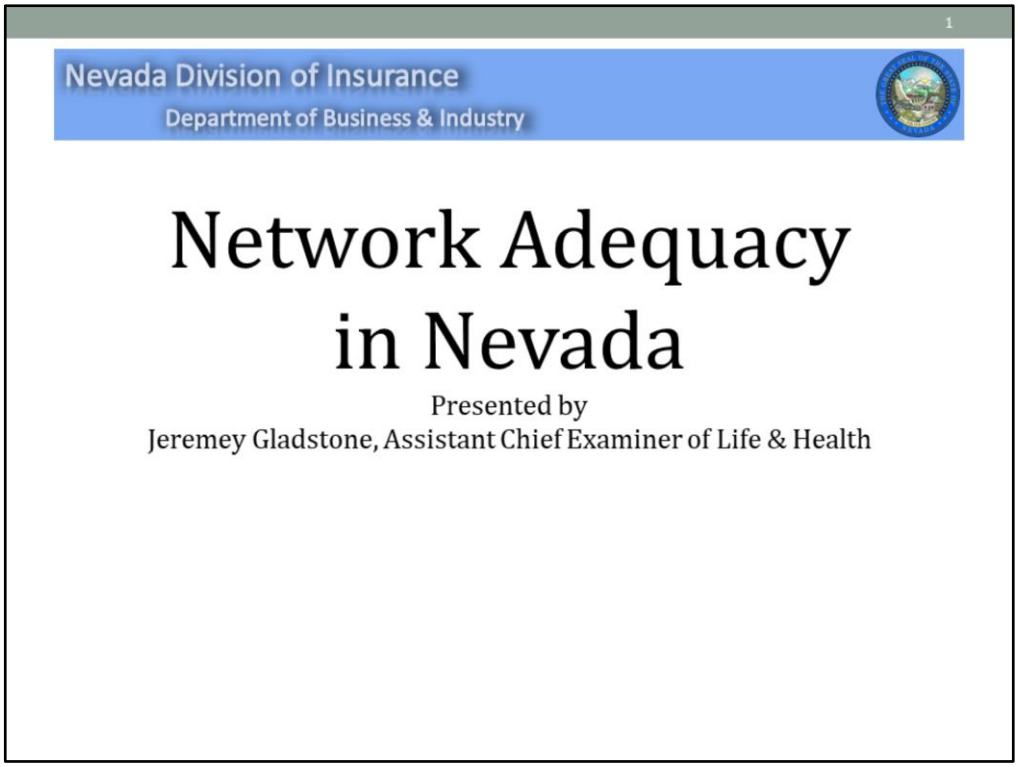
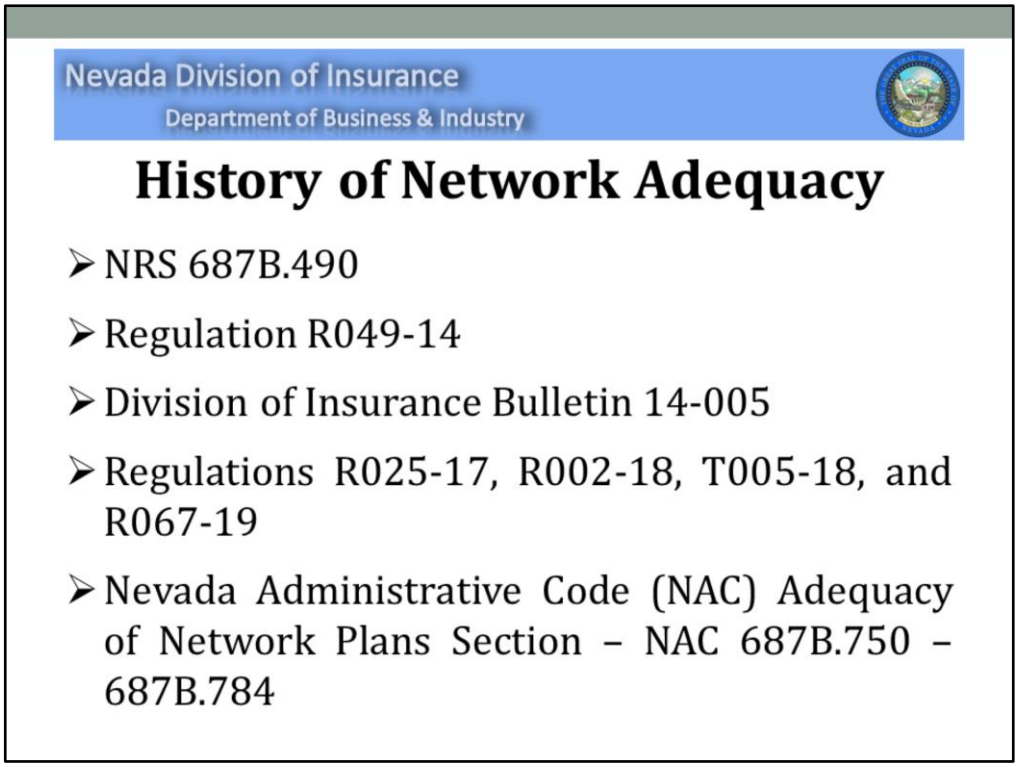
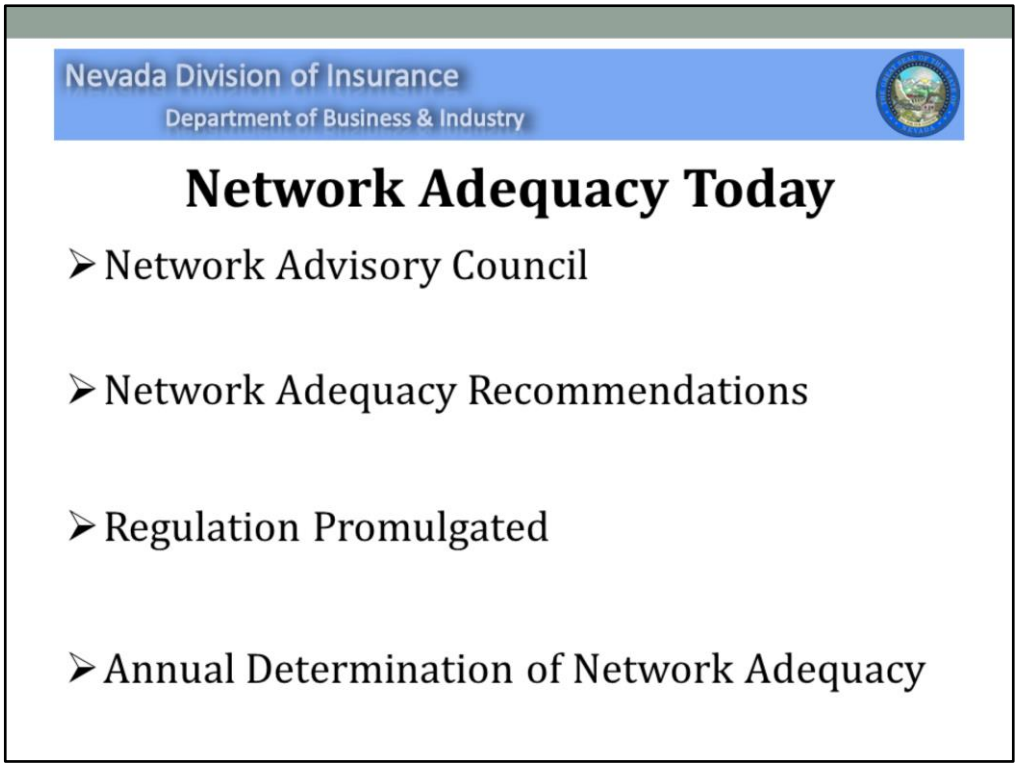


The following presentation provides a look at network adequacy in Nevada and reviews the various components which influence, impact, or dictate how network adequacy is defined in the state of Nevada. While the presentation attempts to take into consideration network adequacy for all health plans in use in Nevada, most of the exhibits and information provided are specific to those plans regulated by the Nevada Division of Insurance (Division). The presentation provides a historical background of network adequacy from the Divisions perspective, a look at the current standards and methodologies used to determine network adequacy, and provides some insights and talking points that have been brought up over the years in the Network Adequacy Advisory Council.

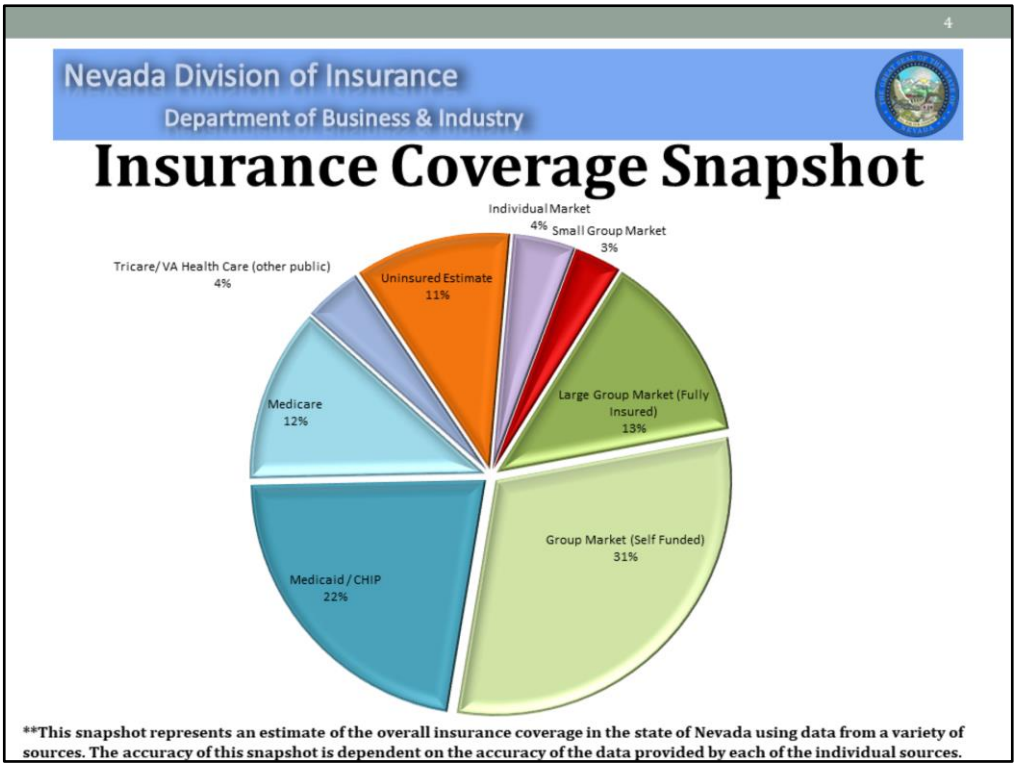
While you review the information included in this presentation I encourage you to ponder what it means for a health plan's network to be adequate. Most definitions of network adequacy characterize it as a networks ability to provide reasonable access to sufficient in-network providers and facilities to ensure care without unreasonable delay. As many of you are probably aware, the debate as to how this definition translates into quantifiable metrics or standards to ensure the adequacy of a network is still very much alive at both the state and federal level and to date a consensus has yet to be found.



The statute requiring the Commissioner of Insurance to determine the adequacy of a health plan's network was adopted during Nevada's 2013 Legislative Session (NRS 687B.490). R049-14 was designed to clarify and interpret the provisions of NRS 687B.490. The regulation was a complicated piece to put together due to the challenges of defining network adequacy. After much deliberation, revisions, and compromise the regulation was adopted on April 4, 2016. During the adoption process of R049-14 the Division of Insurance issued Bulletin 14-005 to establish standards for the 2015 plan year. These standards were transitional until the regulation could be adopted and were the standards for both plan years 2015 and 2016. The review of network adequacy would be done outside normal rate review and plan certification during these years. The process was very involved and timely. In order to comply with the standards under the Affordable Care Act, as well as NRS 687B.490, the Division incorporated the network adequacy review for plan year 2017 and beyond into the rate review and plan certification process which typically begins around May or June and determinations are made by August of September of that same year. Initially, network adequacy standards and adequacy determination depended on the standards provided by the Centers for Medicare and Medicaid Services (CMS) for plans sold in the Federally-Facilitated Marketplace (FFM), however, over the years the Commissioner has adopted several regulations based on the recommendations of the Network Adequacy Advisory Council which have incorporated the original standards set by CMS and added additional state specific standards to the Adequacy of Network Plans section of the Nevada Administrative Code (NAC).

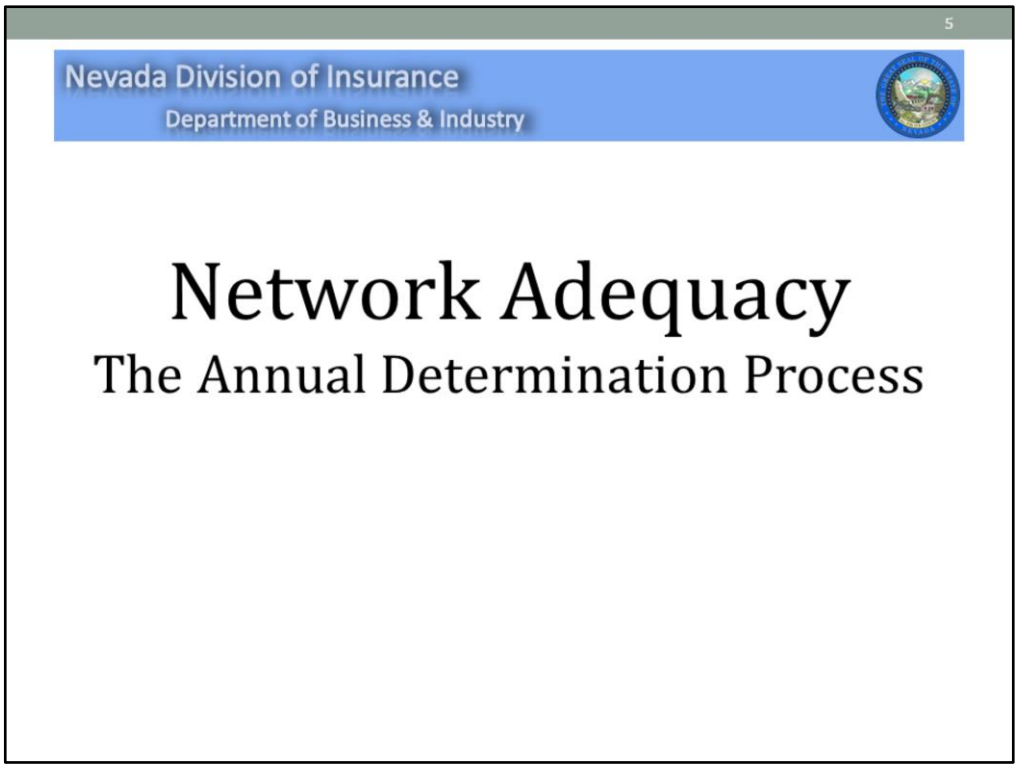


The adoption of R049-14 gives the Commissioner the authority to establish a Network Adequacy Advisory Council (Council) made up of representatives from industry, providers, and consumer groups. The 9 person council is charged with making recommendations to the Commissioner for network adequacy by September 15 of each year. Based on the recommendations of the Council, the Commissioner proposes a regulation to establish the network adequacy standards for future plan years. To allow the necessary time to make recommendations, to facilitate the rule making process, and to provide notice to health benefit plans of the standards, the Council's recommendations and the subsequent regulation are for the plan year two years in the future. For example, the Council is meeting in calendar year 2020 to make recommendations for plan year 2022. The recommendations of the Council can address any area where they feel deficiencies exist when considering access to health care in Nevada. A later slide will present some of the areas which have been brought to the attention of the Council through the open meeting process.

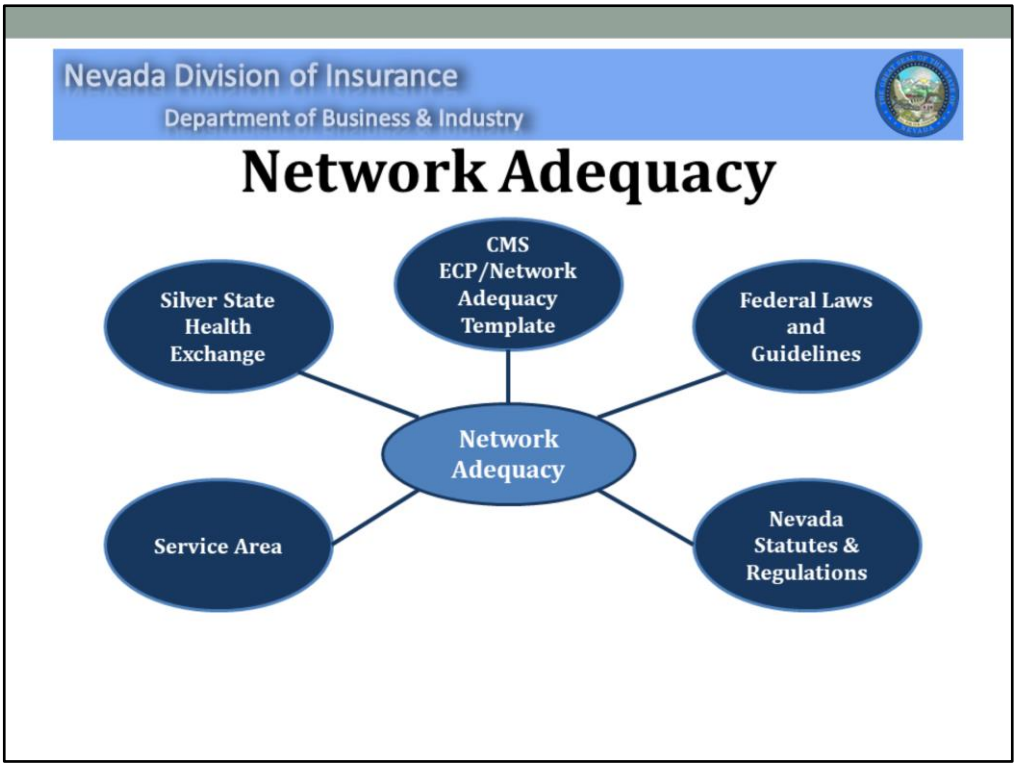


As previously indicated in the introduction, the statutes and regulations under the Insurance Code related to network adequacy do not apply to all health products sold in the state of Nevada. The following pie chart is compiled using a variety of sources and provides an approximation of the insurance market in Nevada and the percentage of Nevadans in each of the markets. Of these markets, the current statutes only require annual determination of a network's adequacy for the individual and small employer group markets. These market segments represent approximately 7% of Nevada's population. Although it is outside the authority of the Division, both Medicaid and Medicare companies are subject to some form of network adequacy standards.

31% - Self-Funded Group market
22% - Medicaid/CHIP
13% - Large Group Market – Fully Insured
12% - Medicare
11% - Uninsured
4% - Individual Market
4% - Tricare/VA Health Care (Other Public)
3% - Small Employer Group Market



The preceding slides focused on the history and background of network adequacy in the state of Nevada. The slides that follow will provide greater insight into the process and components that the goes into the Division's annual determination of network adequacy.

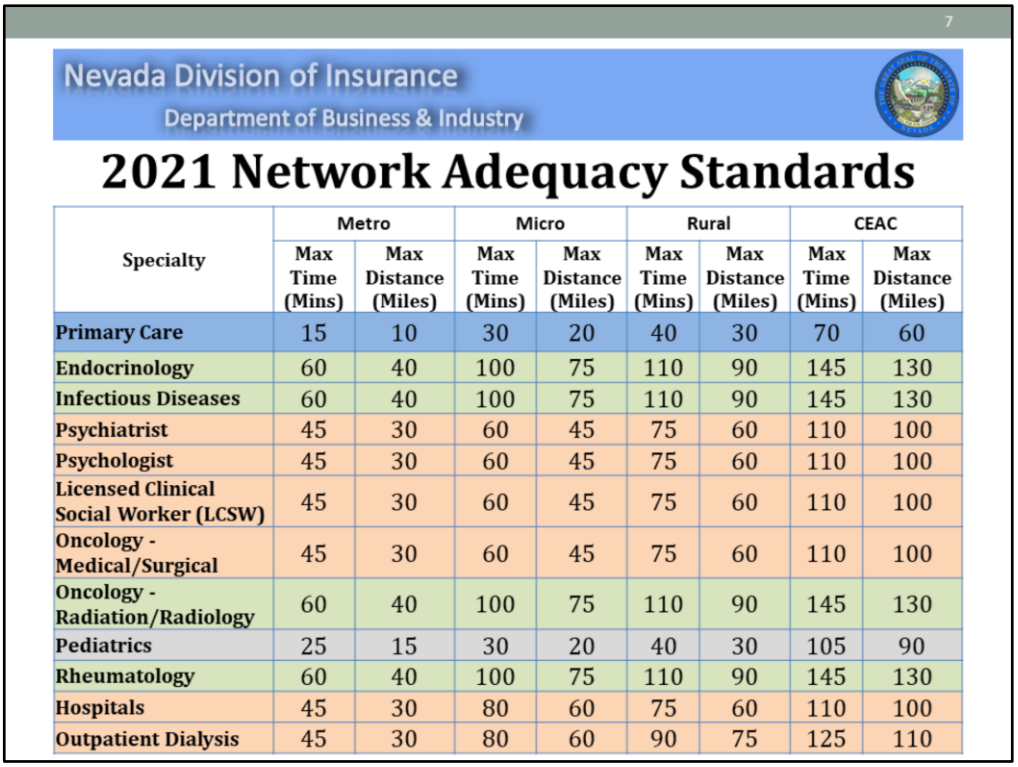


There are several factors that go into the process of setting the standards for network adequacy. As previously discussed, Nevada's own statutes and regulations lay the foundation for what standards will be used. Previous slides included detail information on the statutes and regulations which dictate the network adequacy process and standards in Nevada. While Nevada is no longer using the federal exchange, and therefore has greater independence related to the federal laws and guidelines that dictate network adequacy, the Division must continually monitor changes at the federal level to determine any potential impact on network adequacy. Furthermore, the Division still relies on templates provided by the Centers for Medicare and Medicaid Services (CMS) in performing annual determination which influences how the health plan networks are analyzed.

Another component to consider, is the Silver State Health Exchange or SSHIX. SSHIX is responsible for overseeing carriers on the state based exchange and they have their own regulations and guidelines pertaining to these plans. SSHIX has the option to implement additional network adequacy requirements for plans sold on the exchange.

Another important aspect of Network Adequacy is the service area. Service area determines the geographic area where a health insurance plan accepts members and it is this area and the population of this area which will have to be analyzed to determine the adequacy of a network. How we determine the adequacy of a service area can have a significant impact on the determination process. Given Nevada's disproportionate population distribution and it's extensive geographic area, how adequacy is defined at the service are level can influence the adequacy of a plan's network.

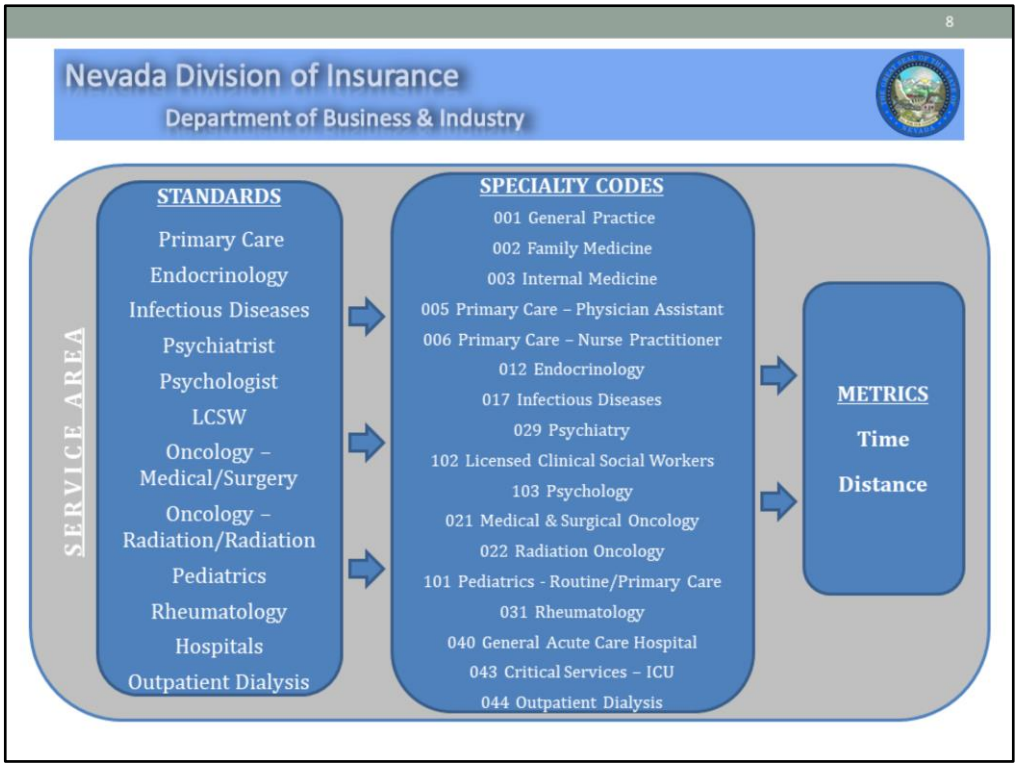
This is a high level overview of the various pieces of Network Adequacy as regulated by the Division of Insurance. For the purposes of determining adequacy, the current standards focus on two primary areas of a health plan's networks, providers and facilities and Essential Community Providers (ECP). The next several slides will outline the metrics for both of these areas of focus.



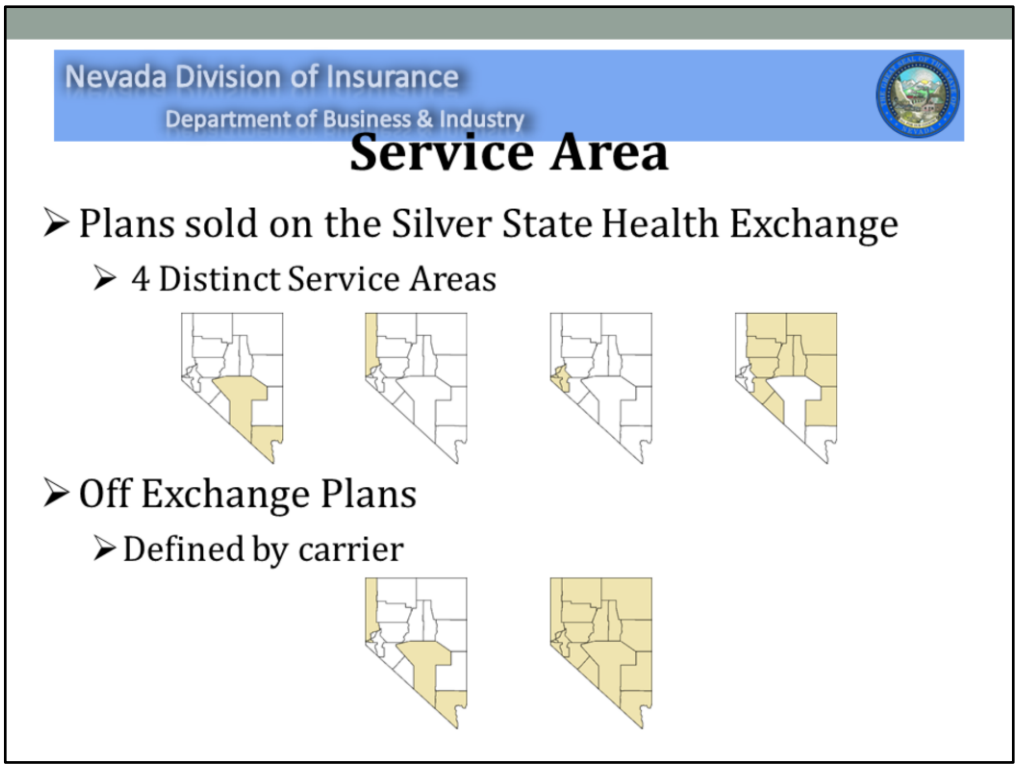
2021 Network Adequacy Standards

Specialty	Metro		Micro		Rural		CEAC	
	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Primary Care	15	10	30	20	40	30	70	60
Endocrinology	60	40	100	75	110	90	145	130
Infectious Diseases	60	40	100	75	110	90	145	130
Psychiatrist	45	30	60	45	75	60	110	100
Psychologist	45	30	60	45	75	60	110	100
Licensed Clinical Social Worker (LCSW)	45	30	60	45	75	60	110	100
Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
Pediatrics	25	15	30	20	40	30	105	90
Rheumatology	60	40	100	75	110	90	145	130
Hospitals	45	30	80	60	75	60	110	100
Outpatient Dialysis	45	30	80	60	90	75	125	110

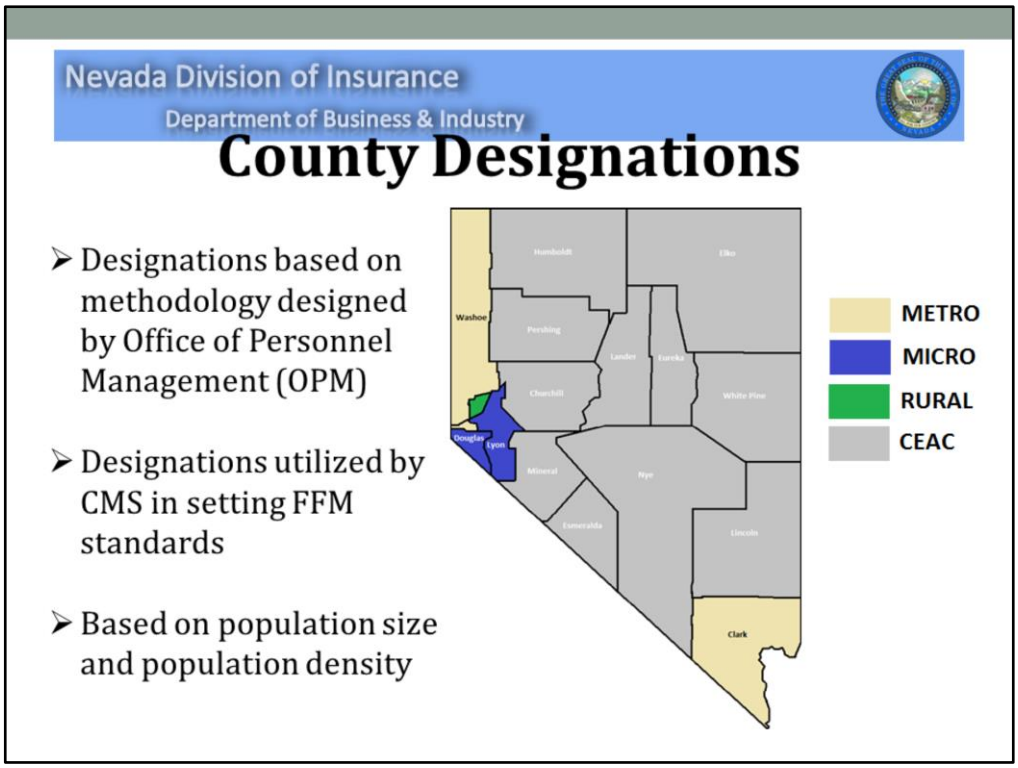
In analyzing providers and facilities, the current standards use time or distance metrics to determine the adequacy of a health plan's network. The following table shows the 12 different provider types which are currently required and the corresponding maximum time or distance metrics that must be met. The time and distance metrics vary by county designation. The slides to come will explain in greater detail how these metrics are applied to determine network adequacy and how the county designations are determined.



The graphic illustrates the process for determining adequacy. The 12 provider and facility specialties required by law are assigned to the corresponding specialty codes included in the CMS ECP/Network Adequacy template (Template) and each code is ran against the corresponding time or distance metrics based on the counties in the service area. For example, to meet the adequacy requirements for endocrinology, a network would have to have a provider classified as specialty code 012 in their Template and 90% of the sample population would have to have access to at least one provider with in the time or distance metrics specified in regulation. For a health network servicing multiple counties, the analysis is performed on each county based on the assigned designation. The county analysis is totaled for the entire service area to determine if 90% of the sample population for the service area has access to at least one provider of endocrinology.



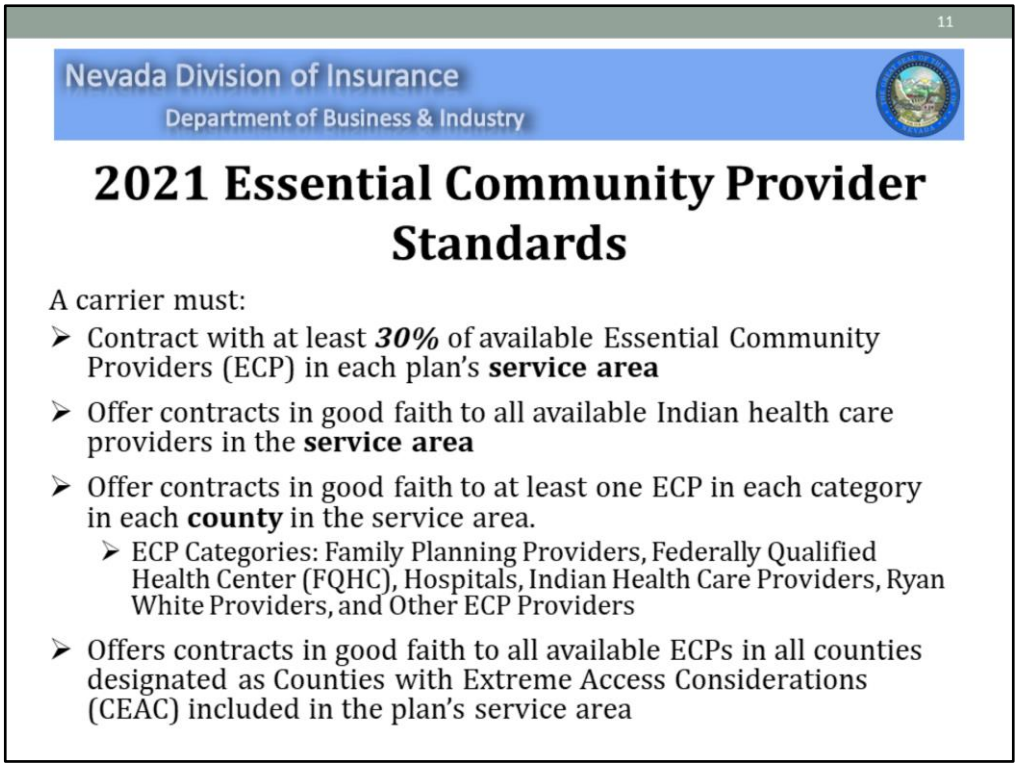
As previously mentioned, service area can be a factor that impacts the overall adequacy of a network. For health benefit plans sold on the state based exchange, there are only four distinct service areas. Service Area 1, Clark and Nye County, area 2, Washoe County, area 3, the counties of Storey, Lyon, Carson City, and Douglas, and area 4, the remainder of the state. Off Exchange plans or plans not sold on the state based exchange do not have predefined service areas. The carrier defines the service area for the network which can include the entire state, select counties, or even a subset of a county.



To determine which metrics correspond to which county the Division uses designations developed by the Office of Personnel Management (OPM) which were originally used by the Center for Medicare and Medicaid Services (CMS) for analyzing adequacy for plans sold on the Federally Facilitated Marketplace (FFM). The methodology developed by OPM uses population size and population density to assign a designation to a county. The map illustrates how counties in Nevada are designated. These designations include, metro, micro, rural, and counties with extreme access conditions or CEAC.

This map provides some insight into the challenges facing both regulators and health insurance carriers when considering how to determine and provide adequate access to Nevadans. Consider, Carson City and Elko County. Both of these counties have similar populations, however their designations are very different. Metro vs. CEAC. The important factor is the population density. The land area of Carson City is 145 square miles vs. Elko which is over 17,000 square miles.

Approximately 89% of Nevada's population is made up of the counties of Clark and Washoe. With Clark making up 73.7% of the state's population. This can present a unique challenge when trying to design network adequacy standards which meet the needs of all of Nevadans.



Along with the time and distance standards previously mentioned, the Division analyzes the adequacy of the Essential Community Providers (ECP) within a plans network. The following slide highlights the standards which must be met to obtain adequacy. The ECP categories are Family Planning Services, Federally Qualified Health Centers, Hospitals, Indian Health Care Providers, Ryan White Providers, and Other ECP Providers. A more detailed breakdown of these categories is provided below.

Family Planning Services: Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics

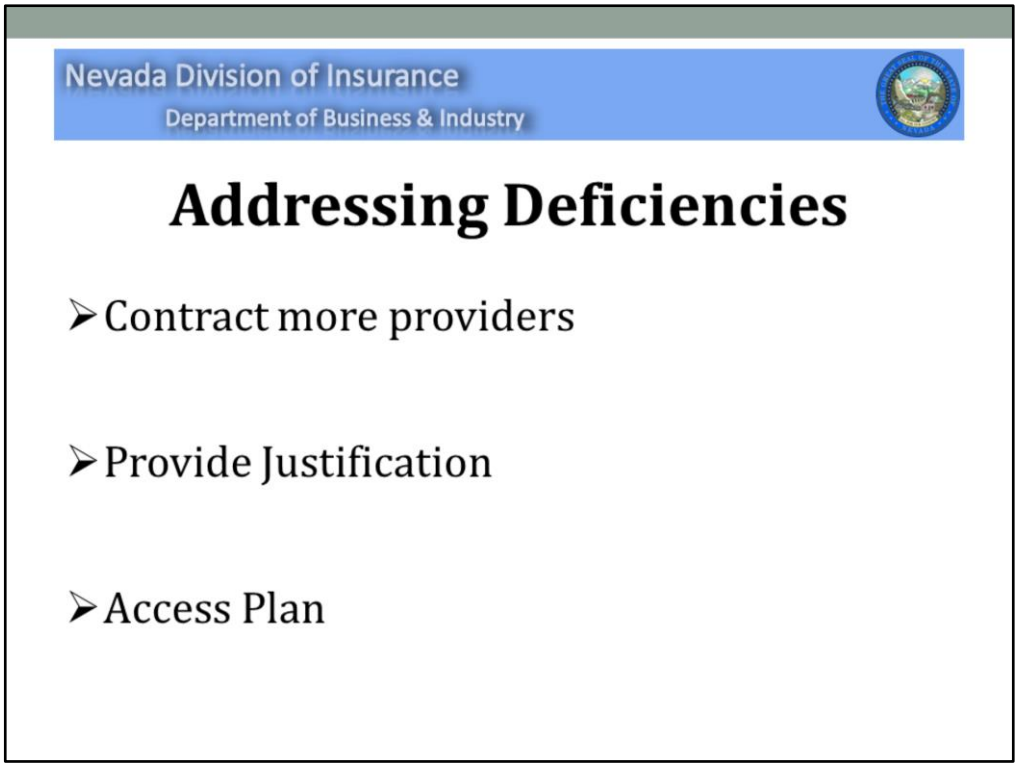
Federally Qualified Health Center (FQHC): FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations

Hospitals: Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals

Indian Health Care Providers: Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations

Ryan White Providers: Ryan White HIV/AIDS Program Providers

Other ECP Providers: STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals

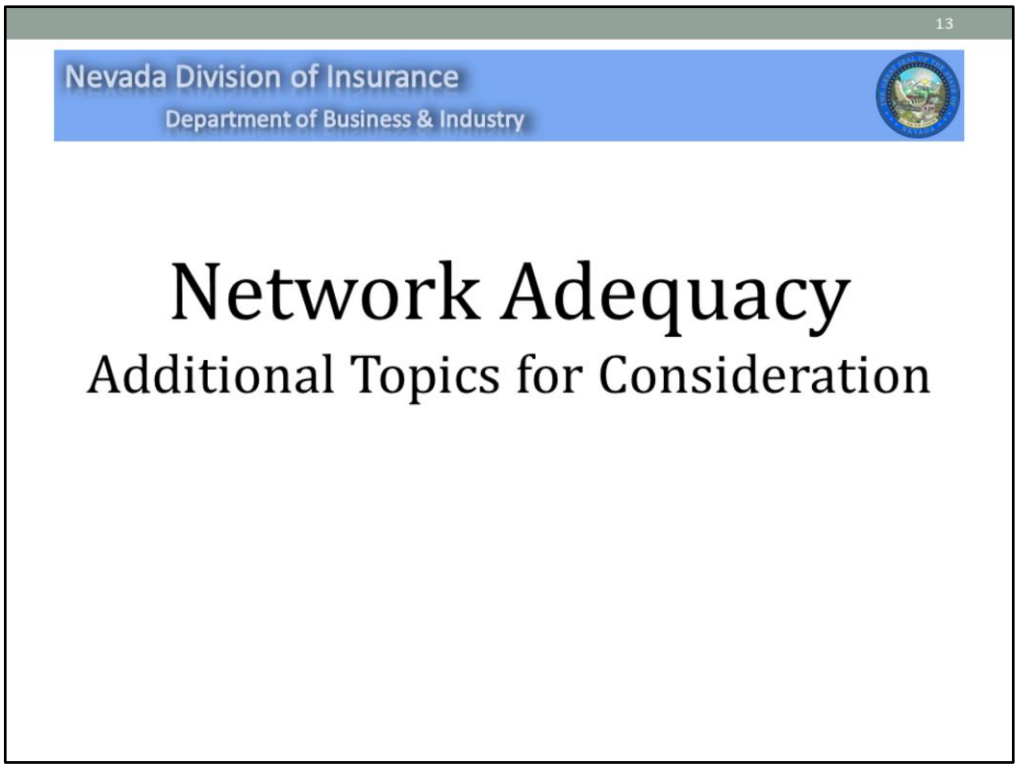


While the Division strives to ensure that network adequacy standards are met by all health benefit plans offering networks in the individual and small employer group markets, there are instances where lack of availability of providers in certain counties can lead to deficiencies in adequacy. The Division has procedures in place to address these deficiencies. First and foremost the Division works with the carrier to determine whether a suitable provider is available to address the deficiency. The Division compiles a list of all contracted providers and facilities based on the data collected in the CMS ECP/Network Adequacy templates for all networks and provides that to any deficient networks. If the deficiency can not be addressed due to a lack of an available provider, the Division requires a justification which includes an access plan to be submitted by the carrier reflecting how members in the deficient areas will get access to care. The justification must include the following information.

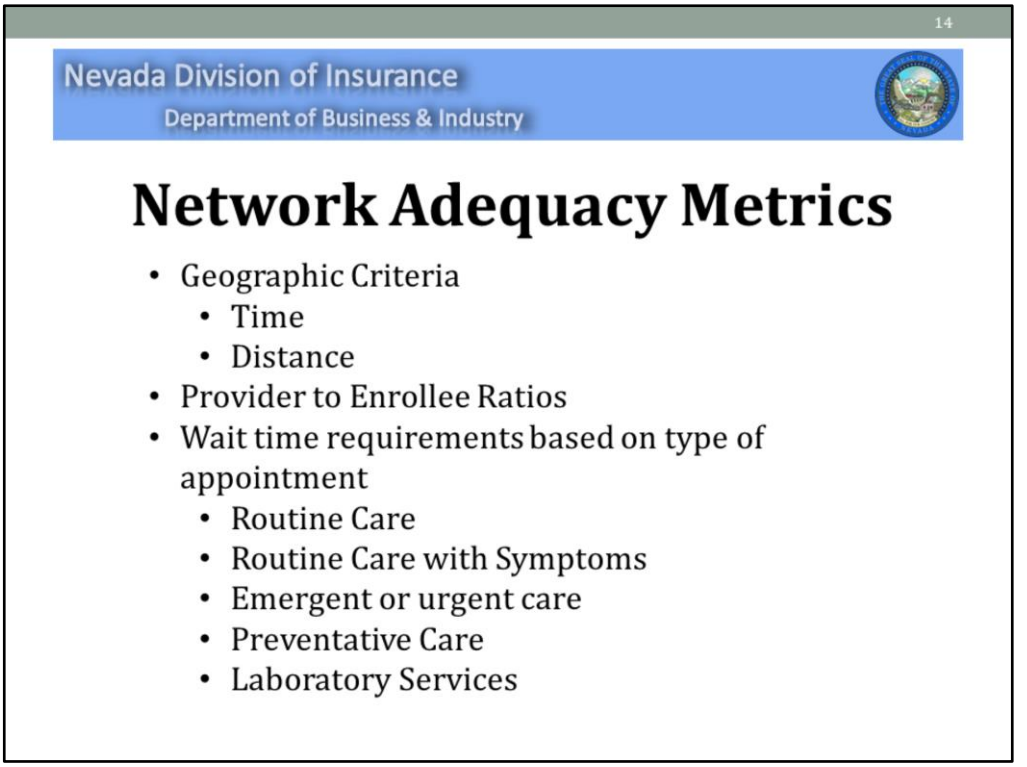
1. An explanation of how the issuer will provide reasonable access to healthcare providers in the county(ies) identified and any other considerations and information that the issuer believes is pertinent, such as applicable patterns of care, information about provider availability in the area, and applicable policies and procedures.
2. The explanation reference in item 1 should address each county/specialty combination specifically listed as being deficient.
3. The issuer should state if it has received enrollee complaints about the lack of access to healthcare providers in the identified county(ies), and if so, the number of these complaints and an explanation of how the complaints were

resolved.

4. An explanation of the current recruitment efforts in each combination specifically listed as being deficient.
5. An explanation of the applicable policy or pattern of care when in-network providers are not available and enrollees are required to use an out-of-network provider for treatment purposes.



Now that I have given background on the history of network adequacy and the Division's process for determining adequacy, I would like to spend the last couple slides discussing talking points and items for consideration which have come up over the years through the Network Adequacy Advisory Council and various other public forums.



This slide highlights some of the metrics which are currently being used to determine network adequacy through out the United States. For the purpose of this slide I will try to provide an understanding of how the metrics are used to determine adequacy and provide feedback from public discussions on the advantages or disadvantages of each metric.

Time/Distance

Many states, similar to Nevada, use the metrics of time and distance in their determination of their networks. These metrics use geographic criteria to determine a member's access to care or adequacy. One of the primary concerns which has been raised about these metrics is that they don't properly address a providers capacity. While it may seem like a member has adequate access because they live with in five miles or ten minutes of their provider, these metrics mean very little if the capacity of that provider to see patients is such that a member has to wait six months to see their provider.

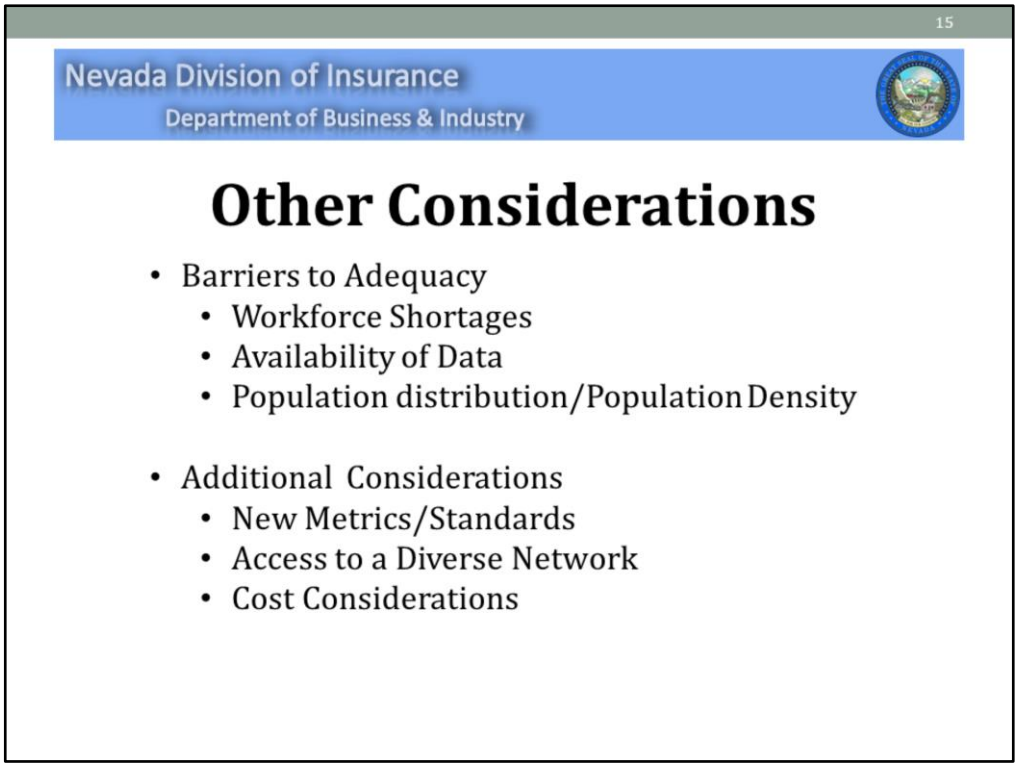
Provider to Enrollee Wait Times

Provider to enrollee ratios do have the potential to allow analysis of a provider's capacity, however, to truly understand the capacity of a provider it is not enough to just look at the enrollees for a particular insurance carrier or the enrollees in one insurance market. To truly understand the capacity of a provider the appropriate metric would need to look at all of the enrollees that a provider is servicing for all insurance market segments e.g. individual, small group, large group, self-funded, Medicaid, Medicare, etc.

Wait Times

The wait time to see a provider has been discussed as good metric of access to care. While this does not take into account geographic proximity to the member, it does indirectly capture capacity. The challenge with this metric is how to properly track this data in an efficient and cost effective manner so it can be incorporated into network adequacy analysis.

None of these metrics have ever been discussed as the sole source for defining network adequacy and it is often the combination of metrics which is used by some states to determine adequacy.



As part of the recommendations that are discussed by the Network Adequacy Advisory Council, the Council also discusses items for consideration related to barriers to network adequacy. One of the considerations which has been included in their report since their first submission to the Commissioner is to support efforts to expand the development of the health workforce in critical provider categories required for network adequacy. The Council over the years has received data and presentations from various parties illustrating the workforce shortages that exist in Nevada. These shortages present a roadblock to adequate access regardless of what standards are in place.

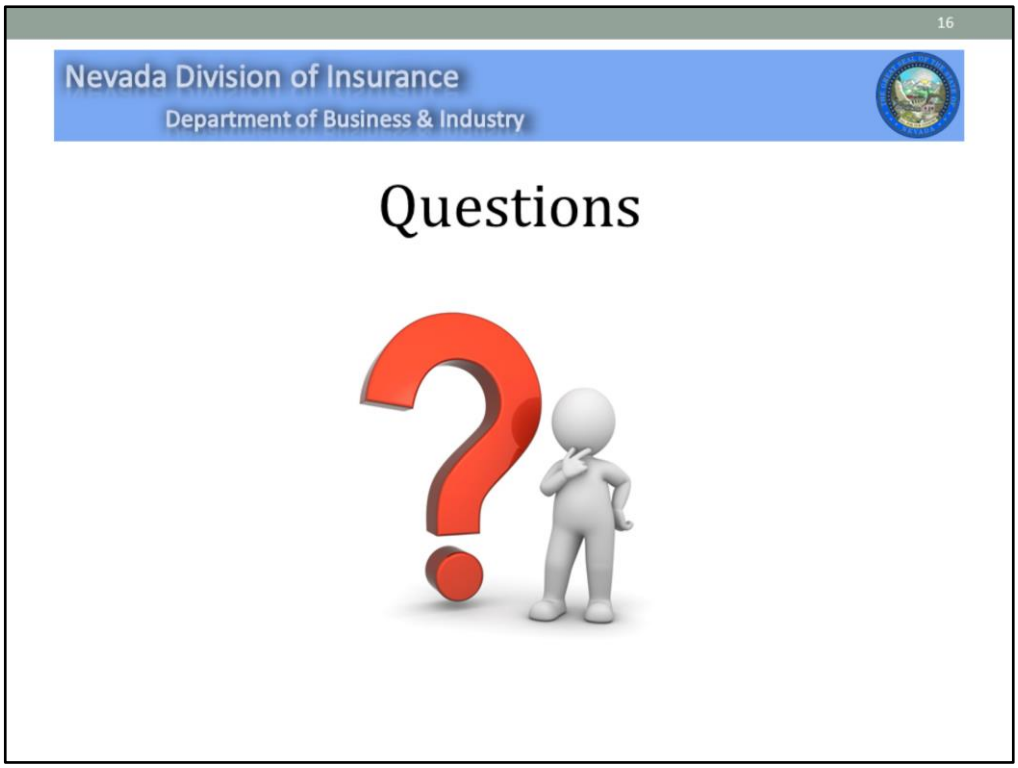
The next item that has been a topic of continual discussion since the Council's inception, is access to reliable data. It is difficult to make decisions on what adequate access is if you don't understand the availability of health care providers and facilities in Nevada. The Council has consistently noted future actions towards obtaining better data from providers and licensing agencies and improved work force data.

Some of the other items to consider when envisioning what it means to be an adequate network are listed above. The presentation provided a high level overview of other metrics which states are using to conduct network adequacy review. While these metrics may provide some insights in the adequacy of a network, it is important to continue to explore other standards or metrics which could more appropriately indicate the adequacy of a network. Another item that has been discussed in various public forums is how well a network reflects the diversity of the population it is servicing and to what degree should network adequacy require diversity in a network. While there are very few states with

regulations related to network diversity, it is a topic which some legislators and other state regulators have expressed interest in pursuing. The final item which often is discussed is the cost of insurance. While everyone agrees that reasonable access to health care must be required, a balance must be struck so that the cost of compliance doesn't put health care premiums into an unaffordable range.

Many of the topics discussed in the presentation have been the subject of discussions during the Network Adequacy Advisory Council public meetings and I would be remiss if I did not acknowledge the time and effort of the Council members that have encouraged these discussions and helped develop the knowledge and understanding the Division has about network adequacy. I highly recommend looking over the Council's webpage for additional information.

http://doi.nv.gov/Insurers/Life_and_Health/Network_Adequacy_Advisory_Council/



Please feel free to reach out to me with any questions.

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