

Assembly Bill No. 292—Assemblyman Oscarson

Joint Sponsors: Senators Hardy and Goicoechea

CHAPTER.....

AN ACT relating to public health; requiring a provider of health care who provides certain services to patients located in this State through telehealth to have a valid license or certificate in this State; making persons who provide such services through telehealth to patients subject to the laws and jurisdiction of this State; requiring certain insurers to provide coverage to insureds for services provided through telehealth to the same extent as though provided in person; authorizing a hospital to provide staff privileges to certain providers of health care to provide services through telehealth; requiring the Commissioner of Insurance to consider health care services that may be provided by providers through telehealth when evaluating certain network plans; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes certain providers of health care to provide certain health care services electronically, telephonically or by fiber optics. (NRS 630.020, 630.261, 630.275, 632.237, 633.165, 639.0727, 639.235) **Section 3** of this bill defines "telehealth" as the delivery of health care services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail. **Section 3** also prohibits a provider of health care, except for an employee or contractor of certain nonprofit organizations that administer health programs for American Indians, from using telehealth to direct or manage care, render a diagnosis or write a treatment order or prescription for a patient located in this State without a valid license or certificate to practice his or her profession in this State. Finally, **section 3** provides that any person who provides such services through telehealth to a patient located in this State: (1) is subject to the laws, including regulations, and jurisdiction of this State; and (2) is required to comply with all federal and state laws that would apply if the person were providing services from a location in this State. **Sections 6-18** of this bill clarify that certain provisions regulating the provision of health care services electronically, telephonically or by fiber optics apply to health care services provided through telehealth. **Section 44** of this bill repeals certain requirements of existing law concerning the use of telemedicine by an osteopathic physician because it is addressed by **sections 3, 10 and 11**.

Sections 27-32, 36-39 and 41-43 of this bill require any policy of health insurance, a policy of industrial insurance that provides benefits for injuries and the State Plan for Medicaid to include coverage for health care services provided to a covered person through telehealth to the same extent as though provided in person.

Existing federal regulations allow the governing body of a hospital at which patients receive services through telemedicine to have its medical staff rely upon the credentialing and privileging decisions made by the staff of a facility from which services are provided when deciding whether to extend staff privileges to a



provider of health care who provides services through telemedicine from that facility. (42 C.F.R. §§ 482.12, 482.22, 485.616) **Section 22** of this bill authorizes a hospital to grant staff privileges to a provider of health care who is at another location so that the provider may provide services through telehealth to patients at the hospital as prescribed in federal regulations.

Existing law requires the Commissioner of Insurance to make certain determinations concerning the adequacy of a network plan that an insurer proposes to offer and approve the network plan before the network plan is issued. Existing law also requires the Commissioner to make an annual determination concerning the availability and accessibility of the health care services of any existing network plan. (NRS 687B.490) **Section 28** of this bill requires the Commissioner to consider health care services that may be provided by providers through telehealth pursuant to the network plan when making such a determination.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~omitted material~~ is material to be omitted.

WHEREAS, Shortages of primary providers of health care and providers of health care who specialize in certain areas and the distances some people must travel to reach a provider of health care affects the ability of many people to obtain the health care services they need; and

WHEREAS, Parts of this State have experienced difficulty attracting and retaining providers of health care and supporting health care facilities that provide the necessary variety of health care services to persons; and

WHEREAS, Providers of health care located in underserved areas may not have access to mentors and colleagues to support them personally and professionally or information resources that may assist them in their practices; and

WHEREAS, Telehealth is a mode of delivering health care and public health services using information and audio-visual communication technology to enable diagnosis, consultation, treatment, care management and provision of information to patients from providers of health care at other locations; and

WHEREAS, Telehealth may help to address the problem of an inadequate distribution of providers of health care and develop health care systems in underserved areas of the State; and

WHEREAS, Telehealth can reduce the costs of providing health care and increase the quality of and access to health care in underserved areas of the State; and

WHEREAS, Telehealth provides economic benefits to underserved areas by reducing the need for persons to leave those areas to obtain health care services and preserving and creating jobs relating to the provision of health care in those areas; and



WHEREAS, Patients receive many benefits from telehealth, including increased access to providers of health care, the ability to receive health care services in a faster and more convenient manner, increased continuity of care, reduction of lost work time and travel costs and the ability to remain near family and friends while receiving health care services; and

WHEREAS, Without the assurance that providers of health care will be reimbursed by insurers for services provided through telehealth and the resolution of other legal barriers to the provision of services through telehealth, the full benefits of telehealth cannot be realized; now, therefore,

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 629 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *The Legislature hereby finds and declares that:*

1. Health care services provided through telehealth are often as effective as health care services provided in person;

2. The provision of services through telehealth does not detract from, and often improves, the quality of health care provided to patients and the relationship between patients and providers of health care; and

3. It is the public policy of this State to:

(a) Encourage and facilitate the provision of services through telehealth to improve public health and the quality of health care provided to patients and to lower the cost of health care in this State; and

(b) Ensure that services provided through telehealth are covered by policies of insurance to the same extent as though provided in person or by other means.

Sec. 3. *1. Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient, the provider must hold a valid license or certificate to practice his or her profession in this State, including, without limitation, a special purpose license issued pursuant to NRS 630.261. The requirements of this subsection do not apply to a provider of health care who is providing services within the scope of his or her employment by or pursuant to a contract entered into with an urban Indian organization, as defined in 25 U.S.C. § 1603.*



2. *The provisions of this section must not be interpreted or construed to:*

(a) *Modify, expand or alter the scope of practice of a provider of health care; or*

(b) *Authorize a provider of health care to provide services in a setting that is not authorized by law or in a manner that violates the standard of care required of the provider of health care.*

3. *A provider of health care who is located at a distant site and uses telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient:*

(a) *Is subject to the laws and jurisdiction of the State of Nevada, including, without limitation, any regulations adopted by an occupational licensing board in this State, regardless of the location from which the provider of health care provides services through telehealth.*

(b) *Shall comply with all federal and state laws that would apply if the provider were located at a distant site in this State.*

4. *As used in this section:*

(a) *“Distant site” means the location of the site where a telehealth provider of health care is providing telehealth services to a patient located at an originating site.*

(b) *“Originating site” means the location of the site where a patient is receiving telehealth services from a provider of health care located at a distant site.*

(c) *“Telehealth” means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.*

Sec. 4. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

“Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 5. NRS 630.005 is hereby amended to read as follows:

630.005 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 630.007 to 630.026, inclusive, *and section 4 of this act* have the meanings ascribed to them in those sections.

Sec. 6. NRS 630.020 is hereby amended to read as follows:

630.020 “Practice of medicine” means:

1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other



condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy.

2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions.

3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, from within or outside this State or the United States.

4. To offer, undertake, attempt to do or hold oneself out as able to do any of the acts described in subsections 1 and 2.

Sec. 7. NRS 630.261 is hereby amended to read as follows:

630.261 1. Except as otherwise provided in NRS 630.161, the Board may issue:

(a) A locum tenens license, to be effective not more than 3 months after issuance, to any physician who is licensed and in good standing in another state, who meets the requirements for licensure in this State and who is of good moral character and reputation. The purpose of this license is to enable an eligible physician to serve as a substitute for another physician who is licensed to practice medicine in this State and who is absent from his or her practice for reasons deemed sufficient by the Board. A license issued pursuant to the provisions of this paragraph is not renewable.

(b) A special license to a licensed physician of another state to come into this State to care for or assist in the treatment of his or her own patient in association with a physician licensed in this State. A special license issued pursuant to the provisions of this paragraph is limited to the care of a specific patient. The physician licensed in this State has the primary responsibility for the care of that patient.

(c) A restricted license for a specified period if the Board determines the applicant needs supervision or restriction.

(d) A temporary license for a specified period if the physician is licensed and in good standing in another state and meets the requirements for licensure in this State, and if the Board determines that it is necessary in order to provide medical services for a community without adequate medical care. A temporary license issued pursuant to the provisions of this paragraph is not renewable.

(e) A special purpose license to a physician who is licensed in another state to perform any of the acts described in subsections 1 and 2 of NRS 630.020 by using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, from within or outside this



State or the United States. A physician who holds a special purpose license issued pursuant to this paragraph:

(1) Except as otherwise provided by specific statute or regulation, shall comply with the provisions of this chapter and the regulations of the Board; and

(2) To the extent not inconsistent with the Nevada Constitution or the United States Constitution, is subject to the jurisdiction of the courts of this State.

2. For the purpose of paragraph (e) of subsection 1, the physician must:

(a) Hold a full and unrestricted license to practice medicine in another state;

(b) Not have had any disciplinary or other action taken against him or her by any state or other jurisdiction; and

(c) Be certified by a specialty board of the American Board of Medical Specialties or its successor.

3. Except as otherwise provided in this section, the Board may renew or modify any license issued pursuant to subsection 1.

Sec. 8. NRS 630.275 is hereby amended to read as follows:

630.275 The Board shall adopt regulations regarding the licensure of a physician assistant, including, but not limited to:

1. The educational and other qualifications of applicants.

2. The required academic program for applicants.

3. The procedures for applications for and the issuance of licenses.

4. The tests or examinations of applicants by the Board.

5. The medical services which a physician assistant may perform, except that a physician assistant may not perform those specific functions and duties delegated or restricted by law to persons licensed as dentists, chiropractors, podiatric physicians and optometrists under chapters 631, 634, 635 and 636, respectively, of NRS, or as hearing aid specialists.

6. The duration, renewal and termination of licenses.

7. The grounds and procedures respecting disciplinary actions against physician assistants.

8. The supervision of medical services of a physician assistant by a supervising physician, including, without limitation, supervision that is performed electronically, telephonically or by fiber optics from within or outside this State or the United States.

9. A physician assistant's use of equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics , *including,*



without limitation, through telehealth, from within or outside this State or the United States.

Sec. 9. NRS 632.237 is hereby amended to read as follows:

632.237 1. The Board may issue a license to practice as an advanced practice registered nurse to a registered nurse who:

(a) Has completed an educational program designed to prepare a registered nurse to:

- (1) Perform designated acts of medical diagnosis;
- (2) Prescribe therapeutic or corrective measures; and
- (3) Prescribe controlled substances, poisons, dangerous drugs and devices;

(b) Except as otherwise provided in subsection 5, submits proof that he or she is certified as an advanced practice registered nurse by the American Board of Nursing Specialties, the National Commission for Certifying Agencies of the Institute for Credentialing Excellence, or their successor organizations, or any other nationally recognized certification agency approved by the Board; and

(c) Meets any other requirements established by the Board for such licensure.

2. An advanced practice registered nurse may:

(a) Engage in selected medical diagnosis and treatment; and

(b) If authorized pursuant to NRS 639.2351 and subject to the limitations set forth in subsection 3, prescribe controlled substances, poisons, dangerous drugs and devices.

↪ An advanced practice registered nurse shall not engage in any diagnosis, treatment or other conduct which the advanced practice registered nurse is not qualified to perform.

3. An advanced practice registered nurse who is authorized to prescribe controlled substances, poisons, dangerous drugs and devices pursuant to NRS 639.2351 shall not prescribe a controlled substance listed in schedule II unless:

(a) The advanced practice registered nurse has at least 2 years or 2,000 hours of clinical experience; or

(b) The controlled substance is prescribed pursuant to a protocol approved by a collaborating physician.

4. An advanced practice registered nurse may perform the acts described in subsection 2 by using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics , *including, without limitation, through telehealth, as defined in section 3 of this act*, from within or outside this State or the United States.

5. The Board shall adopt regulations:



(a) Specifying any additional training, education and experience necessary for licensure as an advanced practice registered nurse.

(b) Delineating the authorized scope of practice of an advanced practice registered nurse.

(c) Establishing the procedure for application for licensure as an advanced practice registered nurse.

6. The provisions of paragraph (b) of subsection 1 do not apply to an advanced practice registered nurse who obtains a license before July 1, 2014.

Sec. 10. NRS 633.511 is hereby amended to read as follows:

633.511 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony relating to the practice of osteopathic medicine or practice as a physician assistant;

(c) A violation of any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive;

(d) Murder, voluntary manslaughter or mayhem;

(e) Any felony involving the use of a firearm or other deadly weapon;

(f) Assault with intent to kill or to commit sexual assault or mayhem;

(g) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

(h) Abuse or neglect of a child or contributory delinquency; or

(i) Any offense involving moral turpitude.

3. The suspension of a license to practice osteopathic medicine or to practice as a physician assistant by any other jurisdiction.

4. Malpractice or gross malpractice, which may be evidenced by a claim of malpractice settled against a licensee.

5. Professional incompetence.

6. Failure to comply with the requirements of NRS 633.527.

7. Failure to comply with the requirements of subsection 3 of NRS 633.471.

8. Failure to comply with the provisions of NRS 633.694.

9. Operation of a medical facility, as defined in NRS 449.0151, at any time during which:

(a) The license of the facility is suspended or revoked; or



(b) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

➔ This subsection applies to an owner or other principal responsible for the operation of the facility.

10. Failure to comply with the provisions of subsection 2 of NRS 633.322.

11. Signing a blank prescription form.

12. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(a) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(b) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328; or

(c) Is marijuana being used for medical purposes in accordance with chapter 453A of NRS.

13. Attempting, directly or indirectly, by intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.

14. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

15. In addition to the provisions of subsection 3 of NRS 633.524, making or filing a report which the licensee knows to be false, failing to file a record or report that is required by law or willfully obstructing or inducing another to obstruct the making or filing of such a record or report.

16. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

17. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.

18. Engaging in any act that is unsafe in accordance with regulations adopted by the Board.



19. Failure to comply with the provisions of ~~NRS 633.165.~~ *section 3 of this act.*

20. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

Sec. 11. NRS 633.711 is hereby amended to read as follows:

633.711 1. The Board, through an officer of the Board or the Attorney General, may maintain in any court of competent jurisdiction a suit for an injunction against any person:

(a) Practicing osteopathic medicine or practicing as a physician assistant without a valid license to practice osteopathic medicine or to practice as a physician assistant; or

(b) ~~Engaging in telemedicine~~ *Providing services through telehealth, as defined in section 3 of this act,* without a valid license. ~~pursuant to NRS 633.165.~~

2. An injunction issued pursuant to subsection 1:

(a) May be issued without proof of actual damage sustained by any person, this provision being a preventive as well as a punitive measure.

(b) Must not relieve such person from criminal prosecution for practicing without such a license.

Sec. 12. Chapter 639 of NRS is hereby amended by adding thereto a new section to read as follows:

“Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 13. NRS 639.001 is hereby amended to read as follows:

639.001 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 639.0015 to 639.016, inclusive, *and section 12 of this act* have the meanings ascribed to them in those sections.

Sec. 14. NRS 639.0151 is hereby amended to read as follows:

639.0151 “Remote site” means:

1. A pharmacy staffed by a pharmaceutical technician and equipped to facilitate communicative access to a pharmacy and its registered pharmacists; or

2. An office of a dispensing practitioner that is staffed by a dispensing technician and equipped to facilitate communicative access to the dispensing practitioner,

↳ electronically, telephonically or by fiber optics , *including, without limitation, through telehealth,* during regular business hours from within or outside this State or the United States.



Sec. 15. NRS 639.0153 is hereby amended to read as follows:

639.0153 “Satellite consultation site” means a site that only dispenses filled prescriptions which are delivered to that site after the prescriptions are prepared:

1. At a pharmacy where a registered pharmacist provides consultation to patients; or

2. At an office of a dispensing practitioner where the dispensing practitioner provides consultation to patients,

→ electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, during regular business hours from within or outside this State or the United States.

Sec. 16. NRS 639.0154 is hereby amended to read as follows:

639.0154 “Telepharmacy” means:

1. A pharmacy; or

2. An office of a dispensing practitioner,

→ that is accessible by a remote site or a satellite consultation site electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, from within or outside this State or the United States.

Sec. 17. NRS 639.0727 is hereby amended to read as follows:

639.0727 The Board shall adopt regulations:

1. As are necessary for the safe and efficient operation of remote sites, satellite consultation sites and telepharmacies;

2. To define the terms “dispensing practitioner” and “dispensing technician,” to provide for the registration and discipline of dispensing practitioners and dispensing technicians, and to set forth the qualifications, powers and duties of dispensing practitioners and dispensing technicians;

3. To authorize registered pharmacists to engage in the practice of pharmacy electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, from within *or outside* this State; and

4. To authorize prescriptions to be filled and dispensed to patients as prescribed by practitioners electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, from within or outside this State or the United States.

Sec. 18. NRS 639.235 is hereby amended to read as follows:

639.235 1. No person other than a practitioner holding a license to practice his or her profession in this State may prescribe or write a prescription, except that a prescription written by a person who is not licensed to practice in this State, but is authorized by the laws of another state to prescribe, shall be deemed to be a legal



prescription unless the person prescribed or wrote the prescription in violation of the provisions of NRS 453.3611 to 453.3648, inclusive.

2. If a prescription that is prescribed by a person who is not licensed to practice in this State, but is authorized by the laws of another state to prescribe, calls for a controlled substance listed in:

(a) Schedule II, the registered pharmacist who is to fill the prescription shall establish and document that the prescription is authentic and that a bona fide relationship between the patient and the person prescribing the controlled substance did exist when the prescription was written.

(b) Schedule III or IV, the registered pharmacist who is to fill the prescription shall establish that the prescription is authentic and that a bona fide relationship between the patient and the person prescribing the controlled substance did exist when the prescription was written. This paragraph does not require the registered pharmacist to inquire into such a relationship upon the receipt of a similar prescription subsequently issued for that patient.

3. A pharmacist who fills a prescription described in subsection 2 shall record on the prescription or in the prescription record in the pharmacy's computer:

(a) The name of the person with whom the pharmacist spoke concerning the prescription;

(b) The date and time of the conversation; and

(c) The date and time the patient was examined by the person prescribing the controlled substance for which the prescription was issued.

4. For the purposes of subsection 2, a bona fide relationship between the patient and the person prescribing the controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics , *including, without limitation, through telehealth*, within or outside this State or the United States by the person prescribing the controlled substances within the 6 months immediately preceding the date the prescription was issued.

Sec. 19. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where



necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, and 689B.287 *and section 31 of this act* apply to coverage provided pursuant to this paragraph.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district,



municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, “legal services organization” means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 20. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.167, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, *and section 43 of this act* in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.



Sec. 21. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Director shall include in the State Plan for Medicaid:

(a) A requirement that the State, and, to the extent applicable, any of its political subdivisions, shall pay for the nonfederal share of expenses for services provided to a person through telehealth to the same extent as though provided in person or by other means; and

(b) A provision prohibiting the State from:

(1) Requiring a person to obtain prior authorization that would not be required if a service were provided in person or through other means, establish a relationship with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to paying for services as described in paragraph (a). The State Plan for Medicaid may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or through other means.

(2) Requiring a provider of health care to demonstrate that it is necessary to provide services to a person through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to paying for services as described in paragraph (a).

(3) Refusing to pay for services as described in paragraph (a) because of the distant site from which a provider of health care provides services through telehealth or the originating site at which a person who is covered by the State Plan for Medicaid receives services through telehealth.

(4) Requiring services to be provided through telehealth as a condition to paying for such services.

2. The provisions of this section do not:

(a) Require the Director to include in the State Plan for Medicaid coverage of any service that the Director is not otherwise required by law to include; or

(b) Require the State or any political subdivision thereof to:

(1) Ensure that covered services are available to a recipient of Medicaid through telehealth at a particular originating site; or

(2) Provide coverage for a service that is not included in the State Plan for Medicaid or provided by a provider of health care that does not participate in Medicaid.

3. As used in this section:

(a) "Distant site" has the meaning ascribed to it in section 3 of this act.



(b) "Originating site" has the meaning ascribed to it in section 3 of this act.

(c) "Provider of health care" has the meaning ascribed to it in NRS 439.820.

(d) "Telehealth" has the meaning ascribed to it in section 3 of this act.

Sec. 22. Chapter 449 of NRS is hereby amended by adding thereto a new section to read as follows:

A hospital may grant staff privileges to a provider of health care who is at another location for the purpose of providing services through telehealth, as defined in section 3 of this act, to patients at the hospital in the manner prescribed in 42 C.F.R. §§ 482.12, 482.22 and 485.616.

Sec. 23. NRS 449.0302 is hereby amended to read as follows:

449.0302 1. The Board shall adopt:

(a) Licensing standards for each class of medical facility or facility for the dependent covered by NRS 449.030 to 449.2428, inclusive, *and section 22 of this act* and for programs of hospice care.

(b) Regulations governing the licensing of such facilities and programs.

(c) Regulations governing the procedure and standards for granting an extension of the time for which a natural person may provide certain care in his or her home without being considered a residential facility for groups pursuant to NRS 449.017. The regulations must require that such grants are effective only if made in writing.

(d) Regulations establishing a procedure for the indemnification by the Division, from the amount of any surety bond or other obligation filed or deposited by a facility for refractive surgery pursuant to NRS 449.068 or 449.069, of a patient of the facility who has sustained any damages as a result of the bankruptcy of or any breach of contract by the facility.

(e) Any other regulations as it deems necessary or convenient to carry out the provisions of NRS 449.030 to 449.2428, inclusive ~~†~~, *and section 22 of this act.*

2. The Board shall adopt separate regulations governing the licensing and operation of:

(a) Facilities for the care of adults during the day; and

(b) Residential facilities for groups,

↳ which provide care to persons with Alzheimer's disease.

3. The Board shall adopt separate regulations for:



(a) The licensure of rural hospitals which take into consideration the unique problems of operating such a facility in a rural area.

(b) The licensure of facilities for refractive surgery which take into consideration the unique factors of operating such a facility.

(c) The licensure of mobile units which take into consideration the unique factors of operating a facility that is not in a fixed location.

4. The Board shall require that the practices and policies of each medical facility or facility for the dependent provide adequately for the protection of the health, safety and physical, moral and mental well-being of each person accommodated in the facility.

5. In addition to the training requirements prescribed pursuant to NRS 449.093, the Board shall establish minimum qualifications for administrators and employees of residential facilities for groups. In establishing the qualifications, the Board shall consider the related standards set by nationally recognized organizations which accredit such facilities.

6. The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 and 454.213 to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. The regulations must require at least the following conditions before such assistance may be given:

(a) The ultimate user's physical and mental condition is stable and is following a predictable course.

(b) The amount of the medication prescribed is at a maintenance level and does not require a daily assessment.

(c) A written plan of care by a physician or registered nurse has been established that:

(1) Addresses possession and assistance in the administration of the medication; and

(2) Includes a plan, which has been prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention if an adverse condition results.

(d) The prescribed medication is not administered by injection or intravenously.

(e) The employee has successfully completed training and examination approved by the Division regarding the authorized manner of assistance.

7. The Board shall adopt separate regulations governing the licensing and operation of residential facilities for groups which provide assisted living services. The Board shall not allow the



licensing of a facility as a residential facility for groups which provides assisted living services and a residential facility for groups shall not claim that it provides “assisted living services” unless:

(a) Before authorizing a person to move into the facility, the facility makes a full written disclosure to the person regarding what services of personalized care will be available to the person and the amount that will be charged for those services throughout the resident’s stay at the facility.

(b) The residents of the facility reside in their own living units which:

(1) Except as otherwise provided in subsection 8, contain toilet facilities;

(2) Contain a sleeping area or bedroom; and

(3) Are shared with another occupant only upon consent of both occupants.

(c) The facility provides personalized care to the residents of the facility and the general approach to operating the facility incorporates these core principles:

(1) The facility is designed to create a residential environment that actively supports and promotes each resident’s quality of life and right to privacy;

(2) The facility is committed to offering high-quality supportive services that are developed by the facility in collaboration with the resident to meet the resident’s individual needs;

(3) The facility provides a variety of creative and innovative services that emphasize the particular needs of each individual resident and the resident’s personal choice of lifestyle;

(4) The operation of the facility and its interaction with its residents supports, to the maximum extent possible, each resident’s need for autonomy and the right to make decisions regarding his or her own life;

(5) The operation of the facility is designed to foster a social climate that allows the resident to develop and maintain personal relationships with fellow residents and with persons in the general community;

(6) The facility is designed to minimize and is operated in a manner which minimizes the need for its residents to move out of the facility as their respective physical and mental conditions change over time; and

(7) The facility is operated in such a manner as to foster a culture that provides a high-quality environment for the residents, their families, the staff, any volunteers and the community at large.



8. The Division may grant an exception from the requirement of subparagraph (1) of paragraph (b) of subsection 7 to a facility which is licensed as a residential facility for groups on or before July 1, 2005, and which is authorized to have 10 or fewer beds and was originally constructed as a single-family dwelling if the Division finds that:

(a) Strict application of that requirement would result in economic hardship to the facility requesting the exception; and

(b) The exception, if granted, would not:

(1) Cause substantial detriment to the health or welfare of any resident of the facility;

(2) Result in more than two residents sharing a toilet facility; or

(3) Otherwise impair substantially the purpose of that requirement.

9. The Board shall, if it determines necessary, adopt regulations and requirements to ensure that each residential facility for groups and its staff are prepared to respond to an emergency, including, without limitation:

(a) The adoption of plans to respond to a natural disaster and other types of emergency situations, including, without limitation, an emergency involving fire;

(b) The adoption of plans to provide for the evacuation of a residential facility for groups in an emergency, including, without limitation, plans to ensure that nonambulatory patients may be evacuated;

(c) Educating the residents of residential facilities for groups concerning the plans adopted pursuant to paragraphs (a) and (b); and

(d) Posting the plans or a summary of the plans adopted pursuant to paragraphs (a) and (b) in a conspicuous place in each residential facility for groups.

10. The regulations governing the licensing and operation of facilities for transitional living for released offenders must provide for the licensure of at least three different types of facilities, including, without limitation:

(a) Facilities that only provide a housing and living environment;

(b) Facilities that provide or arrange for the provision of supportive services for residents of the facility to assist the residents with reintegration into the community, in addition to providing a housing and living environment; and

(c) Facilities that provide or arrange for the provision of alcohol and drug abuse programs, in addition to providing a housing and



living environment and providing or arranging for the provision of other supportive services.

➡ The regulations must provide that if a facility was originally constructed as a single-family dwelling, the facility must not be authorized for more than eight beds.

11. As used in this section, “living unit” means an individual private accommodation designated for a resident within the facility.

Sec. 24. NRS 449.0306 is hereby amended to read as follows:

449.0306 1. Money received from licensing medical facilities and facilities for the dependent must be forwarded to the State Treasurer for deposit in the State General Fund.

2. The Division shall enforce the provisions of NRS 449.030 to 449.245, inclusive, *and section 22 of this act* and may incur any necessary expenses not in excess of money appropriated for that purpose by the State or received from the Federal Government.

Sec. 25. NRS 449.160 is hereby amended to read as follows:

449.160 1. The Division may deny an application for a license or may suspend or revoke any license issued under the provisions of NRS 449.030 to 449.2428, inclusive, *and section 22 of this act* upon any of the following grounds:

(a) Violation by the applicant or the licensee of any of the provisions of NRS 439B.410 or 449.030 to 449.245, inclusive, *and section 22 of this act*, or of any other law of this State or of the standards, rules and regulations adopted thereunder.

(b) Aiding, abetting or permitting the commission of any illegal act.

(c) Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a license is issued.

(d) Conduct or practice detrimental to the health or safety of the occupants or employees of the facility.

(e) Failure of the applicant to obtain written approval from the Director of the Department of Health and Human Services as required by NRS 439A.100 or as provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive, *and section 22 of this act*, and 449.435 to 449.965, inclusive, if such approval is required.

(f) Failure to comply with the provisions of NRS 449.2486.

2. In addition to the provisions of subsection 1, the Division may revoke a license to operate a facility for the dependent if, with respect to that facility, the licensee that operates the facility, or an agent or employee of the licensee:



(a) Is convicted of violating any of the provisions of NRS 202.470;

(b) Is ordered to but fails to abate a nuisance pursuant to NRS 244.360, 244.3603 or 268.4124; or

(c) Is ordered by the appropriate governmental agency to correct a violation of a building, safety or health code or regulation but fails to correct the violation.

3. The Division shall maintain a log of any complaints that it receives relating to activities for which the Division may revoke the license to operate a facility for the dependent pursuant to subsection 2. The Division shall provide to a facility for the care of adults during the day:

(a) A summary of a complaint against the facility if the investigation of the complaint by the Division either substantiates the complaint or is inconclusive;

(b) A report of any investigation conducted with respect to the complaint; and

(c) A report of any disciplinary action taken against the facility.

➔ The facility shall make the information available to the public pursuant to NRS 449.2486.

4. On or before February 1 of each odd-numbered year, the Division shall submit to the Director of the Legislative Counsel Bureau a written report setting forth, for the previous biennium:

(a) Any complaints included in the log maintained by the Division pursuant to subsection 3; and

(b) Any disciplinary actions taken by the Division pursuant to subsection 2.

Sec. 26. NRS 449.220 is hereby amended to read as follows:

449.220 1. The Division may bring an action in the name of the State to enjoin any person, state or local government unit or agency thereof from operating or maintaining any facility within the meaning of NRS 449.030 to 449.2428, inclusive ~~H~~, *and section 22 of this act:*

(a) Without first obtaining a license therefor; or

(b) After his or her license has been revoked or suspended by the Division.

2. It is sufficient in such action to allege that the defendant did, on a certain date and in a certain place, operate and maintain such a facility without a license.

Sec. 27. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Every policy of insurance issued pursuant to chapters 616A to 617, inclusive, of NRS must include coverage for services



provided to an employee through telehealth to the same extent as though provided in person or by other means.

2. An insurer shall not:

(a) Require an employee to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an employee through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an employee receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A policy of insurance issued pursuant to chapters 616A to 617, inclusive, of NRS must not require an employee to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a policy of insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an employee through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.

5. A policy of insurance subject to the provisions of chapters 616A to 617, inclusive, of NRS that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in section 3 of this act.



(b) “Originating site” has the meaning ascribed to it in section 3 of this act.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 28. NRS 687B.490 is hereby amended to read as follows:

687B.490 1. A carrier that offers coverage in the group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the



protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. *When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider services that may be provided through telehealth, as defined in section 3 of this act, pursuant to the network plan or proposed network plan to be available services.*

8. As used in this section, “network plan” has the meaning ascribed to it in NRS 689B.570.

Sec. 29. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. *A policy of health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.*

2. *An insurer shall not:*

(a) *Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;*

(b) *Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;*

(c) *Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or*

(d) *Require covered services to be provided through telehealth as a condition to providing coverage for such services.*

3. *A policy of health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A policy of health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.*



4. *The provisions of this section do not require an insurer to:*
(a) *Ensure that covered services are available to an insured through telehealth at a particular originating site;*

(b) *Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or*

(c) *Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.*

5. *A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.*

6. *As used in this section:*

(a) *“Distant site” has the meaning ascribed to it in section 3 of this act.*

(b) *“Originating site” has the meaning ascribed to it in section 3 of this act.*

(c) *“Provider of health care” has the meaning ascribed to it in NRS 439.820.*

(d) *“Telehealth” has the meaning ascribed to it in section 3 of this act.*

Sec. 30. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive **H**, and *section 29 of this act.*

Sec. 31. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. *A policy of group or blanket health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.*

2. *An insurer shall not:*

(a) *Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;*

(b) *Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide*



services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A policy of group or blanket health insurance must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for that service when provided in person. A policy of group or blanket health insurance may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require an insurer to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the insurer is not otherwise required by law to do so.

5. A policy of group or blanket health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) "Distant site" has the meaning ascribed to it in section 3 of this act.

(b) "Originating site" has the meaning ascribed to it in section 3 of this act.

(c) "Provider of health care" has the meaning ascribed to it in NRS 439.820.

(d) "Telehealth" has the meaning ascribed to it in section 3 of this act.

Sec. 32. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.



2. *A carrier shall not:*

(a) *Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;*

(b) *Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;*

(c) *Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or*

(d) *Require covered services to be provided through telehealth as a condition to providing coverage for such services.*

3. *A health benefit plan must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A health benefit plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.*

4. *The provisions of this section do not require a carrier to:*

(a) *Ensure that covered services are available to an insured through telehealth at a particular originating site;*

(b) *Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or*

(c) *Enter into a contract with any provider of health care or cover any service if the carrier is not otherwise required by law to do so.*

5. *A plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.*

6. *As used in this section:*

(a) *“Distant site” has the meaning ascribed to it in section 3 of this act.*

(b) *“Originating site” has the meaning ascribed to it in section 3 of this act.*

(c) *“Provider of health care” has the meaning ascribed to it in NRS 439.820.*



(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 33. NRS 689C.155 is hereby amended to read as follows:

689C.155 The Commissioner may adopt regulations to carry out the provisions of NRS 689C.109 to 689C.143, inclusive, 689C.156 to 689C.159, inclusive, 689C.165, 689C.183, 689C.187, 689C.191 to 689C.198, inclusive, ***and section 32 of this act,*** 689C.203, 689C.207, 689C.265, 689C.325, 689C.355 and 689C.610 to 689C.940, inclusive, and to ensure that rating practices used by carriers serving small employers are consistent with those sections, including regulations that:

1. Ensure that differences in rates charged for health benefit plans by such carriers are reasonable and reflect only differences in the designs of the plans, the terms of the coverage, the amount contributed by the employers to the cost of coverage and differences based on the rating factors established by the carrier.

2. Prescribe the manner in which rating factors may be used by such carriers.

Sec. 34. NRS 689C.156 is hereby amended to read as follows:

689C.156 1. As a condition of transacting business in this State with small employers, a carrier shall actively market to a small employer each health benefit plan which is actively marketed in this State by the carrier to any small employer in this State. A carrier shall be deemed to be actively marketing a health benefit plan when it makes available any of its plans to a small employer that is not currently receiving coverage under a health benefit plan issued by that carrier.

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, ***and section 32 of this act,*** and 689C.610 to 689C.940, inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

3. If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, the carrier shall provide a system for resolving any complaints of an employee concerning those health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.



Sec. 35. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, *and section 32 of this act* to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 36. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A benefit contract must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

2. A society shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A benefit contract must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A benefit contract may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require a society to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the society is not otherwise required by law to do so.



5. *A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.*

6. *As used in this section:*

(a) *“Distant site” has the meaning ascribed to it in section 3 of this act.*

(b) *“Originating site” has the meaning ascribed to it in section 3 of this act.*

(c) *“Provider of health care” has the meaning ascribed to it in NRS 439.820.*

(d) *“Telehealth” has the meaning ascribed to it in section 3 of this act.*

Sec. 37. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. *A contract for hospital, medical or dental services subject to the provisions of this chapter must include services provided to an insured through telehealth to the same extent as though provided in person or by other means.*

2. *A medical services corporation that issues contracts for hospital, medical or dental services shall not:*

(a) *Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;*

(b) *Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;*

(c) *Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or*

(d) *Require covered services to be provided through telehealth as a condition to providing coverage for such services.*

3. *A contract for hospital, medical or dental services must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A contract for hospital, medical or dental services may require prior authorization for a service*



provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require a medical services corporation that issues contracts for hospital, medical or dental services to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the medical services corporation is not otherwise required by law to do so.

5. A contract for hospital, medical or dental services subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in section 3 of this act.

(b) “Originating site” has the meaning ascribed to it in section 3 of this act.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 38. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan of a health maintenance organization must include coverage for services provided to an enrollee through telehealth to the same extent as though provided in person or by other means.

2. A health maintenance organization shall not:

(a) Require an enrollee to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an enrollee through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;



(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an enrollee receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A health care plan of a health maintenance organization must not require an enrollee to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require a health maintenance organization to:

(a) Ensure that covered services are available to an enrollee through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the health maintenance organization is not otherwise required by law to do so.

5. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in section 3 of this act.

(b) “Originating site” has the meaning ascribed to it in section 3 of this act.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 39. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title



except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170 to 695C.173, inclusive, 695C.1733 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 *and section 38 of this act* apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 40. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, *and section 38 of this act* or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;



(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further



operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 41. Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:

1. A plan for dental care must include coverage for services provided to a member through telehealth to the same extent as though provided in person or by other means.

2. An organization for dental care shall not:

(a) Require a member to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to a member through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which a member receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A plan for dental care must not require a member to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. A plan for dental care may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require an organization for dental care to:

(a) Ensure that covered services are available to a member through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the organization for dental care is not otherwise required by law to do so.

5. A plan for dental care subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage



required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) “Distant site” has the meaning ascribed to it in section 3 of this act.

(b) “Originating site” has the meaning ascribed to it in section 3 of this act.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 42. NRS 695F.090 is hereby amended to read as follows:

695F.090 Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

1. NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

2. NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

3. The requirements of NRS 679B.152.

4. The fees imposed pursuant to NRS 449.465.

5. NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

6. The assessment imposed pursuant to NRS 679B.700.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS 689A.035, 689A.410, 689A.413 and 689A.415 **H** *and section 29 of this act.*

10. NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to “insurer” must be replaced by a reference to “prepaid limited health service organization.”

11. Chapter 692C of NRS, concerning holding companies.

12. NRS 689A.637, concerning health centers.

Sec. 43. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to



an insured through telehealth to the same extent as though provided in person or by other means.

2. A managed care organization shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;

(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or

(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

3. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. The provisions of this section do not require a managed care organization to:

(a) Ensure that covered services are available to an insured through telehealth at a particular originating site;

(b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or

(c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.

5. Evidence of coverage that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

6. As used in this section:

(a) "Distant site" has the meaning ascribed to it in section 3 of this act.



(b) “Originating site” has the meaning ascribed to it in section 3 of this act.

(c) “Provider of health care” has the meaning ascribed to it in NRS 439.820.

(d) “Telehealth” has the meaning ascribed to it in section 3 of this act.

Sec. 44. NRS 633.165 is hereby repealed.

Sec. 45. This act becomes effective on July 1, 2015.



