SPINE SURGERY CENTER of Eugene

Glenn L. Keiper, Jr., MD, *Owner & Medical Director*
Jonathan D. Sherman, MD, *Owner & Director*
Laura J. Hartman, MD, *Director of Anesthesia*
P. Evalyn Cole, MHSA, CASC, CEO/Administrator
Brooke Guthrie, RN, *Director of Nursing*

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MEMO TO: Representative Mitch Greenlick &
Members of the House Health Care Committee

DESCRIPTION: HEARING ON OR SB 901

INTRODUCTION: My name is Evalyn Cole. I have a master's degree in Health Services Administration and a Board Certification as a Surgery Center Administrator. For 7 years, I have been the CEO for Spine Surgery Center of Eugene.

ASCs are a definite WIN-WIN for everyone.

- Surgeons can select equipment and implants to provide their best surgical care to patients.
- Patients have no exposure to nosocomial infections and ASCs save them money.

Even so, some insurers delay or deny contracts to ASCs. Because there is no contract, these insurers send payments to patients. Surgeries involve many providers; each sending a bill – surgeon, anesthesiologist, facility, etc. A patient could get a check for each provider; they are often confused and don't understand what to do with these checks; 1) they may keep the check, believing it's reimbursement for medical bills; 2) they may forward the check to the wrong provider; 3) They may deny they got a check or in the stack of their mail, the check may be lost or inadvertently discarded. Insurers tell the ASC that, since their "contract is only with the patient," the ASC is Out of Network (OON) and they don't tell OON providers what was "allowed," if or when checks were sent to a patient, and if it was cashed. Here are two examples from my center:

1) Patient #1 received three checks from his insurer for his surgery. He signed the first check over to nerve monitoring company. When the second check arrived, he discovered that he should have sent the first check to the surgery center. His insurer's explanations further confused him, so when a third check arrived, he was totally frustrated. We could not help because the insurance company would not tell us how much they allowed; how much they paid and for which services.

2) Patient #2 was going through a divorce from her husband when she had a fusion. The surgery center's bill was $41,600; the insurer sent 3 checks totaling over $20,000 to her ex-husband (policyholder). The divorce left his wife in a women's shelter, and he kept the checks. The divorce decree assigned responsibility to him for her surgery bills. Then, he called us to ask, "Why should I have to pay the surgery center more than the $8,000 "Maximum Out of Pocket" limit on my plan?" We told him, "That's because the insurer sent our payments to you." He is now paying payments on a $30,000 balance. Now he will pay $250 / month for 10 years. If the insurance checks had been sent to us we would have known what his insurer allowed, written off the "not allowed," and the $6,350 he has sent would have paid his copay.

All of these situations would be solved with the passage of SB 901, which requires insurers to pay ALL medical service providers, directly...and not send OON checks to patients, which puts a burden on patients unnecessarily and creates hardships and legal fees for OON providers. The results are increased healthcare costs. I will be happy to answer questions?

1410 Oak Street, Suite 300 • Eugene, Oregon 97401
Ph: 541.228.3666 • Fax: 541.228.3667 • Toll-Free: (877) 852-7246
website: www.eugenespine.com