SPINE SURGERY CENTER of Eugene

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MEMO TO: Chair Monnes Anderson k & Members of the Senate Health Care Committee

DESCRIPTION: HEARING ON OR SB 901

My name is Evalyn Cole. I am a board Certified Surgery Center Administrator. For 7 years, I have been employed as 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 their 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, forcing the center to take extreme measures to get paid. Patients are confused when they get insurance checks; they may forward the check to the wrong provider; they may keep the check, believing it's somehow reimbursement for medical bills. They may deny they got a check. The insurers tell the ASC that, since their "contract" is only with the patient, they will not tell an "OON" provider how much they "allow," details about the check sent to the patient or if it was cashed. Surgeries involve many providers; each sends a bill – surgeon, anesthesiologist, monitor techs, etc. So a patient could get a check for each provider; they don't understand what to do with these checks. Here are examples from my center:

1) Patient #1 received many 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 confused him. When a third check arrived, he was totally lost and frustrated. We could not help him because the insurance company will not tell us how much they allow; 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 billed $41,600 and the insurer sent 3 checks totaling $20,600 to the ex-husband. Even though the divorce resulted in his wife's move to a women's shelter, he kept the checks and 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 my *8,000 "Maximum Out of Pocket benefit?" We told him, "That's because the insurer sent our payments to you." He is now paying payments on a $30,000 balance. If the checks had been sent to us so we could see what his insurer allowed, we would have written off the not allowed, and the $6,350 he has already paid would have satisfied his copay. Now he will pay $250 per month for 10 years.

All of these situations would be solved with the passage of SB 901, which requires insurers to pay OON medical service providers, directly...and not send our money to our patients. This confuses and frustrates patients unnecessarily and creates extreme hardships for an ASC.

I will be happy to answer any questions?

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