



Memorandum in Opposition to NV AB204

On behalf of OB-GYN Associates and Nevada MGMA, we oppose AB204 as it shifts financial responsibility for care to providers that are not compensated.

We share the goal of expanding access to care — that’s something all of us in healthcare support. But we worry that if the ability to collect patient responsibility up front is severely limited, the long-term result will be fewer independent providers available to serve patients. The impact may not be immediate, but it will accumulate over time. As practices face rising costs and reduced reimbursement, the financial viability of remaining independent becomes more difficult. In our market, we are actively competing with out-of-state employers and health systems to recruit physicians — and compensation, which depends on collections, is a major factor. For practices like ours, 20% of collections are from patient payments and are likely to increase as deductibles and copays continue to go up.

We have reviewed the recent amendments to AB 204 and noticed that cosmetic services appear to have secured a clear exemption. That only deepens concern, as it seems to reinforce that the bill is intended to apply broadly across other healthcare specialties. In effect, it reads like an expansion of EMTALA principles to nearly all healthcare settings — with an exception carved out for services deemed “not medically necessary.”

While our practice does not routinely refer patients to collections, we work diligently to ensure transparency and collect patients’ expected share of costs **prior to scheduling**. For many private practices like ours, this is the only realistic and effective means of securing payment for services. AB 204 could directly undermine that.

Key Concerns:

1. Increased Financial Risk to Practices

The amended bill appears to prohibit requiring payment before delivering medically necessary care unless certain criteria are met (e.g., hardship screening, payment plans). This raises multiple issues:

- We may be prevented from collecting **copays, deductibles, or patient balances** in advance — even when insurance coverage is confirmed, especially if the patient refuses payment prior to service.

- It will result in **uncompensated care**, especially if patients default after receiving services. As written, the law may require us to continue providing services for **six months or more**, even in cases of nonpayment. For practices like ours, 20% of collections are from patient payments.
- The result will be increased **bad debt, administrative costs**, and significant strain on independent practices that lack the financial infrastructure of hospital systems or venture capital backed practices.

2. Ambiguity Around “Medically Necessary” Care

Section 6 defines “medically necessary care” in broad terms:

“Health care services that are provided to a patient for the purpose of preventing, diagnosing or treating an illness, injury, condition, disease or its symptoms...”

The problem is that we often cannot determine whether a service meets that definition until the patient has been seen — and by then, the costs already have been incurred.

This affects common OB/GYN services such as:

- **Annual exams** where symptoms or concerns are raised,
- **Prenatal visits** (notably, it's a standard practice to collect the patient's expected share of cost by the **28th week of pregnancy**),
- **Diagnostic ultrasounds** ordered during routine visits.

These would likely fall under “medically necessary,” but it's unclear whether collecting upfront would be permissible under the new framework.

3. Disparate Treatment of Physician Practices vs. Facilities (Section 16)

Section 16 provides some flexibility to healthcare **facilities**, allowing them to engage in extraordinary collection actions if those are part of their billing policy. However, there is no comparable provision for **physician-owned practices**. Does this mean practices are still subject to the same 6+ month requirement to continue care without resolution while facilities would be waived if it's outlined on their billing policies?

Sec. 16. 1. If a medical debt was incurred for medical services, products or devices provided by a medical facility, the medical facility or a collection agency shall not engage in any extraordinary collection action unless such action is outlined in the facility's billing policy.

This raises serious equity issues in how different types of providers are treated under the law.

4. Risk of Enforcement Without Clear Standards (Section 18)

Section 18 allows the Commissioner to initiate legal action against any individual or entity who “**is about to violate**” any provision of Sections 2 through 18:

*“If the Commissioner has reason to believe that any person has violated **or is about to violate** any of the provisions of sections 2 to 18, inclusive, of this act, the Commissioner may institute an appropriate legal proceeding against the person...”*

This language is extremely broad and creates significant uncertainty for providers. The idea that a practice **could face legal proceedings for an action not yet taken**, and potentially based on unclear definitions (e.g., what constitutes "medically necessary" care), is deeply concerning. It creates a chilling effect and exposes practices to **preemptive enforcement** without due process or clear guidance.

This issue is a priority for our industry and for provider practices and would welcome an opportunity to work on solutions. Thank you very much for your attention to this important matter. Please feel free to contact me directly if we may be of assistance.

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