Pacific Law Journal Review of Selected Nevada Legislative

Volume 1989 | Issue 1 Article 105

1-1-1989

Insurance; non-profit corporations providing health services

The University of the Pacific, McGeorge School of Law

Insurance; non-profit corporations providing health services

NEV. REV. STAT. § 695B.___ (new); §§ 695B.180, 695B.185, 695B.194, 695B.230 (amended).
SB 184 (Committee on Commerce and Labor); 1989 STAT. Ch. 237

Existing law regulating nonprofit corporations for hospital,[1] medical,[2] and dental services[3] contains no provisions regulating the order in which policies for health insurance will be applied when the insured is covered by more than one policy.[4] Policies that Chapter 237 does not designate as primary policies are secondary,[5] and Chapter 237 provides that secondary insurers cannot reduce benefits because of payments made by the primary policy unless there is a duplication of benefits.[6] Under Chapter 237, policies issued by non-profit corporations for medical services that do not coordinate with other policies are always primary,[7] as are policies that cover a person as an employee, member, or subscriber.[8]

Dependent children[9] whose parents are not divorced are covered primarily by the policy of the parent whose birthday falls earlier in the year.[10] For dependent children of divorced parents, the benefits are determined in the following order: (1) The policy of the custodial

---

1. *See* NEV. REV. STAT. § 695B.030 2 (1987) (definition of hospital services).
2. *See id.* § 695B.030 3 (definition of medical services).
3. *See id.* § 695B.030 1 (definition of dental services).
4. *Id.* §§ 695B.010-.320 (nonprofit hospital, medical and dental service corporation law).
5. 1989 Nev. Stat. ch. 237, sec. 1, at 514 (enacting NEV. REV. STAT. § 695B.___). If the categories delineated by Chapter 237 do not cover a specific situation, the policy that covered a subscriber, member, or employee no longer is primary. *Id.*
6. *Id.* Chapter 237 also alters the prior requirement that a contract for hospital, medical, or dental services must provide benefits for the treatment of alcohol or drug abuse by limiting the requirement to group contracts. *Id.* sec. 2, at 515 (amending NEV. REV. STAT. § 695B.180). *See* NEV. REV. STAT. § 695B.194 (1987) (outlines required contract provisions for the treatment of alcohol and drug abuse). Under Chapter 237, insurers are only required to file copies of the contract with the Insurance Commissioner when more than one class of risk is included, but the filing requirement is extended to nongroup contracts. 1989 Nev. Stat. ch. 237, sec. 5, at 517 (amending NEV. REV. STAT. § 695B.230). Chapter 237 also requires the insuring corporation to file its schedule of premiums under either group or nongroup contracts with the Insurance Commissioner and to wait for 30 days or until receiving written approval before issuing or using those premiums. *Id.*
7. 1989 Nev. Stat. ch. 237, sec. 1, at 514 (enacting NEV. REV. STAT. § 695B.___).
8. *Id.* Policies that cover a person as a current employee are primary while those that cover a person as a laid-off or retired employee are secondary. *Id.*
9. *See* NEV. REV. STAT. § 128.0124 (1987) (definition of child).
10. 1989 Nev. Stat. ch. 237, sec. 1, at 514 (enacting NEV. REV. STAT. § 695B.___). If both parents have the same birthday, the policy that has been in effect the longest is the primary policy. *Id.*

parent; (2) the policy of the spouse of the custodial parent; and (3) the policy of the non-custodial parent.[11] If, however, a court decrees which parent is responsible for the child's health care expenses, that parent's policy is primary.[12]

Prior law imposed a limit of $500 per admission on the deductible that subscribers must pay when using non-preferred inpatient health care facilities.[13] Chapter 237 provides that the insurer may require up to a $600 difference in the deductible charged for preferred and non-preferred inpatient facilities, and a $500 difference in the deductible charged for other preferred and non-preferred providers.[14]

Prior law allowed for a twenty percent difference in the copayments that may be required of subscribers who use non-preferred health care providers.[15] Chapter 237 increases the permitted copayment difference to thirty percent.[16]

KAO

---

11. *Id.*
12. *Id.* A parent under a court order to provide health care for a child has a duty to notify the insurer of the terms of the decree. *Id.*
13. 1987 Nev. Stat. Ch. 729, sec. 2, at 1782 (amended by 1989 Nev. Stat. ch. 237, sec. 3, at 1680-81) (limiting deductibles and copayments charged under group contracts that offer different payments for health services depending on whether the provider was preferred or non-preferred).
14. 1989 Nev. Stat. ch. 237, sec. 3, at 515-16 (amending NEV. REV. STAT. § 695B.185).
15. 1987 Nev. Stat. Ch. 729, sec. 2, at 1782 (amended by 1989 Nev. Stat. Ch. 237, sec. 3, at 1680).
16. 1989 Nev. Stat. ch. 237, sec. 3, at 1515-16 (amending NEV. REV. STAT. § 695B.185).

Insurance; rate increases

NEV. REV. STAT. § 686B.120 (repealed); §§ 680A.150, 686B.070, 686B.100, 686B.110 (amended).
AB 399 (Porter); 1989 STAT. Ch. 885

Prior law required all insurers and rate service organizations[1] to file their established rates with the Insurance Commissioner.[2] Chapter

---

1. *See* NEV. REV. STAT. § 686B.020 2 (1987) (defining rate service organization as any entity other than an employee of an insurer who aids insurers in establishing or filing rates by: (1) collecting and furnishing statistics; (2) recommending or filing rates or supplementary rate information; or (3) advising insurers about rates).
2. 1987 Nev. Stat. ch. 655, sec. 3, at 1533 (amended by 1989 Nev. Stat. ch. 885, sec. 2, at 2176). In addition to established rates, life and health insurers were required to file