SENATE BILL NO. 56–COMMITTEE ON COMMERCE AND LABOR

(ON BEHALF OF THE CLARK REGIONAL BEHAVIORAL HEALTH POLICY BOARD)

PREFILED NOVEMBER 18, 2020

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing insurance coverage of behavioral health services. (BDR 57-124)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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

AN ACT relating to insurance; imposing certain requirements governing coverage of behavioral health services; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law defines the term "telehealth" to mean 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. (NRS 629.515) Existing law imposes certain requirements concerning coverage of telehealth services by insurers and certain other third-party payers. Those requirements: (1) include a requirement that an insurer or other third-party payer must cover services provided through telehealth to the same extent as if provided in person or by other means; and (2) apply to health coverage, including Medicaid and health plans for state and local government employees, and workers' compensation coverage. (NRS 287.010, 287.04335, 422.2721, 616C.730, 689A.0463, 689B.0369, 689C.195, 695A.265, 695B.1904, 695C.1708, 695F.090, 695G.162) **Sections 1-5.3 and 6.6** of this bill extend those requirements, as they apply to health insurers other than Medicaid, to also apply to behavioral health services provided by standard telephone. **Sections 1-5.3 and 6.6** require such health insurers to cover behavioral health services provided by standard telephone in the same amount as if those services were provided in person or by other means.

Section 8 of this bill requires the Director of the Department of Health and Human Services to: (1) apply for any waiver of federal law necessary to receive federal financial participation to include in Medicaid coverage for behavioral health services provided by standard telephone; and (2) include such coverage in Medicaid if a waiver is obtained or federal financial participation is otherwise available. **Sections 5.3, 5.6, 6.3 and 6.6** of this bill require Medicaid managed care plans to

provide such coverage if federal financial participation is obtained pursuant to **section 8**.

Additionally, **sections 1-5, 6, 7 and 8** of this bill prohibit a health insurer, including Medicaid, from issuing coverage of behavioral health services provided in a person's home that depends on the geographic location of the home.

Section 6.3 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of authority of a health maintenance organization that fails to comply with the requirement in **section 5.3** to provide coverage for behavioral health services provided by standard telephone to the same extent and in the same amount as if those services were provided in person or by other means. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of this bill. (NRS 680A.200)

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

Section 1. NRS 689A.0463 is hereby amended to read as follows:

689A.0463 1. A policy of health insurance must include coverage for ***:***

(a) Behavioral health services provided to an insured through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means; and

(b) Other 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 ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to ~~[demonstrate]~~ ***:***

(1) Demonstrate that it is necessary to provide ***behavioral health services to an insured through telehealth or by standard telephone or other*** services to an insured through telehealth ***as a condition to providing the coverage described in subsection 1;*** or ~~[receive]~~

(2) Receive any additional type of certification or license to provide ***behavioral health services through telehealth or by standard telephone or other*** 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]~~ ***:***

(1) The distant site from which a provider of health care provides ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth ***;*** or ~~[the]~~

(2) The originating site at which an insured receives ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth; or

(d) Require ***covered behavioral health services to be provided through telehealth or by standard telephone or require other*** 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 ***behavioral health service provided through telehealth or by standard telephone or any other*** 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 ***behavioral health service provided through telehealth or by standard telephone or another*** service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. ***If a policy of health insurance includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

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

(a) Ensure that covered services are available to an insured through telehealth ***or by standard telephone*** 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.]~~ ***6.*** 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,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 2. NRS 689B.0369 is hereby amended to read as follows:

689B.0369 1. A policy of group or blanket health insurance must include coverage for ***:***

(a) Behavioral health services provided to an insured through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means; and

(b) Other 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 ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to ~~[demonstrate]~~ ***:***

(1) Demonstrate that it is necessary to provide ***behavioral health services to an insured through telehealth or by standard telephone or other*** services to an insured through telehealth ***as a condition to providing the coverage described in subsection 1;*** or ~~[receive]~~

(2) Receive any additional type of certification or license to provide ***behavioral health services through telehealth or by standard telephone or other*** 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]~~ ***:***

(1) The distant site from which a provider of health care provides ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth ***;*** or ~~[the]~~

(2) The originating site at which an insured receives ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth; or

(d) Require ***covered behavioral health services to be provided through telehealth or by standard telephone or require other*** 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 ***behavioral health service provided through telehealth or by standard telephone or any other*** 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 ***behavioral health service provided through telehealth or by standard telephone or another*** service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. ***If a policy of group or blanket health insurance includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

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

(a) Ensure that covered services are available to an insured through telehealth ***or by standard telephone*** 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.]~~ ***6.*** 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,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 3. NRS 689C.195 is hereby amended to read as follows:

689C.195 1. A health benefit plan must include coverage for ***:***

(a) Behavioral health services provided to an insured through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means; and

(b) Other 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 ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to ~~[demonstrate]~~ ***:***

(1) Demonstrate that it is necessary to provide ***behavioral health services to an insured through telehealth or by standard telephone or other*** services to an insured through telehealth ***as a condition to providing the coverage described in subsection 1;*** or ~~[receive]~~

(2) Receive any additional type of certification or license to provide ***behavioral health services through telehealth or by standard telephone or other*** 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]~~ ***:***

(1) The distant site from which a provider of health care provides ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth ***;*** or ~~[the]~~

(2) The originating site at which an insured receives ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth; or

(d) Require ***covered behavioral health services to be provided through telehealth or by standard telephone or require other*** 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 ***behavioral health service provided through telehealth or by standard telephone or any other*** 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 ***behavioral health service provided through telehealth or by standard telephone or another*** service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. ***If a health benefit plan includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

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

(a) Ensure that covered services are available to an insured through telehealth ***or by standard telephone*** 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.]~~ ***6.*** A plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, ~~[2015,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 4. NRS 695A.265 is hereby amended to read as follows:

695A.265 1. A benefit contract must include coverage for ***:***

(a) Behavioral health services provided to an insured through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means; and

(b) Other 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 ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to ~~[demonstrate]~~ ***:***

(1) Demonstrate that it is necessary to provide ***behavioral health services to an insured through telehealth or by standard telephone or other*** services to an insured through telehealth ***as a condition to providing the coverage described in subsection 1;*** or ~~[receive]~~

(2) Receive any additional type of certification or license to provide ***behavioral health services through telehealth or by standard telephone or other*** 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]~~ ***:***

(1) The distant site from which a provider of health care provides ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth ***;*** or ~~[the]~~

(2) The originating site at which an insured receives ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth; or

(d) Require ***covered behavioral health services to be provided through telehealth or by standard telephone or require other*** 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 ***behavioral health service provided through telehealth or by standard telephone or any other*** service provided through telehealth that is not required for the service when provided in person. A benefit contract may require prior authorization for a ***behavioral health service provided through telehealth or by standard telephone or another*** service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. ***If a benefit contract includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

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

(a) Ensure that covered services are available to an insured through telehealth ***or by standard telephone*** 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.]~~ ***6.*** A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, ~~[2015,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 5. NRS 695B.1904 is hereby amended to read as follows:

695B.1904 1. A contract for hospital, medical or dental services subject to the provisions of this chapter must include ***coverage for:***

(a) Behavioral health services provided to an insured through telehealth or by standard telephone to the same extent and in the same amount as though provided in person or by other means; and

(b) Other 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 ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth as a condition to providing the coverage described in subsection 1;

(b) Require a provider of health care to ~~[demonstrate]~~ ***:***

(1) Demonstrate that it is necessary to provide ***behavioral health services to an insured through telehealth or by standard telephone or other*** services to an insured through telehealth ***as a condition to providing the coverage described in subsection 1;*** or ~~[receive]~~

(2) Receive any additional type of certification or license to provide ***behavioral health services through telehealth or by standard telephone or other*** 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]~~ ***:***

(1) The distant site from which a provider of health care provides ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth ***;*** or ~~[the]~~

(2) The originating site at which an insured receives ***behavioral health services through telehealth or by standard telephone or other*** services through telehealth; or

(d) Require ***covered behavioral health services to be provided through telehealth or by standard telephone or require other*** 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 ***behavioral health service provided through telehealth or by standard telephone or any other*** 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 ***behavioral health service provided through telehealth or by standard telephone or another*** service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.

4. ***If a contract for hospital, medical or dental services includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

5. 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 ***or by standard telephone*** 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.]~~ ***6.*** 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,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 5.3. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a health care plan of a health maintenance organization must include coverage for behavioral health services provided to an enrollee by standard telephone to the same extent and in the same amount as though provided in person, through telehealth or by other means.

2. Coverage of behavioral health services provided pursuant to this section is subject to the provisions of NRS 695C.1708 to the same extent as if those behavioral health services were provided by telehealth.

3. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, 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.

4. A health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services is only required to comply with the provisions of this section with regard to those health care services to the extent that federal financial participation to include such coverage in the State Plan for Medicaid is available pursuant to subsection 2 of NRS 422.2721.

5. As used in this section:

(a) "Behavioral health services" has the meaning ascribed to it in NRS 422.2721.

(b) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 5.6. 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, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 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 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and 695C.1757 ***and, to the extent provided in that section, section 5.3 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. 6. NRS 695C.1708 is hereby amended to read as follows:

695C.1708 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. ***If a health care plan of a health maintenance organization includes coverage for behavioral health services provided in the home of an enrollee, such coverage must not depend on the geographic location at which the home is located.***

5. 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.]~~ ***6.*** Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, ~~[2015,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 6.3. 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 5.3 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 or creditors or to the general public;

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

1. Except as otherwise provided in subsection 4, a health care plan issued by a managed care organization must include coverage for behavioral health services provided to an insured by standard telephone to the same extent and in the same amount as though provided in person, through telehealth or by other means.

2. Coverage of behavioral health services provided pursuant to this section is subject to the provisions of NRS 695G.162 to the same extent as if those behavioral health services were provided by telehealth.

3. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2021, 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.

4. A managed care organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services is only required to comply with the provisions of this section with regard to those health care services to the extent that federal financial participation to include such coverage in the State Plan for Medicaid is available pursuant to subsection 2 of NRS 422.2721.

5. As used in this section:

(a) "Behavioral health services" has the meaning ascribed to it in NRS 422.2721.

(b) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 7. NRS 695G.162 is hereby amended to read as follows:

695G.162 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. ***If a health care plan of a managed care organization includes coverage for behavioral health services provided in the home of an insured, such coverage must not depend on the geographic location at which the home is located.***

5. 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.]~~ ***6.*** Evidence of coverage that is delivered, issued for delivery or renewed on or after July 1, ~~[2015,]~~ ***2021,*** 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.]~~ ***7.*** As used in this section:

(a) ***"Behavioral health services" has the meaning ascribed to it in NRS 422.2721.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 8. NRS 422.2721 is hereby amended to read as follows:

422.2721 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 Director shall apply to the Secretary of Health and Human Services for any waiver of federal law necessary to receive federal financial participation to include in the State Plan for Medicaid coverage of behavioral health services provided to a person by standard telephone. If such a waiver is granted or federal financial participation for such coverage is otherwise available under federal law:***

(a) The Director must include such coverage in the State Plan for Medicaid; and

(b) To the extent authorized by the terms of the waiver or federal law, that coverage is subject to the provisions of this

section to the same extent as behavioral health services provided to a person through telehealth.

3. If the State Plan for Medicaid includes a requirement that the State, and, to the extent applicable, any of its political subdivisions, must pay for the nonfederal share of expenses for behavioral health services provided in the home of a person, such payment must not depend on the geographic location at which the home is located.

4. 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 ***or by audio-only technology*** 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.]~~ ***5.*** As used in this section:

(a) ***"Behavioral health services" means services for the evaluation, management or treatment of a mental health condition or an alcohol or other substance use disorder.***

(b) "Distant site" has the meaning ascribed to it in NRS 629.515.

~~[(b)]~~ ***(c)*** "Originating site" has the meaning ascribed to it in NRS 629.515.

~~[(c)]~~ ***(d)*** "Provider of health care" has the meaning ascribed to it in NRS 439.820.

~~[(d)]~~ ***(e)*** "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 9. (Deleted by amendment.)

Sec. 10. This act becomes effective on July 1, 2021.

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