Pacific Law Journal Review of Selected Nevada Legislative

Volume 1989 | Issue 1 Article 104

1-1-1989

Insurance; health coverage

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NEV. REV. STAT. §§ 449.___, 689A.___, 689B.___, 695A.___, 695B.___, 695C.___, (new); §§ 361.088, 449.001, 449.0115, 449.0151, 449.030, 449.037, 449.260, 608.157, 616.503, 617.395, 679A.095, 689A.030, 689A.041, 689B.030, 689B.0375, 695B.180, 695B.191, 695C.171, 695C.176 (amended).
AB 750 (Diamond); 1989 STAT. Ch. 791
SB 442 (Committee on Commerce and Labor); 1989 STAT. Ch. 877
AB 619 (Thompson); 1989 STAT. Ch. 482

Existing law regulates health insurance contracts,[1] group[2] and blanket[3] health insurance, health service nonprofit corporations,[4] and health maintenance organizations.[5] Chapter 791 requires that health insurance must provide coverage for the detection of breast cancer and for breast reduction.[6] Chapter 791 defines reconstructive surgery as a surgical procedure following a mastectomy of one or both breasts.[7] Under Chapter 791, dental procedures may be excluded

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1. *See* NEV. REV. STAT. § 689A.030 (1971) (establishing general terms and form required for health insurance contracts).

2. *See id.* § 689B.020 (1971) (defining group health insurance as insurance coverage for a group of two or more people, which was formed for purposes other than securing insurance).

3. See id. § 689B.070 (1987) (defining blanket insurance as insurance covering groups specified within this code section, such as passengers of common carriers, or employees and students of a school district).

4. *See id.* § 695B.010 (1971) (regulating hospital, medical and dental nonprofit service corporations).

5. *See* chapters 689A, 689B, 695B, 695C of the Nevada Revised Statutes (codifying regulations for health insurance contracts, group and blanket health insurance, nonprofit medical service corporations and health maintenance organizations). See also NEV. REV. STAT. § 695C.030 (7) (1973) (defining a health maintenance organization as any person which provides or arranges to provide medical services to its enrollees).

6. 1989 Nev. Stat. ch. 791, secs. 1, 3, 5, 7, at 1888-91 (enacting NEV. REV. STAT. §§ 689A.___, 689B.___, 695B.___, 695C.___). Benefits must provide coverage for the expenses of: (1) Annual cytologic screening test for women over 17 years of age; (2) annual baseline mammogram for women 35 to 40 years old; and (3) annual mammogram for women 40 years of age or older. *Id.* Any policy provision in conflict with these sections is void. *Id.* Health insurance must provide coverage for breast reduction which is determined by a licensed physician to be in the best interest of the woman's health. *Id.*

7. *Id.* secs. 2, 4, 6, 8-11, at 1889-91 (amending NEV. REV. STAT. §§ 689A.041, 689B.0375, 695B.191, 695C.171, 608.157, 616.503, 617.395). The purpose of reconstructive surgery is to regain symmetry of the breasts. *Id.* Reconstructive surgery includes, but is not limited to, mastopexy, and augmentation and reduction mammoplasty. *Id.* This provision applies to insurance policies, group and blanket health insurance policies, nonprofit health care corporations, health maintenance organizations, employee health care benefits, industrial employee insurance, and coverage for injury due to occupational diseases. *Id.*

from insurance coverage and coverage for temporomandibular joint treatment may be limited, but not excluded.[8]

Chapter 482 eliminates the allowance for conditional inclusion of hospice care in insurance coverage and requires that hospice care be provided for.[9] Under Chapter 482, existing law regarding medical and other related facilities is augmented to include an expanded explanation of hospice care and freestanding facilities for hospice care.[10]

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8. *Id.* ch. 877, secs. 1-6, at 2137-39 (enacting NEV. REV. STAT. §§ 689A.___, 689B.___, 695A.___, 695B.___, 695C.___,) (requiring coverage for the treatment of the temporomandibular joint in health insurance contracts, group and blanket health insurance, nonprofit corporate hospital or medical services, health maintenance organization services, and fraternal benefit society health care plans). Insurers may limit coverage of the temporomandibular joint to no more than 50 percent of the customary charges for such treatment and to treatment which is medically necessary. *Id.* The definition of "medically necessary" is a service that is appropriate and necessary for the diagnosis and treatment of illness or injury according to generally accepted medical practices. NEV. ADMIN. CODE ch. 695C § 055 (1986).

9. *Id.* ch. 482, secs. 2, 3, 4, 5, at 1031-33(amending NEV. REV. STAT. §§ 689A.030, 689B.030, 695B.180, 695C.176) (health insurance policies, group and blanket health insurance, medical service corporations and health maintenance organizations must provide coverage for hospice care costs).

10. *Id.* sec. 8.5, at 1034 (enacting NEV. REV. STAT. § 449.___; amending NEV. REV. STAT. § 449.0115) Providers of hospice care must provide a program directed by a licensed physician, who is knowledgeable about the psychosocial and medical aspects of hospice care and who will augment the interdisciplinary team as a medical resource. *Id.* The hospice care must provide medical, nursing, psychological and social services as required by the patients and their families, including the care of patients to relieve the families of the stress of daily patient care. *Id.* Emotional support is to continue for families after the death of patients. *Id.* at secs. 8, 9, at 1034 (enacting NEV. REV. STAT. § 449.___). A freestanding facility for hospice care is a structure, physically separate from other medical facilities, which operates as a hospice care provider. *Id.* A licensed freestanding facility for hospice care may provide any services delineated for hospice care programs. *Id. See id.* secs. 12, 13, at 1035 (amending NEV. REV. STAT. §§ 449.0151, 449.260) (classifying a freestanding facility for hospice care as both a medical and health facility).