For example, if an additional \$100 of direct expenditure is spent on groceries, this would stimulate spending by the grocery sector (e.g., added spending on suppliers, farmers, etc.). This additional spending will be less than the initial \$100; let us assume it is \$40.

In turn, there may be a need for

¹ For a complete survey of IO models and their various strengths and weaknesses, see for example Raa, T.T., (2005) “The Economics of Input-Output Analysis” Cambridge University Press



AN ORCA WHALE BREACHES THE EARLY MORNING SURFACE OF PUGET SOUND IN FRONT OF WASHINGTON’S MT. BAKER

additional labor in the grocery sector, generating additional income and thus additional “secondary” spending. Let assume this additional spending is \$60. Taken together, the *aggregate impact* of the initial \$100 injection was \$200 to the economy. Thus, in this simple example, the multiplier would be 2.00.

In order to conduct the ASC impact simulation models, we obtain industry multipliers from the Bureau of Economic Analysis (BEA) RIMS II database. The BEA multipliers are derived by the BEA from several data sources, including the U.S. Economic Census, the U.S. Bureau of Labor Statistics, and other industry data. The stimulus that we model is simply total ASC operating expenditures. Our database of ASC financial data is based on data supplied by a sample of ASCs in the state ($n = 17$).²

We calculated per-ASC estimates

² Given the sample is relatively low response rate, we (1) compared ASC characteristics of respondents vs. characteristics of ASCs reported by VMG Health in their annual ASC report; and (2) compared total expense data (the most important variable in calculating economic impact) with VMG Health and the U.S. Economic Census (discussed in text).



based on the sample, and multiplied those estimates by the number of ASCs in the state.³ The simulation models use economic data from 2009 and ASC count data from February 2010. Given the small sample size, we verify our survey findings using data from two reputable sources: detailed industry data from the U.S. Economic Census and annual regional ASC survey data from VMG Health.

³ Based on the number of ASC reported by the National Ambulatory Surgery Center Association (2010)

The ASC sector in Washington makes a markedly large contribution to the state’s economy, with a multiplier of 2.32,⁴ meaning that for every dollar spent in the ASC sector of the state economy, \$2.32 worth of economic value is created *in the state*. The ASC multiplier, like other health care multipliers, is substantially higher than multipliers for other services industries. For example, the multiplier for professional (non-health care) services in Washington is approximately 1.75. In addition, the ASC multiplier of 2.32 is somewhat higher than the general hospital multiplier in Washington (2.28), implying that (per dollar spent) there is essentially no difference between the economic value of a dollar spent by an ASC versus the same dollar spent by a general hospital; proportionately, the two kinds of facilities generate the same level of indirect economic activity.

⁴ Bureau of Economic Analysis, RIMS II Multipliers (1997/2006) *Table 3.5 Total Multipliers for Output, Earnings, Employment, and Value Added by State: 621B00: Other Ambulatory Health Care Services (Type II)*.



TWO FISHERMEN IN THE FOGGY GOLDEN DAWN NEAR BELLINGHAM, WASHINGTON *PHOTO COURTESY BELLINGHAM WHATCOM COUNTY TOURISM

ECONOMIC IMPACT

The results are summarized in **Table 1**. In 2009, Washington's 250 ASCs employ approximately 5,854 full-time equivalent individuals.

The average ASC incurred is approximately \$3,092,469 in total operating expenses, resulting in a direct economic impact (excluding taxes paid) of more than \$773 million statewide. After applying the ASC multiplier, the total statewide expenditure impact of

the ASC sector in Washington is approximately \$1.79 billion. Adding the total taxes paid by Washington ASCs (\$305,116 per ASC; \$76.3 million statewide), the total economic impact of Washington ASCs in 2009 is approximately \$1.87 billion statewide (**Table 1**).

SENSITIVITY ANALYSIS

To verify these estimates, we examined data from two different sources: (1) detailed industry data from the 2002 U.S. Economic Census (USEC), and regional ASC financial and benchmarking survey data compiled by VMG Health. Both of these sources are confirmatory of survey results reported here.

The U.S. Census Bureau conducts the Economic Census every five years,

TABLE 1 Economic Impact of Ambulatory Surgery Centers in Washington in 2009

	AVERAGE PER ASC	STATE TOTAL
Number of ASCs ^a	NA	250
Number of Full-Time Equivalent Employees (FTEs) ^b	23	5,854
Total Operating Expenditures (direct effect) ^c	\$3,092,469	\$773,117,324
Expenditure Multiplier ^d	NA	2.32
Expenditure Impact (total effect)	NA	\$1,793,632,191
Tax Expenditures ^e	\$305,116	\$76,278,985
TOTAL IMPACT		\$1,869,911,176

Sources and Notes: (a) Source: Reported by the National Ambulatory Surgery Center Association (2010); (b) To calculate FTEs, consider this example: if there are a total of 30 employees on the payroll, but 10 of those are part-timers, working about 50% time, then you would report that you have $20 + (10 \times 50\%) = 25$ FTEs. We are interested only in paid FTEs. An alternative is to base the calculation on the total number of paid work hours in a year (typically 2,080). An employee is equal to one FTE if they work 2,080 hours per year. A part-time employee working 20 hours per week (1,040 hours per year) would be considered half of one FTE because $1040 / 2080 = 0.5$; (c) Defined as the sum of expenses attributable to payroll, benefits, capital (equipment; building), supplies, maintenance, insurance (property; general liability; malpractice), rent/lease costs, and other expenses commonly referred to as "trade payables;" (d) Source: Bureau of Economic Analysis, RIMS II Multipliers (1997/2006) *Table 3.5 Total Multipliers for Output, Earnings, Employment, and Value Added by State: 621B00: Other Ambulatory Health Care Services (Type II)*; (e) Defined as the sum of all municipal, state and federal taxes paid

profiling U.S. businesses at the national to the local level. In 2002, that latest year for which complete data is available, the USEC collected data on nearly 25 million business establishments in the U.S., accounting for about 97% of business receipts.

The Census results in a substantial amount of information at both the industrial sector and geographic level of detail, including industry-level information (categorized by NAICS, or North American Industrial Classification System, code) on number of establishments, employment, revenues generated and operating expenses.

It also provides detailed data at the national, state, MSA and county level, although in many cases geographic-specific estimates for detailed (5+ digit) NAICS codes are not supported.¹ While the industry information provided in the Economic Census is detailed, it does not provide enough detail to obtain direct estimates of ASC operating costs (the key variables in calculating overall economic impact). The closest NAICS code is 621493 (entitled “Freestanding Ambulatory Surgical and Emergency Centers”).

This vast majority of establishments in this category are ASCs, but the category also captures a large number of urgent care centers. Urgent care centers have considerably lower operating costs, thereby biasing downward the operating expense data in this category.

The USEC reports average operating expenses for NAICS 621493 of about \$3.1 million per ASC (2002 census data

trended forward using CPI; 2007 is not available yet). However, this number does not include “construction and all other capital improvements.” We believe that this exclusion is likely to exclude a large amount of equipment expenses common to ASCs.

Although there is considerable range in our ASC dataset, reported capital expenses average \$352,516. If we add capital to the USEC expenses estimate, the U.S. average “total expenditures” per ASC is approximately \$3.4 million, which is very similar to the survey estimate reported in Table 1.

As a further sensitivity test, we compared our survey data to 2009 data collected annually by VMG Health in their *Intellimarker ASC Benchmarking Study*.²

The recently released 2009 VMG study is based on a national survey of 174 ASCs of various sizes and representing more than 1.1 million cases. VMG obtains enough responses to support calculations of key variables at regional levels, and performs several analyses to verify consistency and comparability. For the West region ($n = 39$), which includes Washington and nine other states, the median total operating expenditures per ASC is \$4,480,000.

This estimate is higher than our sample estimate of \$3,092,469. The implication of the USEC and VMG findings is that our sample results in a conservative estimate-- lower than the VMG sample but in line with the generally conservative USEC estimate.

CONCLUSIONS

ASCs provide a vital component of the economy in Washington. The ASC industry in Washington employs approximately 5,850 full-time equivalent individuals. The industry is associated with a relatively high multiplier, which results in a large amount of economic activity attributable to ASCs. ASCs add \$1.79 billion in economic activity to the statewide economy, and another \$76 million in taxes.

THE NET RESULT IS
A TOTAL STATEWIDE
ASC ECONOMIC
IMPACT OF MORE
THAN
\$1.87 BILLION

As lawmakers consider new policies aimed at ASCs, policy makers must take into consideration the large economic value generated by ASCs.



1 Further details on the 2002 Economic Census and NAICS classification schemes can be found at the following web site: <http://www.census.gov/econ/census02/>.

2 VMG Health, Dallas, TX (www.vmghealth.com)

THE TEAM

DR. JOHN E. SCHNEIDER

OXFORD OUTCOMES, INC.,
DEPARTMENT OF ECONOMICS, DREW UNIVERSITY

Dr. John E. Schneider is a health economist currently a Partner at Health Economics Consulting Group. Dr. Schneider is part of an experienced group of expert researchers specializing in health services and provides consulting for pharmaceutical manufacturers, health plans and managed care providers, trade associations, and public relations firms, among others.

Completing his undergraduate and Masters degrees at the University of Maine, he later went on to receive his PhD at the University of California, Berkeley. Dr. Schneider has gained extensive knowledge of the market while serving as the Director of Research at the California Association of Health Plans, then becoming an Assistant Professor at the University of Iowa in their Department of Health Management and Policy.

A seasoned professional in the areas of managed care, hospital regulation and competition, specialty hospitals, ambulatory surgery centers, and medical

groups, he has shown his prowess in complex cost analysis and data analysis.

Currently, he is involved in research on health insurance market reform, specialty hospitals, and the economic impact of health cost inflation. As a veteran in the industry, he has given expert testimony, served on various advisory boards, and has been published in several peer-reviewed journals.

JAKE ERNST

RESEARCH ASSOCIATE

Jake Ernst joined the WASCA team in 2009 as a Research Associate. Prior to joining WASCA, Mr. Ernst worked as a Legislative Correspondent for Sen. Wayne Allard in Washington, D.C. There he was involved with legislation concerning energy policy, natural resources, agriculture, public lands, and several other issue areas.

Two significant pieces of legislation Mr. Ernst dealt with were the 2008 Farm Bill, and the renewal and expansion of PEPFAR (the President's Emergency Plan For AIDS Relief). He performed his undergraduate studies at the University

of Colorado, Boulder where he earned a B.S. in Economics and a B.A. in Finance.

MATTHEW MEIER

GRAPHIC DESIGNER

As a freelance graphic designer, Matt has worked across the country for non-profits such as the Williamstown Theatre Festival (Williamstown, Mass./New York); Lincoln Amphitheatre (Santa Claus/Lincoln, Ind.); Schmidt Opera Series (University of Evansville, Ind.); Fabrefaction Theatre Company (Atlanta, Ga.); and The National Theatre Conservatory (Denver, Colo.).

Originally from Great Falls, Montana, Matt graduated *cum laude* from the University of Evansville in Indiana with a B.S. in Visual Communication Design. During his senior year at UE, he designed the 2009 *Life in College* yearbook for University Student Publications, which won multiple awards, including the 2010 Indiana Collegiate Press Association's Yearbook of the Year Award.

Matthew now lives in Denver, designs freelance and works as a designer at Circuit Media. www.mMeier.com



LEFT: THE WORLD FAMOUS PUBLIC FARMER'S MARKET IN SEATTLE, WASHINGTON;
RIGHT: FARM FRESH WASHINGTON APPLES, PLUMS AND PEARS AT A MARKET IN WENATCHEE, WASHINGTON *PHOTO COURTESY MARCIA JANKE

REFERENCES

- Balicki, B., W.P. Kelly, and H. Miller. 1995. Establishing benchmarks for ambulatory surgery costs. *Healthc Financ Manage* 49 (9):40-2, 44, 46-8.
- Castells, X., J. Alonso, M. Castilla, and M. Comas. 2000. [Efficacy and cost of ambulatory cataract surgery: a systemic review]. *Med Clin (Barc)* 114 Suppl 2:40-7.
- Clement, J.P. 1997. Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s. *Inquiry* 34 (Winter):340-350.
- Cullen, K.A., M.J. Hall, and A. Golosinskiy. 2009. Ambulatory surgery in the United States, 2006. *Natl Health Stat Report* (11):1-25.
- Fleisher, L.A., L.R. Pasternak, R. Herbert, and G.F. Anderson. 2004. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. *Arch Surg* 139 (1):67-72.
- Freestanding ambulatory surgery centers cost less to run than in-hospital ORs. 1999. *Health Care Cost Reengineering Rep* 4 (10):158-9.
- Healy, D., J. Cromwell, and F.G. Thomas. 2007. Repricing specialty hospital outpatient services using ambulatory surgery center prices. *Health Care Financ Rev* 29 (2):81-90.
- Jacobs, V.R., and J.E. Morrison, Jr. 2008. Comparison of institutional costs for laparoscopic preperitoneal inguinal hernia versus open repair and its reimbursement in an ambulatory surgery center. *Surg Laparosc Endosc Percutan Tech* 18 (1):70-4.
- Joshi, G.P. 2008. Efficiency in ambulatory surgery center. *Current Opinion in Anesthesiology* 21 (6):695-698.
- Marcinko, D.E., and H.R. Hetico. 1996. Economic outcomes analysis from an ambulatory surgical center. *J Foot Ankle Surg* 35 (6):544-9.
- Warner, M.A., S.E. Shields, and C.G. Chute. 1993. Major morbidity and mortality within 1 month of ambulatory surgery and anesthesia. *Jama* 270 (12):1437-41.



A FIELD OF TULIPS NEAR BELLINGHAM, WASHINGTON *PHOTO COURTESY BELLINGHAM WHATCOM COUNTY TOURISM