Assembly

MINUTES

COMMERCE COMMITTEE - NEVADA STATE LEGISLATURE - 58TH SESSION

MARCH 12, 1975

The meeting was called to order by Chairman Robinson at 3:05 P.M.

MEMBERS PRESENT: Mr. Benkovich
Mr. Demers
Mr. Getto
Mr. Harmon
Mr. Hickey
Mr. Moody
Mr. Wittenberg
Mr. Chairman

MEMBERS ABSENT: Mr. Schofield (excused)

SPEAKING GUESTS: Senator Monroe
Dr. William Edwards, Health Division
Bob Alkire, Kennecott Copper
Joe Braswell, Mountain States Regional Medical Program - Regional Advisory Council
Sharon Greene, Nevada Hospital Association
Miner Kelso
Erma Edwards, Nevada Insurance Division
Dr. Mark Herman, Helath Division
Dr. Donald Pickering
Patricia Peer, Nevada Nurses Association
Blaine Sullivan Rose
Milos Terzich, HIAA

The purpose of this meeting was to hear testimony on the following bills:

SB 5
SB 69
AB 112

Dr. Robinson began the discussion with SB 5 which:

> Requires health insurance coverage to include home health care.

Senator Monroe spoke in favor of this bill saying its intent was for health insurance companies to provide home health care insurance in Nevada so people now being forces to stay in hospitals for extended time can go home and have this service paid for by insurance. It promises to save insurance companies money because these people can be treated at home which would amount to approximately 1/3 of what it would cast in a hospital. At the present time, insurance companies are not permitted to provide this type of coverage. He said Arizona is trying this and after two years has not had a claimant. The difference between Arizona and Nevada is that Nevada has an active home health care service which is unique to Nevada. It is organized and incorporated and active. Arizona does not have this. Dr. Robinson wonderd if there was any objection from the insurance commissioner. Senator Monroe said the commissioner had given the measure a clean bill of health.

Senator Monroe said this would make it mandatory of insurance companies to offer this coverage and they can set their premium schedule accordingly.

Dr. Edwards then spoke as a proponent of SB 5. There is a $48,000 work program with the various home health agencies in Nevada which serve 11 counties. There are only $15,000 State dollars in the program. There is no objection from the Insurance Commissioner or from the insurance companies. We feel it will be a savings. It will require no additional personnel.

Bob Alkire of Kennecott Copper and the Nevada Mines Division spoke also as a proponent. They feel it is a logical step because they presently have in-hospital and nursing home care coverage. It will help to control the costs. They liked the fact that it is physician controlled. As for savings, he has had high estimates of $4,000 per claim and as low as $150 per claim. It would depend on the type of patient. It will help modify the sky-rocketing hospital costs. As for number of days this would eliminate in hospital care, he said it could amount to months in some cases. It would alleviate the hospital bed-load.

Mr. Joe Braswell said the Mountain States Regional Medical Program have been administering in home care programs and it has been very beneficial and he definitely supports this bill. Their program has enabled elderly people to remain in their homes and receive care and it has resulted in early dismissal from hospitals. He also spoke as a consumer in favor of the bill stating he would rather leave the hospital a day early than pay the additional costs. This bill would result in savings for both the consumer and insurance companies. Some long term nursing home patients would still be able to function in their homes.

With no further testimony on this bill, discussion then turned to SB 69 which:

> Requires insurers to accept and helath and care facilities to utilize Uniform Billing and Claim Forms.

Sharon Greene spoke in favor of this bill. She said a uniform billing project began in 1968 by the American Hospital Association with the hopes of replacing the multitude of forms hospitals now use which cause much frustration and additional expense. The objectives of this program were to devise a form which would:

1. The forms must be useable by all hospitals.
2. Must furnish all the various information required by all third party purchasers.
3. Must be acceptable as a claim form to all third party purchasers.
4. Must result in savings of time and materials and result in a cash flow improvement.

This six year program developed a uniform billing form which would accomplish all these objectives. A copy of this form is attached hereto. There is a form for computer use and one for manual use.

She said there were two problems with the bill. One was that it refers to all health and care facilities. This is not necessary because such facilities as child care centers and detoxication centers do not need to be governed under this bill. Therefore, in each instance that "health and care facility" appears, this should be changed to read "hospitals" A second changed would be on line 16 having the line read: NRS 449.012 may utilize the Uniform Billing. This would be changing the reference to NRS and changing the word shall to may. This word change would pertain to those hospitals that have expensive computer systems which will not utilize this form so that they will not be forced to purchase additional equipment. Ms. Greene was asked to provide a typewritten amendment to this effect and she agreed she would.

Miner Kelso said Title 19 Welfare supports the idea of a uniform billing form. However, he said there are some problems to the existing bill and recommended the following amendments:

1. In agreement with Sharon Greene that it should be limited to hospitals only and not the other care facilities.

2. They want it left up to the Insurance Commissioner to prescribe the appropriate forms.

He said the bill should address itself to both hospitals as well as out patient services as provided by the physician in his office. In his support of the bill he said they process some 500,000 claims each year. If this information must go into computers from a multiplicity of form, much time and money is wasted. There is a real need for a common data base. He then read the Oregon law which was passed in 1973 and which they would be in accord with and felt it more appropriate to the need:

> "The Commissioner shall prescribe uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this State and all State agencies that require state health claim forms for their records."

This leaves it up the the Insurance Commissioner to prescribe the kind of forms to be used for both in-patient and out-patient services.

Dr. Robinson said they would be better of to have the Commissioner regulate this rather than put it in the statutes. Erma Edwards said a statute would be needed to give the Commissioner this authority. Dr. Robinson said they would have to start with a new bill or amend this one. Mr. Getto suggested getting together with Ms. Edwards and Mr. Kelso in order to determine exactly what is necessary to get this accomplished. Dr. Robinson said action would be defered on this bill until the committee hears back from Mr. Getto, Mr. Kelso and Ms. Edwards.

Mr. Demers moved Mr. Getto have the bill drafters draft a bill to this effect. This motion was seconded by Mr. Wittenberg and passed

the committee unanimously. Discussion then turned to AB 112.

Dr. Herman saying he originally put in the bill draft request. The intent of his bill was to make certain that families covered by insurance would also have insurance coverage for a newborn from the moment of birth commenting how overwhelming costs can be when a child is born with congenital defects. This bill would make insurance coverage commence at the moment of birth. This would save the parents from the catastrophic costs and keep them self-reliant and off the welfare rolls. He submitted a chart to the committee covering conditions at birth and cost and insurance details (a copy of which is attached hereto). He said often parents do not understand what type of coverage they have. He added that costs can amount to $4,000 to $6,000 in a few days following birth. He said the idea of this bill was that the coverage of newborn infants of an insured shall begin at the time of birth and shall in no way be limited.

Dr. Donald Pickering then spoke in favor of this bill saying insurance companies do allow an increase of 25¢ to 75¢ per month per dependent family for this type of coverage.

Patricia Peer spoke in favor of this bill. Her testimony is attached hereto.

Dr. Pickering then continued to speak commenting on the type of care an infant now receives as opposed to that he received in the past and how the mortality rate is much improved but that cost has increased substantially too. He also added that they are now able to produce productive citizens who might previously gone to institutions for up to 40 years at the public's expense. He spoke about the difficulty of defining a normal baby and that the Governor of Washington has left that wording out of the law. He felt a normal baby could be construed as a nearly ill baby. He said he felt this bill would provide better infant care.

Blaine Sullivan Rose said she represents the Rehabilitation Department and the Nevada Association for Retarded Children and they wish to go on record in support of AB 112.

Mr. Braswell spoke saying he was in support of this bill but felt there should be some language changes with regard to what the insurance companies interpretation of pre-existing conditions might be with congenital anomalies. He submitted a proposed amendment to AB 112 regarding the coverage of infants. He said the critical period for infants is the first 28 days. He quoted some statistics from the department of HEW covering the period from January 1974 through November 1974. Deaths under one year of age amounted to 4,775 or a rate of 16.6 per thousand live births. Those who died under 28 days were 3,552 of this 4,775 so it is a very critical period and with costs so high, it can ruin many young families.

Sharon Greene stated the Nevada Hospital Association was in favor of AB 112.

Milos Terzich then spoke representing the American Life Insurance Association (represents 95% of life insurance companies in U.S. and Canada) and the Health Insurance Association of America (membership composed primarily of the American Life Insurance Association). He said his clients were not opposed to the concept of this type of coverage. They think it is an excellent concept and a law should be made. However, they do oppose some of the language in this bill, specifically: "shall in no way be limited". He said with this language, no maximum limit of coverage would be possible, no deduction would be possible, no surgical schedule could be used and there could be no co-insurance. These things are not possible because of this wording. This would cover each and every newborn child whether they be considered well or "normal" up through the age of 18 years of age. It would have to cover from this language, innoculation shots, 3-month physical exams and the sequence of exams and health maintenance that is necessary and of acceptable standards for a child. The way it reads, it would cover all hospital and medical visits or treatment from birth to 18 years of age. HIAA has attempted to estimate cost for providing such coverage as under this language and came up with $500 to $600 per life additional cost over and above normal coverage. He presented a model bill to the committee which was prepared in conjunction with the American Academy of Pediatrics with the assistance of HIAA. He said 24 states have adopted this model legislation perhaps with a few changes. Some companies are already offering this type of coverage on a voluntary basis. The cost of this would be 20¢ to 30¢ under the model legislation compared to $500 to $600 under the present AB 112. Under this model legislation, coverage would include first 31 days and if you choose to continue coverage after that point, you must contact the insurance company. The effective date of this model legislation is 120 days after passage. The purpose of this is to give the companies time to prepare forms because they must go through the Insurance Commissioner's Office for his approval. To be fair, this should be included under NRS Chapter 695 for equality of the consumer. This deals with the "Blues" i.e. Blue Shield Insurance, Blue Cross Insurance, etc. They should have the same benefits because the purpose is to benefit the entire public. Mr. Hickey wondered if 31 days was fair. Dr. Pickering said the major financial burden would be accumulated within the first 31 days in most cases. He prefered 60 days. He felt 60 days would take in 95% of the babies.

Dr. Robinson asked Milo Terzich to get the actuarial costs of this for the committee and commented that he and Mrs. Brookman have requested a bill to the effect of this model legislation which is presently being drafted and he said a sub-committee would be formed to look at this bill when it comes out and the chairman of that sub-committee will be Harley Harmon who will work with Milo Terzich and Dr. Pickering. Dr. Robinson said the hearing on this bill would be continued at a later date.

Dr. Robinson then brought up a BDR regarding the licensing and registration of real estate appraisers and asked for a motion for committee introduction. Mr. Getto so moved. Mr. Hickey seconded and it carried the committee unanimously with Mr. Benkovich not voting.

Meeting adjourned at 4;40 P.M.

ASSEMBLY

HEARING

COMMITTEE ON COMMERCE

Date MARCH 12, 1975 Time 3:00 P.M. Room 316

Bill or Resolution to be considered	Subject
SB 5	Requires health insurance coverage to include home health care.
SB 69 DO PASS AS AMENDED	Requires insurers to accept and health and care facilities to utilize Uniform Billing and Claims Forms.
AB 112 DO PASS AS AMENDED	Requires that health insurance coverage of newborn infants of insured begins at time of birth.

AMENDMENTS RECOMMENDED by Sharon Greene

S. B. 69

SENATE BILL NO. 69—SENATORS RAGGIO, HERR, YOUNG, NEAL, GOJACK, SHEERIN, CLOSE, WILSON, ECHOLS, BLAKEMORE, GIBSON, HILBRECHT, MONROE, BROWN, LAMB, DODGE, FOOTE AND WALKER

JANUARY 29, 1975

Referred to Committee on Health, Welfare and State Institutions

SUMMARY—Requires insurers to accept and ~~health and care facilities~~ HOSPITALS to utilize Uniform Billing and Claims Forms. Fiscal Note: No. (BDR 57-536)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to health insurance; requiring insurers to accept and ~~health and care facilities~~ HOSPITALS to utilize Uniform Billing and Claims Forms; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

1 SECTION 1. Chapter 689A of NRS is hereby amended by adding
2 thereto a new section which shall read as follows:
3 *Any insurer under a health insurance contract shall accept from a*
4 *~~health and care facility~~* HOSPITAL *the Uniform Billing and Claims Forms estab-*
5 *lished by the American Hospital Association in lieu of their individual*
6 *billing and claims forms.*
7 SEC. 2. Chapter 689B of NRS is hereby amended by adding thereto
8 a new section which shall read as follows:
9 *Any insurer under a group health insurance ~~contract or a~~ blanket*
10 *health insurance contract shall accept from a ~~health and care facility~~* HOSPITAL *the*
11 *Uniform Billing and Claims Forms established by the American Hospital*
12 *Association in lieu of their individual billing and claims forms.*
13 SEC. 3. Chapter 449 of NRS is hereby amended by adding thereto
14 a new section which shall read as follows:
15 *Every ~~health and care facility~~* HOSPITAL *licensed pursuant to the provisions of*
16 *~~NRS 449.001 to 449.240, inclusive,~~* NRS 449.012 *~~shall~~* MAY *utilize the Uniform Billing*
17 *and Claims Forms established by the American Hospital Association.*
18 SEC. 4. NRS 449.001 is hereby amended to read as follows:
19 449.001 As used in NRS 449.001 to 449.245, inclusive, *and section*
20 *3 of this act,* unless the context otherwise requires, the words and terms
21 defined in NRS 449.003 to 449.018, inclusive, have the meanings
22 ascribed to them in such sections.

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(3) PATIENT'S IDENT. NO. | (4) SEX M F | (5) BIRTHDATE | (6) PHYSICIAN | (7) ADMISSION-DATE HR. | (8) DATES (A) DISCHARGE | (B) STILL PATIENT | (C) EXPIRED

(9) PRIMARY PAYOR - NAME | (10) NAME & RELATIONSHIP OF INSURED | (11) CLAIM - CERTIFICATE - I.D. NO. | (12) GROUP NO. OR NAME | (13) BENEFITS ASSIGNED YES NO

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(19) BILL TO

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(25) PVT. RM. MED. NECESSARY DAYS | (26) SEMI-PVT. RATE $

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(44) TOTAL CHARGES | (45) PRIMARY PAYOR | (46) SECONDARY PAYOR | (47) PAID BY PATIENT | (48) DUE FROM PATIENT | ◀ THIS AMOUNT IS NOW DUE

(49) EMPLOYMENT RELATED - NAME OF EMPLOYER YES NO | (50) DATE OF ACCIDENT | (51) PREGNANCY-DATE OF LMP | BLOOD RECORD ▶ (PINTS) | (52) FURNISHED | (53) REPLACED | (54) NOT REPLACED | (55) CHARGE PER PINT | (56) TOTAL BLOOD CHARGES

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(65) DIAGNOSIS(ES) DISCHARGE ☐ ADMITTING ☐

PRIMARY

SECONDARY

(66) OBSTETRICAL OR SURGICAL PROCEDURES - DATES

PRINCIPAL

OTHER

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↑ CARBON ENDS HERE ↑ **NOTICE TO PATIENT** ↑ CARBON ENDS HERE ↑

SINCE THE HOSPITAL IS ACTING SOLELY AS AGENT FOR THE PATIENT IN FILING FOR INSURANCE BENEFITS ASSIGNED TO IT, IT CAN ASSUME NO RESPONSIBILITY FOR GUARANTEEING COVERED CHARGES SHOWN ABOVE FOR PRIMARY PAYOR AND SECONDARY PAYOR. (ACTUAL CREDIT WILL BE SHOWN ON THE BILLING WHEN THE MONEY IS ACTUALLY RECEIVED.)

MISCELLANEOUS CHARGES AND CODES

CHARGES	CODES
AMBULANCE SERVICE	040
ANESTHESIA	070
ANESTHESIA—MD	071
ANESTHESIA—RN	073
ANESTHESIA—SUPPLIES	078
BLOOD SERVICE	100
BLOOD—WHOLE	110
BLOOD—PLASMA	120
BLOOD—OTHER COMPONENTS	125
BLOOD—ADMIN SUPPLIES	130
BMR	150
COT	200

CHARGES	CODES
DENTAL SERVICES	250
DIATHERMY	270
EEG	410
EKG	430
EMERGENCY ROOM	450
EQUIPMENT RENTAL	470
HOUSE PHYSICIAN FEES	500
INTERN AND RESIDENT FEES	510
INTRAVENOUS SOLUTIONS	520
ISOTOPES (X-RAY)	550
MEALS (VISITORS & OTHER)	570
MISCELLANEOUS	580

CHARGES	CODES
NEWBORN	
NEWBORN—SUPPLIES	600
NEWBORN—CIRCUMCISION	620
NEWBORN—NURSERY	640
OUTPATIENT DAY RATE	660
THERAPY	700
MILIEU THERAPY	710
INHALATION THERAPY	720
OXYGEN THERAPY	730
OCCUPATIONAL THERAPY	740
OTHER THERAPY	760
PHYSICAL THERAPY	780

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COVERED CHARGES

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(1) PATIENT'S LAST NAME	FIRST NAME	INITIAL	(2) STREET ADDRESS	CITY	STATE	ZIP

(3) PATIENT'S IDENT. NO.	(4) SEX M F	(5) BIRTHDATE	(6) PHYSICIAN	(7) ADMISSION-DATE	HR	(8) DATES (A) DISCHARGE	(B) STILL PATIENT	(C) EXPIRED

(9) PRIMARY PAYOR - NAME	(10) NAME & RELATIONSHIP OF INSURED	(11) CLAIM - CERTIFICATE - I.D. NO.	(12) GROUP NO. OR NAME	(13) BENEFITS ASSIGNED YES NO
(14) SECONDARY PAYOR - NAME	(15) NAME & RELATIONSHIP OF INSURED	(16) CLAIM - CERTIFICATE - I.D. NO.	(17) GROUP NO. OR NAME	(18) BENEFITS ASSIGNED YES NO

19. DATES OF QUALIFYING STAY
FROM
THRU

20. QUALIFYING AND OTHER PRIOR STAY INFORMATION

21. ADMITTING DIAGNOSES (IF EMPLOYMENT RELATED, ALSO GIVE NAME AND ADDRESS OF EMPLOYER)

MEDICARE

REPORT OF ELIGIBILITY ☐ BLUE CROSS ☐

A. EFFECTIVE DATE - HOSPITAL INSURANCE / /

B. EFFECTIVE DATE - MEDICAL INSURANCE / /

C. HOSPITAL DAYS REMAINING FULL ______ COINSURANCE ______

D. LIFETIME RESERVE DAYS REMAINING

E. MEDICAL PLAN DEDUCTIBLE MET ☐ NOT MET ☐

F. REMAINING INPATIENT DEDUCTIBLE $ ______

G. PINTS REMAINING BLOOD DEDUCTIBLE ______

H. ECF DAYS REMAINING FULL ______ COINSURANCE ______

I. 3 DAY HOSPITAL STAY REQUIREMENT MET ☐ NOT MET ☐

J. 28 DAY TRANSFER REQUIREMENT MET ☐ NOT MET ☐

K. HHA VISITS REMAINING PART A ______ PART B ______

L. PHYSCHIATRIC DAYS REMAINING ______

M. OPEN ITEM INFORMATION
1. INTERMEDIARY
2. PROVIDER
3. DATE ADMITTED
4. DATE DISCHARGED

N. DAYS

O. ROOM COVERAGE

P. ANCILLARY COVERAGE

Q. DEDUCTIBLE

R. COINSURANCE

$______ PER DAY OR ______ DAYS

S. COB YES ☐ NO ☐

T. OTHER COVERAGE INFORMATION

REMARKS:

HOSPITAL NO.	PROVIDER NO.	FED. I.D. NO.	PAGE	OF

(1) PATIENT'S LAST NAME	FIRST NAME	INITIAL	(2) STREET ADDRESS	CITY	STATE	ZIP

(3) PATIENT'S IDENT. NO.	(4) SEX M F	(5) BIRTHDATE	(6) PHYSICIAN	(7) ADMISSION-DATE	HR.	(8) DATES (A) DISCHARGE	(B) STILL PATIENT	(C) EXPIRED

(9) PRIMARY PAYOR - NAME	(10) NAME & RELATIONSHIP OF INSURED	(11) CLAIM - CERTIFICATE - I.D. NO.	(12) GROUP NO. OR NAME	(13) BENEFITS ASSIGNED YES NO
(14) SECONDARY PAYOR - NAME	(15) NAME & RELATIONSHIP OF INSURED	(16) CLAIM - CERTIFICATE - I.D. NO.	(17) GROUP NO. OR NAME	(18) BENEFITS ASSIGNED YES NO

19. DATES OF QUALIFYING STAY
FROM
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20. QUALIFYING AND OTHER PRIOR STAY INFORMATION

21. ADMITTING DIAGNOSES (IF EMPLOYMENT RELATED, ALSO GIVE NAME AND ADDRESS OF EMPLOYER)

MEDICARE

REPORT OF ELIGIBILITY ☐ BLUE CROSS ☐

A. EFFECTIVE DATE - HOSPITAL INSURANCE / /

B. EFFECTIVE DATE - MEDICAL INSURANCE / /

C. HOSPITAL DAYS REMAINING FULL ______ COINSURANCE ______

D. LIFETIME RESERVE DAYS REMAINING

E. MEDICAL PLAN DEDUCTIBLE MET ☐ NOT MET ☐

F. REMAINING INPATIENT DEDUCTIBLE $ ______

G. PINTS REMAINING BLOOD DEDUCTIBLE ______

H. ECF DAYS REMAINING FULL ______ COINSURANCE ______

I. 3 DAY HOSPITAL STAY REQUIREMENT MET ☐ NOT MET ☐

J. 28 DAY TRANSFER REQUIREMENT MET ☐ NOT MET ☐

K. HHA VISITS REMAINING PART A ______ PART B ______

L. PHYSCHIATRIC DAYS REMAINING ______

M. OPEN ITEM INFORMATION
1. INTERMEDIARY
2. PROVIDER
3. DATE ADMITTED
4. DATE DISCHARGED

N. DAYS

O. ROOM COVERAGE

P. ANCILLARY COVERAGE

Q. DEDUCTIBLE

R. COINSURANCE

$ ______ PER DAY OR ______ DAYS

S. COB YES ☐ NO ☐

T. OTHER COVERAGE INFORMATION

REMARKS:

HOSPITAL NO. | PROVIDER NO. | FED. I.D. NO.

(1) PATIENT'S LAST NAME | FIRST NAME | INITIAL | (2) STREET ADDRESS | CITY | STATE | ZIP

(3) PATIENT'S RECORD NO. | (4) SEX M F | (5) DATE OF BIRTH MO DAY YR | (6) RACE W B O | (7) ADMISSION DATE MO DAY YR HR | (8) DATE OF DISCHARGE MO DAY YR

(9) PRIMARY PAYOR - NAME | (10) CLAIM-CERTIFICATE-I.D. NO.

(11) SECONDARY PAYOR - NAME | (12) CLAIM-CERTIFICATE-I.D. NO.

(13) ATTENDING PHYSICIAN NAME | (14) ATT.PHYS.SS NO. | (15) OPERATING PHYSICIAN NAME | (16) OPER.PHYS.SS NO.

17. NATURE OF ADMISSION: A EMERGENCY, B URGENT, C ELECTIVE, D ROUTINE, E NEWBORN

18. EXPECTED PRINCIPAL SOURCE OF PAYMENT (SELECT ONE): A MEDICARE, B MEDICAID, C BLUE CROSS, D INSURANCE CO., E OTHER GOV'T PAYMENT, F WORKMAN'S COMPENSATION, G SELF-PAY, H NO CHARGE, J OTHER

19. DISPOSITION OF PATIENT (SELECT ONE): A DISCHARG. TO HOME OR SELF-CARE (ROUT. DISCHARGE), B DISCHARG/TRANS. TO SKILLED NURSE FACILITY (SNF), C DISCHARGE. TO HOME CARE OF ORGAN. HOME HEALTH SERV., D DISCHARG/TRANS. TO INTERMEDIATE CARE FACIL. (ICF), E TRANSFERRED TO ANOTHER SHORT TERM GEN. HOSP., F DISCHARGED OR TRANSFERRED TO ANOTHER INSTITUT., G DIED, H LEFT AGAINST MED. ADVICE

20. CERTIFICATION DATA (SELECT ONE): A PRE-ADMISSION CERT. PERFORMED, B POST ADMISSION CERT. (WITHIN 24 HRS. OF ADM.), C POST ADMISSION CERT. (AFTER 24 HRS. OF STAY), D PATIENT NOT CERTIFIED

21 NUMBER OF DAYS INITIALLY CERTIFIED | 22 NUMBER OF REQUESTS FOR EXTENSION | 23 TOTAL DAYS CERTIFIED

(24) CODE | (25) a - **PRINCIPAL DIAGNOSIS**

b - OTHER DIAGNOSIS

c - OTHER DIAGNOSIS

d - OTHER DIAGNOSIS

e - OTHER DIAGNOSIS

(26) CODE | (27) PROC. DATE MO DAY YR | (28) a - **PRINCIPAL PROCEDURE**

MO DAY YR | b - OTHER SIGNIFICANT PROCEDURE

MO DAY YR | c - OTHER SIGNIFICANT PROCEDURE

MO DAY YR | d - OTHER SIGNIFICANT PROCEDURE

INSTRUCTIONS

DIAGNOSIS

1 - ENTER ONLY THE PRINCIPAL DIAGNOSIS IN ITEM (25) a.

2 - ENTER ADDITIONAL DIAGNOSES RELATED TO THIS STAY IN ITEMS (32) b thru e.

3 - *Enter only one diagnosis on each line.*

SURGICAL PROCEDURES

1 - ENTER ONLY THE PRINCIPAL PROCEDURE IN ITEM (28) a.

2 - ENTER ADDITIONAL PROCEDURES RELATED TO THIS STAY IN ITEMS (28) b thru d.

3 - *Enter only one procedure on each line.*

0273

DR. HERMAN

File #	DATE of BIRTH	No. of DAYS NOT OOVERED BY INSURANCE	CONDITION	TYPE OF MEDICAL SERV. REQUIRED	COST	INSURANCE CARRIER
7136	10 17 72	14	Cleft lip & palate	Hospital & surgery	$1,040.97	Aetna Life & Casualty
7046	12 10 71	60	Hydrocephalus	Hospital	6,393.19	Culinary
7583	11 22 72	10	Bilateral Club feet	Casting & x-rays	40.00	Occidental
7029	6 25 72	14	Spina bifida	Hospital & surgery	5,722.90	Cal-Western
7300	10 14 72	14	Cleft lip & palate	Hospital & surgery	419.92	Aetna
7595	8 14 73	*8	Cystic fibrosis	Hospital & treatment	2,928.15	Universe Life
7663	1 22 74		Hyaline membrane	ICN- hosp.	989.45	Universe Life
7800	11 14 73	*	Club feet & deformed left hand	Hospital & casting	392.50	Continental Life
8065	5 17 74	14	Hyaline membrane	ICN - hosp.	1,581.95	Aetna
7932	2 20 71	*	Cleft palate	Hospital, dental surgery	2,461.95	Blue Cross
7998	7 15 74	14	Cystic mass - sacral area	Hospital & surgery	1,634.40	Travelers
7966	8 15 74	14 1 yr. pre-existing	Hyaline membrance	ICN - hospital	385.25	Globe Life
8096	8 13 74	14	Multiple anomalies	Hospital & surgery	4,397.45	Metropolitan

*8 - see attached letter
* - insurance will not cover pre-existing condition, birth defects are considered as pre-existing

February 15, 1974

RECEIVED
FEB 19 1974
MCH & CCS

Mr. Harold H. Trisch
1270 Berrum Lane #A
Reno, Nevada 89502

Re: Todd C. Trisch

Dear Mr. Trisch:

We have now completed our review of the claim for your son, Todd.

We would like to point out that any condition existing on the effective date of coverage, will not be covered under the policy if treatment is then received during the first 90 days of coverage. Also, a newborn child is not covered until he is eight days old. Therefore, your son's coverage was effective on August 21, 1973, and any condition which existed on that date would not be covered unless it was not treated during the next 90 days.

As you know, Todd was born with a congenital condition, which was treated regularly during the first 90 days of coverage. Therefore, it is not covered under the terms of the policy.

The policy does state that any condition which goes untreated for a period of six months, may be considered a new sickness. Should your son have a six-month treatment-free period, we may be able to reconsider the claim at a future date.

I am sending a copy of this letter to those persons who have submitted bills and assignments to us. I am also returning your original bills to you.

I sincerely regret that we could not write you more favorably. However, should you have any questions regarding this decision, please don't hesitate to contact us.

Sincerely,

Keith E. Johnson
Assistant Vice President

Insurance refusal

KJ/pm
cc: R. Punches
St. Mary's Hospital
Washoe Medical Center
Crippled Children's Society, State of Nevada
Children's Hospital Medical Center

PATRICIA PEER

Nevada Nurses' Association

0275

1450 East 2nd Street Reno, Nevada 89502 (702) 329-5551

March 12, 1975

COMMITTEE ON COMMERCE

AB-112

Mr. Chairman and Committee Members:

I am Patricia Peer representing the Nevada Nurses' Association as an expert witness. The bill which we are discussing today covers the newborn infant of an insured at the time of birth and shall in no way be limited.

As a pregnancy progresses, complications may develop in the mother which may adversely affect the outcome of the baby. At the time this baby takes its' first breath, it becomes a citizen and a potential taxpayer. Indeed, it becomes a consumer. The first twenty-eight days of a babys' life are the most crucial. Yet insurance coverage does not begin until the 28th day.

Research over the past decade has learned much about intact survival of the newborn. This knowledge has encouraged hospitals throughout the country to develop intensive care areas specifically for the care of the sick newborn. The cost of equipment needed in this unit is only a small part of the burden hospitals and/or parents must absorb in the community who offers this service.

Nurses are being highly trained in an expanded role to function in these intensive care units. Physicians are specializing in Neonatology, and within the past few years, Perinatology which is care of the baby in utero.

The number of infants who will benefit from this change in the insurance law are approximately eight (8%) of the total newborn population. These infants are surviving at a tremendous cost to parents, community, and governmental agencies. Crippled Childrens Service of Nevada has expanded their coverage, when feasable, to assist the parents of the sick newborn. Whether a baby is born in Battle Mountain or Reno, this babys' chance for intact survival has been greatly improved.

There are a certain number of infants who will require only two or three days of intensive care. Others, such as a premature, may require intensive care for two weeks, intermediate care for one week, and recovery care for one week. This is based on the improvement as the baby progresses.

The cost of the intensive care level is - $250.00 per day

The cost of the intermediate care level is - $178.00 per day

The cost of recovery care level is - $ 90.00 per day

This does not include support services such as xray, laboratory, pharmacy, and physicians' fees.

In 1974, there were 143 babies transported into Washoe Medical Center from the outlying areas.

There were 121 babies born in Washoe County who required intensive care.

The parents of these babies who pay insurance premiums for family coverage had no financial assistance for the hospitalization of this infant. The burden has been on the parents, hospital, and or governmental agencies.

Including newborns in coverage of group insurance from time of birth, will encourage hospitals and the health care team to assist that baby in reaching the ultimate goal of intact survival. That baby will be a productive citizen, taxpayer, and consumer. The initial investment will be well spent.

We respectfully request a do pass of AB-112 as it is written.

Thank you.

BRASWELL

0277

PROPOSED AMENDMENT TO AB-112

One line 16 insert a period after the word "birth" and delete the remainder of the sentence, then add the following statement to the section:

"The coverage for newborn infants shall be the same as provided by the policy for other covered persons; provided, however, that for newborn infants there shall be no waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reductions in benefits applicable to all other covered persons;"

AB112

0278

MODEL NEWBORN CHILDREN BILL

Prepared by the American Academy of Pediatrics
with the assistance of
The Health Insurance Association of America
November 21, 1973

1. All individual and group health insurance policies providing coverage on an
2. expense incurred basis and individual and group service or indemnity type
3. contracts issued by a nonprofit corporation which provide coverage for a
4. family member of the insured or subscriber shall, as to such family
5. members' coverage, also provide that the health insurance benefits ap-
6. plicable for children shall be payable with respect to a newly born child of the
7. insured or subscriber from the moment of birth.

8. The coverage for newly born children shall consist of coverage of injury or
9. sickness including the necessary care and treatment of medically diagnosed
10. congenital defects and birth abnormalities.

11. If payment of a specific premium or subscription fee is required to provide
12. coverage for a child, the policy or contract may require that notification of
13. birth of a newly born child and payment of the required premium or fees
14. must be furnished to the insurer or nonprofit service or indemnity corporation
15. within 31 days after the date of birth in order to have the coverage continue
16. beyond such 31 day period.

17. The requirements of this act shall apply to all insurance policies and
18. subscriber contracts delivered or issued for delivery in this state more
19. than 120 days after the effective date of the act.

MILO TERZICH

Statement of Principles Concerning Legislation for Newborn Children Coverages in Health Insurance Policies as adopted by The American Academy of Pediatrics and The Health Insurance Association of America

Principle 1. The provisions of the November 21, 1973 Model Newborn Children Bill are not intended to imply, and should not be construed so as to imply, the inclusion of coverages for routine well-baby care services.

Principle 2. Legislation that would mandate the provision of coverage for routine well-baby care services in all health insurance policies generally would not be in the best interests of the insuring public, since to do so without an appropriate healthcare program containing Federal or state subsidies would simply cause health insurance to become priced beyond the reach of a large segment of the population.

Principle 3. Principles 1 and 2 above do not in any way place in question nor reflect any negative position with regard to:

A. the social or medical value of routine well-baby care services or any other health maintenance services that are considered good medical practice by any professional medical group, or,

B. the propriety of seeking to encourage the voluntary provision of well-baby care coverages through negotiation between the purchasers of insurance and insurance carriers, nor the propriety of encouraging the voluntary inclusion of coverages for well-baby care under group pre-paid practice plans or comprehensive health maintenance organization plans.

- END -

GUEST REGISTER

COMMERCE COMMITTEE

DATE: 3-12

ADDRESS & NAME	REPRESENTING	PLEASE CHECK IF YOU WISH TO SPEAK
PATRICIA A. PEER 1845 CANOGA CT SPARKS	NEVADA NURSES ASSN	✓ (AB112)
Joe Braswell	Mtn States Regional Medical Program - Regional Advisory Council	✓ AB-112
Bob Alkire	Kennecott Copper	✓ SB5
[illegible]	Nevada Insurance Division	
Paul T. Ryan	Title XIX	
Dick Lundstrom	Title XIX	
Nancy Luce	—	
Brad Stom	INTERN John Vergiels	
Milos [illegible]	ALIA HIAA	✓ AB112
[illegible] Edwards	Health Division	
[illegible] Thompson	Health Division	✓ SB 69
Mark L. H. Edwards	Health Division	AB 112