AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

May 4, 2021

The Honorable Nicole J. Cannizzaro
Senate Majority Leader
Nevada State Senate
361 Soubrette Court
Las Vegas, NV 89145

The Honorable Julia Ratti
Chair
Senate Health and Human Services Committee
Nevada State Senate
P.O. Box 4228
Sparks, NV 89432

Re: AMA concerns with Senate Bill 420

Dear Senate Majority Leader Cannizzaro and Chairwoman Ratti:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to express our concerns with Senate Bill (S.B.) 420, legislation to establish a public health benefit plan in Nevada.

The AMA shares your interest in improving access to, and affordability of, health insurance. Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA's proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. Recently, we put forward a updated series of proposals to cover the uninsured that also considers the impact of the COVID-19 pandemic on health insurance coverage, as well as the enactment of the American Rescue Plan into law.

The AMA believes that, with guardrails in place to protect physicians and patients, public options should have the goals of maximizing patient choice of health plan, as well as health plan marketplace competition. In fact, AMA policy offers meaningful criteria that, in our view, could lead to a public option that responds to the unique needs of patients, and physicians and their practices.[1] However, we recognize the limitations of public option proposals as stand-alone reforms to cover the uninsured. With our policy in mind and understanding that debate on S.B 420 is just beginning, we highlight the sections where we think changes to the legislation are most needed to move forward, as well as two important reforms we support.

First, under Section 13 of the legislation, physicians who participate in Medicaid, Nevada's workers compensation program, or the Public Employee's Benefit Program would be required to participate in the networks of the public option program and accept new public option patients in the same manner as they accept new patients in the other programs. The AMA supports physicians' freedom of choice when it comes to health plan participation and, therefore, opposes this effort to require physician participation in the public option by tying it to participation in any of these three other important programs.

This mandatory participation provision in S.B. 420 overlooks the complexity of running a physician practice and the balance involved in determining the capacity and ability of a practice to serve a mix of patients. There are many reasons as to why a practice may not participate with a plan including payment levels, but also perhaps a history of unfair contracting and business practices of a payer, burdensome administrative policies, saturation of practice resources and physician time, engagement in alternative payment models, pending retirement, and so on. It is critical that physicians be able to weigh their contract options and make decisions that are best for their practice, patients, and staff.

Recognizing that provider networks are critical to the success of the public option, we suggest that there are other ways to incent physician contracting as alternatives to mandatory participation. For example, the legislation could require that plans administering the public option reduce prior authorization and other costly and administratively burdensome programs that require physicians to hire extra staff and spend hours on paperwork and interactions with health plans.[2] Additionally, guarantees of transparent business practices, reduced denials of medically necessary services, decreased paperwork, rapid credentialing, and streamlined appeals processes would make the public option an attractive choice for many physicians, negating the need for mandating participation. We urge the legislature to consider such alternative paths to establishing provider networks for the public option.

Second, Section 14 of S.B. 420 would generally establish provider payments using Medicare rates as a floor. While we appreciate that Medicare rates are meant to serve as starting points and not targets for negotiations between providers and plans, many physicians rightfully fear that these rates will become the de facto rates for all public option contracts. This scenario is even more likely if the requirements on participation remain in place and contract negotiations are not required. Moreover, as plans work to meet the premium savings requirements outlined in S.B. 420, it is highly unlikely they will offer rates above the statutory minimum.

Put simply, Medicare rates will not cover the costs of providing care in the commercial market. In fact, according to data from the Medicare Trustees, Medicare physician pay has barely changed for nearly two decades, increasing just 7 percent from 2001 to 2020, or just 0.3 percent per year on average. At the same time, the cost of running a medical practice increased 37 percent between 2001 and 2020, or 1.7 percent per year. Economy-wide inflation, as measured by the Consumer Price Index, increased 46 percent over this period (or 2.0 percent per year). As a result, Medicare physician pay does not go nearly as far as it used to. Specifically, when adjusted for inflation in practice costs, Medicare physician pay declined 22 percent from 2001 to 2020, or by 1.3 percent per year on average.

Given the financial risk of setting the public option rates at a Medicare baseline for physician practices, the AMA urges the Nevada legislature to consider the impact of this policy on the long-term sustainability of physician practices and, ultimately, access to care in Nevada. As such, the AMA respectfully asks that the legislature refrain from using Medicare rates at the floor for physician payments under the public option.

Despite our concerns with the above-mentioned provisions, there are several positive reforms in S.B. 420 for which the AMA has long advocated. For example, the AMA supports the bill's provisions that would extend Medicaid coverage to pregnant women with incomes up to 200 percent of the federal poverty level. Almost half of all U.S. births are to women with public insurance and evidence has demonstrated that Medicaid coverage has improved maternal outcomes for low-income women. Unfortunately, public insurance has large coverage gaps for the low-income women who require it. These gaps contribute to the high—and rising—rate of maternal mortality and morbidity in the U.S. There are also significant disparities in the death rate by race. Alarmingly, Black women are three to four times more likely than white women to die from a pregnancy-related cause and Native American and Alaska Native women are

2.5 times more likely to suffer a pregnancy-related death. Extending coverage to more low-income women in Nevada is an important step toward narrowing these disparities.

Furthermore, AMA also strongly supports expanded coverage for prenatal testing, breastfeeding supplies, and lactation support. The AMA supports access to prenatal care for all women and we recognize that breastfeeding is the optimal form of nutrition for most infants. AMA policy encourages healthcare providers to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services. Coverage for these services is particularly important for low-income and Black women, whose rates of breastfeeding significantly lag rates for women with higher incomes and other racial and ethnic groups. Extending Medicaid coverage to these services will help improve rates of breastfeeding and support infant health.

In conclusion, the AMA, in collaboration with the Nevada State Medical Association, stands ready to work with the Nevada legislature toward a public option that both increases access to affordable care for Nevada patients and protects the financial sustainability of physician practices in Nevada.

If you have any questions or would like to follow-up, please contact Emily Carroll, Senior Legislative Attorney, emily.carroll@ama-assn.org or Annalia Michelman, Senior Legislative Attorney, annalia.michelman@ama-assn.org.

Thank you for your consideration.

Sincerely,

James L. Madara, MD

cc: Nevada State Medical Association

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[1] Options to Maximize Coverage under the AMA Proposal for Reform H-165.823: Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

[2] https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf