Section I – Title Page

Part IA – Technical Proposal	
RFP Title:	Network Carrier Adequacy Analysis
RFP:	3509
Vendor Name:	Oliver Wyman Actuarial Consulting, Inc.
Address:	155 N Wacker Drive Chicago, IL 60606
Opening Date:	January 3, 2018
Opening Time:	2:00 PM

Brief Description of RFP and Overview:

The Nevada Division of Insurance is looking to contract with a vendor to conduct independent examinations of Nevada's Health Insurance carriers to determine if their provider network(s) are compliant with the adequacy standards developed by the Nevada Division of Insurance. Deliverables by the vendor include:

a. Analyzing the various carrier's provider networks annually, and more frequently if required
b. Reviewing provider networks identified by carriers in their initial application for a certificate of authority or a request for expansion of its geographical service area
c. Assist the Nevada Division of Insurance in responding to consumer complaints concerning network adequacy

Oliver Wyman Actuarial currently performs similar work for other state(s) and has developed a proprietary network adequacy tool, which would be updated and adjusted to Nevada specific requirements and specifications. The tool is extremely flexible – at the present time, we check for network adequacy for over 20 different specialties and provider types and by various requirements within the same check, such as three digit zip, county, providers per 1000 population, distance, etc. Any or all of these can be modified or added to meet Nevada's state requirements.

Section II – Table of Contents

Section I – Title Page 1
Section II – Table of Contents 2
Section III – Vendor Information Sheet 3
Section IV – State Documents 4
Section V – Scope of Work 14
Section VI – Company Background and References 31
Section VII – Attachment F – Proposed Staff Resumes 39
Section VIII – Other Informational Material 47

Section III – Vendor Information Sheet

V1	Company Name	Oliver Wyman Actuarial Consulting, Inc.

V2	Street Address	155 N Wacker Drive, Suite 1500

V3	City, State, ZIP	Chicago, IL, 60606

V4	Telephone Number		
	Area Code: 312	Number: 345-3300	Extension:

V5	Facsimile Number		
	Area Code: 312	Number: 345-3301	Extension:

V6	Toll Free Number		
	Area Code:	Number:	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Beth Fritchen
	Title: Partner
	Address: 155 N Wacker Drive, Suite 1500 Chicago, IL 60606
	Email Address: beth.fritchen@oliverwyman.com

V8	Telephone Number for Contact Person		
	Area Code: 312	Number: 345- 3378	Extension:

V9	Facsimile Number for Contact Person		
	Area Code: 312	Number: 345-3301	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: Beth Fritchen	Title: Partner

V11	Signature ***(Individual shall be legally authorized to bind the vendor per NRS 333.337)***	
	Signature: Beth R. Fritchen	Date: 01/02/18

Section IV – State Documents

A. Amendment 01

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 01 to Request for Proposal 3509
RFP TITLE:	Provider Network Adequacy Analysis
DATE OF AMENDMENT:	December 19, 2017
DATE OF RFP RELEASE:	November 29, 2017
OPENING DATE:	January 3, 2018
OPENING TIME:	2:00 PM
CONTACT:	Gail Burchett, Purchasing Officer

The following shall be a part of RFP ***3509.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

1. Regarding Section 2.2.1.1, Will the vendor be granted access to download data from SERFF or will there be API's available to automate the collection of data?

   The vendor will be granted access to download data from SERFF. The Division does not currently work with API's for automating data collection; however, if the vendor is aware of a process for automating the data collection the Division would be willing to consider adding these efficiencies to the process moving forward.

2. Regarding Section 1.3.2 and 1.3.3, What has been the historical frequency of ad hoc examination requests outside of the annual review time?

   Ad hoc examination requests average about 2 a year.

3. Regarding Section 2.1.8.2, Will the vendor need to track when exceptions have been approved?

   The vendor will not be responsible for tracking the exceptions. The Division will be responsible for any exceptions made outside of Nevada's Network Adequacy standards.

4. Regarding Section 2.2.1.2 Can you please provide examples of submission errors? Are errors limited to formatting?

   The CMS ECP/Network Adequacy template provides the framework for submitting the data; however, carriers have inadvertently omitted providers or facilities for a given service area or did not verify the address information to identify errors that may exist.

5. Regarding Section 2.2.1.2 Will the carriers be using the exact same format, including specialty descriptions when submitting data through SERFF?

   All of the carriers are required to submit the data using the uniform templates provided by CMS. A copy of the 2018 ECP/Network Adequacy Template can be found on the Division website.

   http://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Insurers/Life_and_Health/EcpNetworkAdequacyTemplatev7.3.xlsm

6. Regarding 2.1.9.4 Will the state supply the population file for the determination of 90% or will the vendor create a proxy population file for measuring adequacy?

   The vendor will be responsible for creating the population file.

7. Regarding Attachment G- Cost Schedule What are the current Dental standards by county classification?

   Currently Dental is not part of the network adequacy review conducted by the Division.

8. Regarding Attachment G- Cost Schedule, Is the current individual cost assigned per company or per network review?

   The invoices are normally generated by company with a breakdown for each network.

9. What is the current and desired communication flow and delivery of the analysis?

   The current communication flow occurs primarily through email and telephone. The analysis is uploaded to a secure file share website provided by the vendor.

10. Will the vendor be working directly with the companies on submission errors and network reviews or will the communication flow thru the State? Or a combination of both?

    The communication will flow through the State.

11. Will there be finalist presentations during the week of 01/04/2018 -01/18/2018?

    No.

12. Do we have to use the resume format?

    Yes.

13. My we provided work related resume bios?

    Yes; however, they must be in the resume format.

14. Section 8.1.2, page 23 discusses submission requirements. If we chose not to include proprietary and/or confidential information in our response do we need to submit 8.1.2.2 Confidential Technical and 8.1.2.4 Confidential Financial responses?

    No.

15. Just to clarify the state only wants a CD or flash drive delivered via mail service. No hard copies.

    Yes, this is correct.

16. Will portions of the examination be permitted to be conducted remotely, when appropriate, in order to minimize travel expenses?

    Historically all of the examinations have been handled remotely.

17. What are the definitions for sufficient numbers of providers within the network for each region type (Metro, Micro, Rural, etc.)?

    The current standards require that 90% of the population have access to at least one provider within either the time or distance standards specified under 2.1.9.6 through 2.1.9.9 for the appropriate region designation.

18. What sizes are the companies being examined in terms of insured?

    The vendor will be responsible for the examination of all companies in the individual and small group market in Nevada which meet the requirements for annual network adequacy certification

under NRS 687B.490. The number of insureds for each company varies from year to year but ranges from a few hundred to close to 50,000.

19. Will the analysis of websites and datasets (historical and current) containing provider information be included?

    Based on the current network adequacy standards, the analysis will center on the provider and facility data provided by the carrier through the CMS ECP/Network Adequacy Template.

20. In what formats may these datasets be presented to the vendor?

    All of the carriers are required to submit the data using the same Excel template. The template is provided by CMS. A copy of the 2018 ECP/Network Adequacy Template is located on the Division website.

    http://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Insurers/Life_and_Health/EcpNetworkAdequacyTemplatev7.3.xlsm

21. Will the vendor be able to review desensitized referral and reimbursement data in cases of insufficient providers?

    The Division does not anticipate that it will be necessary to review this dat. To date none of the previous examinations conducted have required a review of this data.

22. 2.2.2 Section II – Analysis 2.2.2.1 The vendor must use the data collected in section 2.2.1 to analyze the adequacy of the network. The current standards outlined in section 2.1 use time and distance metrics however these metrics are subject to change and additional metrics could be added.

    a. How is the time metric calculated? (Online map sources, governmental data for transit times, etc.)

       The Division does not require a specific methodology for determining the time between a provider/facility and a population sample point. The only requirement is that the time be representative of how long it would take for someone to drive from the provider/facility to the population sample point.

    b. How are distance units determined (aeronautical or ground-speed)?

       The distance units are determined by ground-speed.

    c. Are there any current changes to the metrics outlined in the RFP?

       With the exception of the Essential Community Providers, there were no changes to the plan year 2019 network adequacy standards. The change was to 2.1.7.1 (A) which for plan year

2019 will require that a carrier must contract with at least 30% of available Essential Community Providers (ECP) in each plan's service area instead of the 20% for plan year 2018.

23. 2.2.3 Section III – Analysis Output and Reports 2.2.3.1 The vendor must be able to provide output of the network adequacy analysis breaking down the results by a specific region, such as: state, service area, county, or zip code. 2.2.3.2 The vendor may be required to provide additional reports, as well as, summary reports on an as needed basis based on the needs of the Division.

    a. How will the data used in the analysis be presented/given to the vendor?

    All of the carriers are required to submit the data using the same template. The template is provided by CMS. A copy of the 2018 ECP/Network Adequacy Template is located on the Division website.

    http://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Insurers/Life_and_Health/EcpNetworkAdequacyTemplatev7.3.xlsm

    b. Is there an authoritative list of Zip Codes, Cities, Service areas, etc. that a vendor must use for the analysis report?

    A list of counties is provided in the CMS ECP/Network Adequacy Template. The service area is defined by each network plan and will be provided by the carrier.

    c. Will any historical mapping be required to notate change in network adequacy over X amount of time?

    Historical mapping has not been employed to date; however, this may be something the Division explores in the future.

    d. Will any data visualization be required?

    Current examinations do not include any visualization; however, the Division has utilized maps illustrating the data in prior years.

24. For the Technical Proposal – Section V states 'Vendors shall place their written response(s) to ***Section 2, Scope of Work*** in ***bold/italics*** immediately following the applicable RFP question, statement and/or section'. Section 2 is made up of 2 subsections (1. Network Adequacy Standards, and 2. Network Adequacy Analysis). Section 2.1 (Network Adequacy Standards) appears to be mostly informational material. Should this section still be included in Section V of the Technical Proposal, or is section 2.2 adequate?

Vendors are required to respond to all questions in the RFP.

25. Cost Proposal - The form appears to be meant for a total cost by year – Can this be done on a per/carrier basis or do we just state that the cost is based ONLY on the currently approximated carriers.

    Vendors shall respond to the cost as requested in the form. Vendors must use the State form to respond to the cost.

26. Will the State review or negotiate the Standard Terms and Conditions which were attached to the RFP?

    No, the State will not negotiate terms and conditions.

27. How many carriers does the Division of Insurance expect will need to be reviewed for network adequacy in Calendar Year 2018?

    The number of carriers and networks varies by year. There were 7 carriers in the individual market and 12 carriers in the small group for plan year 2018.

28. Will the network adequacy assessment occur for all carriers in the June to September timeframe?

    The annual certification for plan year 2018 began June of 2017 and was completed by September of 2017. In past years, the Division began the submission process the first part of May. Note, this timeline is subject to change depending on CMS; however, the Division anticipates the certification process to occur between May and September annually.

29. With a turnaround time requirement of 90 days for the Division, how much time will the Division need for its own purposes related to network adequacy? In other words, will the Contractor be required to conduct its assessment within 60 days of receiving information?

    Please see the sample timeline provided under 2.2.4.2. The Division will require a turnaround time of roughly a week to a week and a half to meet the two week turnaround time.

30. Does the Division collect any claim-level or enrollment-level information from each carrier related to assessing network adequacy?
    a. If yes, is a standard file layout available?
    b. If no, is it possible for the Division to request this information on behalf of the Contractor?

    This data is not currently collected for the purposes of network adequacy certification; the Division does not anticipate collecting this data.

31. With respect to proposal submission requirements, should Sections II and II be resubmitted in their entirety? If not, in Section III, should the respondent enclose the questions or grid information in a separate response and fill this in? For example, Section 3.1.1 or 3.1.5.

    Vendors are required to respond to all questions in the RFP. The responses should be in the State format as provided in the RFP document.

32. What is the page limit for responding to Section II Scope of Work?

    There is no page limit however vendors are requested to be clear and concise when responding.

33. May respondents include example work products in an Appendix?

    Per Section 8.1.11, Proposals are to be prepared in such a way as to provide a straightforward, concise delineation of capabilities to satisfy the requirements of this RFP. Expensive color displays, promotional materials, etc., are not necessary or desired. Emphasis shall be concentrated on conformance to the RFP instructions, responsiveness to the RFP requirements, and on completeness and clarity of content.

34. How many corrective action plans were required from carriers in the previous year?

    To date the Division has not required any corrective action plans from carriers.

ALL ELSE REMAINS THE SAME FOR RFP 3509.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Oliver Wyman Actuarial

Authorized Signature: Beth R Fritcher

Title: Partner Date: 01/02/18

This document must be submitted in the "State Documents" section of vendors' technical proposal.

B. ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **shall not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the submittal instructions of this RFP, vendors are requested to submit confidential information in separate files marked "**Part IB Confidential Technical**" and "**Part III Confidential Financial**".

The State shall not be responsible for any information contained within the proposal. If vendors do not comply with the labeling and packing requirements, proposals shall be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that shall be in an open meeting format, the proposals shall remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act shall constitute a complete waiver and all submitted information shall become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information.

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information			
YES		NO	BF
Justification for Confidential Status			

Part III – Confidential Financial Information			
YES		NO	BF
Justification for Confidential Status			

Oliver Wyman Actuarial
Company Name

Beth R. Fritchen
Signature

Beth Fritchen — 01/02/18
Print Name — Date

C. ATTACHMENT B – VENDOR CERTIFICATIONS

Vendor agrees and shall comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and shall not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, shall remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, shall remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals shall be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion shall be in writing and included in the proposal at the time of submission.

(7) Each vendor shall disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict shall be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest shall automatically result in the disqualification of a vendor's proposal. An award shall not be made where a conflict of interest exists. The State shall determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

A different physical office of Oliver Wyman (Milwaukee) works with Hometown Health. However all staff that would be working for the State of Nevada would be located in our Chicago office, and there would be no one that works on both clients. The State of Nevada would have its own secure network drive that no one other than those consultants working on this would have access to.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and shall be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor shall certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal shall be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

(14)

Oliver Wyman Actuarial
Vendor Company Name

Beth R Fritchen
Vendor Signature

Beth Fritchen 01/02/18
Print Name Date

D. Licensing Agreements and/or Hardware and Software Maintenance Agreements

There are No licensing agreements or hardware/software maintenance agreements applicable to this FRP between the State of Nevada's Department of Insurance and Oliver Wyman Actuarial.

E. Applicable Certifications and/or Licenses

No other applicable certifications or licenses.

Section V – Scope of Work (Responses in *bold/italic*) – Section 2 in RFP 3509

2.1 NETWORK ADEQUACY STANDARDS

The vendor will perform an analysis of the carrier's provider network data to determine the adequacy of the network plan based on the standards outlined in section 2.1. The vendor must be able to provide the necessary summary of the analysis in a timely manner to meet the requirements of NRS 687B.490 which allows the Commissioner 90 days to determine the adequacy of a network from the date of application. Network Adequacy Standards are subject to change annually based on the guidelines issued by CMS and the standards established by the Commissioner of Insurance "Commissioner". The sections that follow are developed from the standards as they exist for plan year 2018.

Oliver Wyman is ready to begin work on this project when the State is ready to award the contract. We have the staff capacity to perform this work and we will provide the reviews in a timely manner and be completed well within the 90 day requirement.

- ***We will review the files submitted by the issuers within 3 days of receipt to make sure we have all of the necessary information and that the files are complete.***
- ***We will perform the initial network adequacy review within 1 week following the verification of all necessary information at which point we will inform the department of any initial failings.***
- ***This time frame will leave sufficient time for carriers to respond to the set of questions, and will keep within the State's required timeline of 2 weeks for responses between the State of Nevada and the carriers.***
- ***We will provide the Department our letter of recommendation in draft form within 2 weeks of completing the review, specifically, after all questions from the carrier are addressed sufficiently. However, the Department will be aware of the status of all reviews and issues, as we give you weekly status reports.***
- ***In our experience, the typical time for reviews is 30 to 60 days, which is well within the State of Nevada's timeline.***

2.1.1 Section I – General Requirements

2.1.1.1 A carrier that offers health coverage through a network plan shall use best efforts to maintain each product provider network in a manner that is sufficient in numbers and types of health care providers, including providers that specialize in mental health and substance abuse services, to assure that all health care services to covered persons will be accessible without unreasonable delay.

2.1.1.2 Each covered person shall have adequate choice among each type of health care provider.

2.1.1.3 In the case of emergency services, covered persons shall have access 24 hours a day, seven (7) days a week.

2.1.1.4 A carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health care services to covered persons.

Oliver Wyman's proprietary Provider Network Adequacy Tool is flexible and can be modified to test the requirements of various specialties, and other requirements for each product offered by carriers. Our testing will reflect the Nevada requirements specified in section 2.1 of the RFP.

2.1.2 Section II – Provider Directory Updates

2.1.2.1 Each carrier shall update its directory of providers of health care at least once each month. Except as otherwise provided in this subsection, each update to the directory must include each provider of health care who, as of the previous month, is no longer in the network plan or has stopped accepting new patients. A carrier shall not be deemed to have violated the provisions of this subsection if a provider of health care fails to provide information to the carrier which the provider of health care is contractually obligated to provide to the carrier.

2.1.2.2 If a change occurs to the network plan of a carrier that results in the network plan failing to meet the standards adopted by reference in section 9 of LCB File No. 049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. 049-14, the carrier must update its directory of providers of health care not later than 5 business days after the effective date of the change and include in the directory a clear description of the change.

2.1.2.3 The directory of providers of health care and each update to the directory must be:

A. Posted to a publicly available Internet website maintained by the carrier not later than 5 business days after the update is completed;

B. Posted in a manner that allows a person who is not enrolled in any plan offered by the carrier to view the directory; and

C. Made available in a printed format to any person upon request.

2.1.2.4 As used in this section:

A. "Directory of providers of health care" means a list of physicians, hospitals and other professionals and organizations that provide health care services, including, without limitation, through telehealth, as part of a network plan.

B. "Telehealth" has the meaning ascribed to it in section 4(c) of Nevada Revised Statutes (NRS) 629.515.

2.1.3 Section III – Submission and Updated Processes

2.1.3.1 Each carrier or other person or entity that applies to the Commissioner for approval to issue a network plan pursuant to NRS 687B.490, shall submit to the Commissioner, annually, sufficient data and documentation to establish that the proposed network plan meets the standards adopted by reference in section 9 of LCB File No. R049-14 and any other requirements of sections 2 to 18, inclusive, of LCB File No. R049-14.

2.1.3.2 The data and documentation submitted to the Commissioner pursuant to subsection 1 must be in a format prescribed by the Commissioner.

2.1.3.3 The Nevada Declaration Document which includes network adequacy standards will be required to be signed by an officer of the company and submitted to the Commissioner with its annual rate filing.

2.1.3.4 The Nevada Declaration Document can be obtained on the Division of Insurance website http://doi.nv.gov/Insurers/Life-Health/Network-Adequacy/

2.1.3.5 A carrier shall within 3 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of LCB File No. R049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. R049-14, notify the Commissioner in writing of the change;

2.1.3.6 A carrier shall within 10 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of LCB File No. R049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. R049-14, provide to the Commissioner a written description of the cause of the change, the impact of the change on the network plan and a

summary of the measures that the carrier will take to bring the network plan into compliance with those standards and requirements.

2.1.3.7 A carrier shall, within 60 days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of LCB File No. R049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. R049-14, submit to the Commissioner for approval a written corrective action plan to bring the network plan into compliance with those standards and requirements.

In regards to the network adequacy failure, Oliver Wyman Actuarial will work with the Nevada Division of Insurance to analyze the proposed corrective action plan (given an updated proposed template) with tighter deadlines, which will be mutually agreed on with the Nevada Division of Insurance.

2.1.3.8 Except as otherwise provided in 2.1.3.9, during the period in which the network plan does not meet the standards adopted by reference in section 9 of LCB File No. R049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. R049-14, the carrier shall, at no greater cost to the covered person:

A. Ensure that each covered person affected by the change may obtain any covered service from a qualified provider of health care who is:

1. Within the network plan; or

2. Not within the network plan by entering into an agreement with the nonparticipating provider of health care pursuant to NRS 695G.164; or

B. Make other arrangements approved by the Commissioner to ensure that each covered person affected by the change is able to obtain the covered service.

Similar to the work we do presently with our other State regulator clients, for network reviews that fail, we receive confirmation from each carrier on how they will address the failings and provide the options to the Department. In work we have performed, a typical response is that they will allow covered persons to seek services from non-network providers at in-network benefits until such time they contract with enough providers to meet the State requirements.

2.1.3.9 The provisions of 2.1.3.8 do not apply to services received from a nonparticipating provider of health care without the prior authorization of the carrier unless the services received are medically necessary emergency services, as defined in subsection 3 of NRS 695G.170.

2.1.3.10 If a network plan does not meet the standards adopted by reference in section 9 of LCB File No. R049-14 or any other requirement of sections 2 to 18, inclusive, of LCB File No. R049-14 and the Commissioner does not approve the corrective action plan submitted pursuant to 2.1.3.7, 2.1.3.8, and 2.1.3.9, the Commissioner may:

A. For a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490; or

B. For any network plan other than a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490 and require the carrier to submit a statement of network capacity to the Commissioner demonstrating that the carrier meets the conditions described in 42 U.S.C. § 300gg-1(c)(1)(B).

2.1.3.11 The provisions of 2.1.2.1 to 2.1.2.4, 2.1.3.1, and 2.1.3.5 to 2.1.3.10, inclusive, of this regulation do not apply during any calendar year to a network plan that:

A. Is issued by a carrier that has been authorized to transact insurance in this State pursuant to chapter 680A of NRS;

B. Had a statewide enrollment of not more than 1,000 persons during the immediately preceding calendar year;

C. Has an anticipated statewide enrollment of not more than 1,250 persons during the next succeeding calendar year; and

D. Is not a qualified health plan.

2.1.3.12 The provisions of sections 2 to 18, inclusive, of LCB File No. R049-14 do not apply to:

A. A network plan issued pursuant to NRS 422.273 for the purpose of providing services through a Medicaid managed care program on behalf of the Department of Health and Human Services;

B. A network plan issued for a health benefit plan that is regulated pursuant to chapter 689B of NRS and is not available for sale to small employers, as defined in NRS 689C.095;

C. A grandfathered plan, as defined in NRS 679A.094; or

D. A plan issued pursuant to Medicare, as defined in NAC 687B.2028, or a Medicare Advantage plan, as defined in NAC 687B.2034.

2.1.3.13 Failure to provide such notification, as required in this section, may lead to the suspension or termination of their certificate of authority and/or participation in the Exchange.

2.1.3.14 Additionally, an administrative fine may be assessed for each violation.

2.1.3.15 The carrier shall have the right to appeal the decision and submit a corrective action plan to the Commissioner for consideration.

2.1.4 Section IV – Referrals and Reimbursement

In any case where the carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall use best efforts to ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the Commissioner.

In these cases, Oliver Wyman will receive written confirmation from the carrier that they will abide by the above requirement.

2.1.5 Section V – Reasonable Effort and Relative Availability

2.1.5.1 Each carrier shall use best efforts to establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons.

2.1.5.2 Carriers shall make reasonable efforts to include providers and facilities in network in a manner that limits the amount of travel required to obtain covered benefits.

2.1.5.3 In determining whether a carrier has complied with this provision, the Commissioner will give due consideration to the relative availability of health care providers or facilities in each geographic area using standards that are realistic for the community, the delivery system and clinical safety.

2.1.5.4 Relative availability includes the willingness of providers or facilities in the geographic area to contract with the carrier under reasonable terms and conditions

In these cases, Oliver Wyman will receive written confirmation from the carrier during our questions that they will meet the above requirements. We will request written explanations for their plan to improve access and what steps they have taken to try to fulfill the network adequacy requirements.

2.1.6 Section VI – Disclosure of Network Limitations

2.1.6.1 The carrier shall disclose to all covered persons that limitations or restrictions to access of participating providers and facilities may arise from the health care service referral and authorization practices of participating providers and facilities.

2.1.6.2 The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes.

2.1.7 Section VII – Essential Community Providers

2.1.7.1 A carrier shall use best efforts to have a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the geographic area. The standards outlined below are based on the standards included in or adopted by reference in LCB File No. T007-16 and are subject to change annually based on the standards established by the Commissioner of Insurance. *doi.nv.gov/uploadedFiles/...Notices/.../2016.10.26_T007-16_*

A. A carrier must contract with at least 20% of available Essential Community Providers (ECP) in each plan's service area.

B. A carrier must offer contracts in good faith to all available Indian health care providers in the service area

C. A carrier must offer contracts in good faith to at least one Essential Community Provider in each category in each county in the service area.

Oliver Wyman will review the ECP requirements as part of our Provider Network Review. We have used the information that carriers provide to CCIIO in the binders to verify the carriers' networks meet the ECP requirements. We have completed these reviews using the information in the binder, the results of the CCIIO tool and questioning the carriers as to the efforts they have made to negotiate with the ECP providers, where they are failing. We typically receive written plans/confirmations.

2.1.7.2 The following table provides a breakdown of the Essential Community Provider categories and the specific provider types and facilities.

ECP Category	ECP Provider Types
Family Planning Providers	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

2.1.7.3 A narrative justification must be included as part of the Qualified Health Plan application or applicants that provide a majority of covered services through employed physicians or a single contracted medical group must have the equivalent number of provider locations in Health Professional Shortage Areas and low-income zip codes.

2.1.8 Section VIII – Establishment of Reasonable Criteria

2.1.8.1 Adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to:

2.1.8.2 Any exceptions or deviations from the standards identified below (refer to 3.1.9 Section IX – Participating Provider Availability and Accessibility Standards) must be approved by Commissioner.

Oliver Wyman would work with the Department/Commissioner if any alternative criteria are discovered during the review. We would notify the Department immediately and provide all relevant information so the Department is able to make a decision. We would be available to help, if the Department/Commissioner desires additional help.

2.1.9 Section IX – Participating Provider Availability and Accessibility Standards

2.1.9.1 Accessibility standards have been developed to address the fact that population density in the carrier's geographic area varies from one (1) defined market region to another.

2.1.9.2 One (1) set of standards for each type of geographic area (metro, micro, rural or Counties with Extreme Access Considerations) will be addressed separately for each category.

County	Designation
CARSON CITY	Metro
CHURCHILL	CEAC
CLARK	Metro
DOUGLAS	Micro
ELKO	CEAC
ESMERALDA	CEAC
EUREKA	CEAC
HUMBOLDT	CEAC
LANDER	CEAC

County	Designation
LINCOLN	CEAC
LYON	Micro
MINERAL	CEAC
NYE	CEAC
PERSHING	CEAC
STOREY	Rural
WASHOE	Metro
WHITE PINE	CEAC

2.1.9.3 County designations are based on the U.S. Office of Personnel Management population and density parameters. The first table below lists the parameters used to determine the county type designations.

	Populations	Density
Metro	≥ 1,000,000	10 - 999.9/mi^2
	500,000 - 999,999	10 - 1,499.9/mi^2
	200,000 - 499,999	10 - 4,999.9/mi^2
	50,000 - 199,999	100 - 4,999.9/mi^2
	10,000 - 49,999	1,000 - 4,999.9/mi^2
Micro	50,000 - 199,999	10 - 99.9/mi^2
	10,000 - 49,999	50 - 999.9/mi^2
Rural	10,000 - 49,999	10 - 49.9/mi^2
	< 10,000	10 - 4,999.9/mi^2
CEAC*	Any	< 10/mi^2

* CEAC - Counties with Extreme Access Conditions

2.1.9.4 Each carrier must demonstrate that its network meets the established time and distance requirements and that 90% of the population of the service area meets the time and distance standards. The 90% standard is based on standards included in or adopted by reference in LCB File No. T007-16 and are subject to change annually based on the standards established by the Commissioner of Insurance

2.1.9.5 Carriers will be held accountable for meeting the standards described. The accessibility standards outlined in 3.1.9.6, 3.9.1.7, 3.9.1.8, and 3.9.1.9 are based on the standards included in LCB File No. T007-16 and are subject to change annually based on the standards established by the Commissioner of Insurance.

2.1.9.6 ACCESSIBILITY STANDARDS: METRO*

Type	**Specialty**	**Max Time (Mins)**	**Max Distance (Miles)**
Provider	Primary Care	15	10
	Endocrinology	60	40
	Infectious Diseases	60	40
	Mental Health	45	30
	Oncology - Medical/Surgical	45	30
	Oncology - Radiation/Radiology	60	40
	Pediatrics	25	15
	Rheumatology	60	40
Facility	Hospitals	45	30
	Outpatient Dialysis	45	30

2.1.9.7 ACCESSIBILITY STANDARDS: MICRO*

Type	Specialty	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	30	20
	Endocrinology	100	75
	Infectious Diseases	100	75
	Mental Health	60	45
	Oncology - Medical/Surgical	60	45
	Oncology - Radiation/Radiology	100	75
	Pediatrics	30	20
	Rheumatology	100	75
Facility	Hospitals	80	60
	Outpatient Dialysis	80	60

2.1.9.8 ACCESSIBILITY STANDARDS: RURAL*

Type	Specialty	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	40	30
	Endocrinology	110	90
	Infectious Diseases	110	90
	Mental Health	75	60
	Oncology - Medical/Surgical	75	60
	Oncology - Radiation/Radiology	110	90
	Pediatrics	40	30
	Rheumatology	110	90
Facility	Hospitals	75	60
	Outpatient Dialysis	90	75

2.1.9.9 ACCESSIBILITY STANDARDS: COUNTIES WITH EXTREME ACCESS CONSIDERATIONS ("CEAC")*

Type	Specialty	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	70	60
	Endocrinology	145	130
	Infectious Diseases	145	130
	Mental Health	110	100
	Oncology - Medical/Surgical	110	100
	Oncology - Radiation/Radiology	145	130
	Pediatrics	105	90
	Rheumatology	145	130
Facility	Hospitals	110	100
	Outpatient Dialysis	125	110

*Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers of facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined in 2.1.9.6, 2.1.9.7, 2.1.9.8, and 2.1.9.9.

The Oliver Wyman proprietary Provider Network Adequacy Tool is flexible with model inputs that handle the requirements listed above in this section (Section 2.1.9). The specific inputs are specialty types, population densities by county, distance and times. The output will determine if the networks meet the Nevada requirements for at least 90% of the eligible population in an area.

2.2 NETWORK ADEQUACY ANALYSIS

2.2.1 Section I – Data Collection

2.2.2.1 The vendor must be able to collect the necessary data through System for Electronic Rate and Form Filing (SERFF). This data includes, but is not limited to, the CMS ECP/Network Adequacy Template, Service Area Template, Plans and Benefits Template and Network ID Template. The data templates that carriers are required to submit for network adequacy analysis are subject to change based on the requirements of CMS and the Division.

Oliver Wyman Actuarial (OWA's) proprietary Network Adequacy Tool is designed to run off of the various templates that carriers submit through SERFF. The above templates appear to be those that are required to be submitted in the HIOS binders. We currently use all of these items when we perform our network reviews for other state regulators. Any future changes to the data templates would be incorporated into our Network Adequacy Tool.

2.2.2.2 The Division will require carriers to review network data prior to submission for errors and proper formatting however the vendor may need to review and scrub the data to identify and remove potential errors which could impact the network adequacy analysis.

When performing the network adequacy analysis, OWA will run a variety of error and consistency checks. These checks would be mutually agreed on between OWA and the Nevada Division of Insurance. Sample checks could include invalid data submissions such as invalid zip codes and invalid ECP codes.

2.2.2 Section II – Analysis

2.2.2.1 The vendor must use the data collected in section 2.2.1 to analyze the adequacy of the network. The current standards outlined in section 2.1 use time and distance metrics however these metrics are subject to change and additional metrics could be added.

OWA's Network Adequacy Tool is currently set up to account for distance and timing requirements. [The timing requirements are based on formulas that take into account distances and the type of area (i.e. Metro, Micro, Rural, CEAC.)] OWA's Network Adequacy Tool will use the current standards outlined in section 2.1 as an input into our model in the form of data table(s). Changes to requirements would simply require updating the table(s). Additional metrics would be treated in a similar manner, assuming the data needed for the additional metrics is included in the standard templates provided by the carriers. If metrics not supported by the data templates are required, the time and effort in updating our tool would depend on the scope of the changes.

2.2.3 Section III – Analysis Output and Reports

2.2.3.1 The vendor must be able to provide output of the network adequacy analysis breaking down the results by a specific region, such as: state, service area, county, or zip code.

OWA's Network Adequacy Tool performs the testing at the zip code level and produces outputs at the state level by zip and county. This is done for each metric that is tested. The output will demonstrate where the specific providers are located, and will color code the zip codes and counties that pass the test versus those that fail the test. A sample output map is included in Section VIII (Other Informational Material) along with additional descriptions of the map.

2.2.3.2 The vendor may be required to provide additional reports, as well as, summary reports on an as needed basis based on the needs of the Division.

In addition to assisting other state(s) with their network adequacy testing, OWA develops various reports for the state(s), including final reports with maps, reports of outstanding issues with carriers and networks, and status reports. Additional reports can be tailored to the Nevada Division of Insurance's specifications. A sample final report will be included in Section VIII (Other Informational Material).

2.2.4 Section IV – Network Adequacy Determination Timeline

2.2.4.1 As stated in the introduction to section 2.2 the Commissioner has 90 days from application to determine the adequacy of a network plan. Network adequacy

determination is currently done during the rate review process which typically begins between May and July of each year.

OWA understands the timeline that the Nevada Division of Insurance is bound by, and is committed to meeting these timelines. OWA has extensive experience with these timelines and understands the various issues that can arise during the rate review process. As such, our expertise in the subject matter can help curtail delays in timing, should issues or special considerations arise.

Oliver Wyman is ready to begin work on this project when the State is ready to award the contract. We have the staff capacity to perform this work and we will provide the reviews in a timely manner and be completed well within the 90 day requirement.

- ***We will review the files submitted by the issuers within 3 days of receipt to make sure we have all of the necessary information and that the files are complete.***
- ***We will perform the initial network adequacy review within 1 week following the verification of all necessary information at which point we will inform the department of any initial failings.***
- ***This time frame will leave sufficient time for carriers to respond to the set of questions, and will keep within the State's required timeline of 2 weeks for responses between the State of Nevada and the carriers.***
- ***We will provide the Department our letter of recommendation in draft form within 2 weeks of completing the review, specifically, after all questions from the carrier are addressed sufficiently. However, the Department will be aware of the status of all reviews and issues, as we give you weekly status reports.***
- ***In our experience, the typical time for reviews is 30 to 60 days, which is well within the State of Nevada's timeline.***

2.2.4.2 The following is an example of the network adequacy timeline for plan year 2018. The timeline is a representation of the process and may vary on a case by case basis. The Division normally allows a two week period for carriers to respond to objections and two weeks for the Division to provide a response to carriers.

June 12, 2017 - Binders due for all carriers

June 26, 2017 - DOI sends first network adequacy objection letter to carriers via SERFF

July 10, 2017 - Revised network adequacy data and documentation due in SERFF
July 24, 2017 - DOI sends second network adequacy objection letter to carriers via SERFF

August 07, 2017 - Revised network adequacy data and documentation due in SERFF

August 21, 2017 - DOI sends third network adequacy objection letter to carriers via SERFF

September 04, 2017 - Revised network adequacy data and documentation due in SERFF

September 10, 2017 - DOI makes final network adequacy determinations

OWA has reviewed the sample dates provided above, and is in agreement with the proposed timeline. The timeline consists of two weeks for the carrier to respond to objections and two weeks for the Nevada Division of Insurance to respond. It is stated in Amendment 01, question 10 that all communication will flow through the state. Therefore, OWA proposes to have analysis/responses to the state 2 days prior to the state's deadline to the carriers in order to allow the state time to review OWA's analysis/responses. If this timing is inadequate for the state, OWA will work with the state to ensure an acceptable delivery date is agreed on. The timelines agreed upon are under the assumption that the carriers will provide the data requested in a timely manner. Should special circumstances accompany the carrier(s), then the timeline will be adjusted and agreed upon between OWA and the Nevada Division of Insurance on a case-by case basis.

Section VI – Company Background and References - Section 3 in RFP 3509

3.1 VENDOR INFORMATION

3.1.1 Vendors shall provide a company profile in the table format below.

Question	Response
Company name:	Oliver Wyman Actuarial Consulting, Inc. – Subsidiary of Marsh & McLennan Companies
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	New York
Date of incorporation:	December 6, 2000
# of years in business:	31 Years
List of top officers:	CEO: Scott McDonald
Location of company headquarters, to include City and State:	New York, NY
Location(s) of the office that shall provide the services described in this RFP:	155 N Wacker Drive Suite 1500 Chicago, IL 60606
Number of employees locally with the expertise to support the requirements identified in this RFP:	4
Number of employees nationally with the expertise to support the requirements in this RFP:	13
Location(s) from which employees shall be assigned for this project:	155 N Wacker Drive Suite 1500 Chicago, IL 60606

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

OWA is not a Nevada-based business.

3.1.3 **Please be advised**, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	Should we be awarded a contract with this RFP, we will obtain a Nevada business license on an expedited basis.
Legal Entity Name:	Oliver Wyman Actuarial Consulting, Inc.

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	X	No	

If "No", provide explanation.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	X

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	X

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or

producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	X

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	Response	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in ***Attachment D, Insurance Schedule for RFP 3509.***

OWA agrees to provide the insurance requirements specified in Attachment D if awarded a contract.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Oliver Wyman is a wholly-owned subsidiary of Marsh & McLennan Companies, a publicly-held company with $13 billion in annual revenue. Its stock (ticker symbol:

MMC) is listed on the New York, Chicago, and London stock exchanges. Oliver Wyman has 15 different offices across the United States. However, the majority of work would be completed by staff in our Chicago, Illinois office.

The Oliver Wyman Actuarial Consulting (Oliver Wyman) practice provides actuarial, financial, operational, and risk management services to a variety of clients including: insurance and financial service companies, health care providers, insurance regulators, governments, trusts, law firms, and corporations that retain risk. Oliver Wyman has 125 credentialed actuaries in the U.S., Canada and the Caribbean, with 26 of the 125 credentialed actuaries in the health practice. We have extensive experience working with various regulatory agencies across the country. Most recently, the health practice has worked with regulatory agencies in ten different states, as well as with the Centers for Medicare and Medicaid Systems (CMS) in the following manner:

- ***OWA has provided support to agencies on network adequacy, composite rating issues, tool development etc. For example, we have a Network Adequacy Tool that displays geographic areas failing the specified distance requirements in a simple and easy to understand map.***
- ***Oliver Wyman performs reviews of rate filings regularly for seven state agencies. These filings include rates for individual health products, small group health products, Medicare supplement products, long-term care insurance and other accident and health products such as hospital indemnity and cancer plans. In addition, we regularly participate as expert witnesses in rate hearings on individual and Medicare supplement rate filings.***
- ***OWA has been retained by three states and CCIIO to help those agencies evaluate their rate review process with regard to the Federal rate review requirements for effective programs as well as benchmarking against other rate review programs and provide additional information for areas of improvement.***
- ***CCIIO retained Oliver Wyman to perform rate compliance reviews and unreasonable rate review for the five states where CCIIO has direct enforcement authority. We review approximately 200 filings.***
- ***We are currently assisting our commercial insurance clients in understanding the impacts of legislative changes so that they may best position themselves in these uncertain times. There are numerous proposals and ideas to change or replace portions or all of the ACA. We have utilized our proprietary models to simulate the impact on the overall market and the various sections of the market (e.g. the individual, small group, large group, Medicaid and uninsured populations).***

We believe our significant amount of experience over the past 20+ years is relevant as the health insurance market continues to change with the possibility that those changes will result in giving state authorities more control.

We are considered by our peers and clients to be on the leading edge of health care reform. We have a solid understanding of the potential impacts that federal health care reforms may have on both the individual and group insurance markets. We have worked with several regulatory agencies helping them with their evaluation of the implementation of public exchanges, market strategies and process for the review and certification of QHPs. We have also worked with agencies and insurers in analyzing the impacts to the health insurance market based on currently proposed legislative changes.

All members of our proposed team possess considerable knowledge and expertise in actuarial science as well as being presenters at Society of Actuaries (SOA) and other meetings. Through our involvement in the Academy and Society, as well as through the work we perform for our clients, we are able to stay abreast of new trends in product development and actuarial science.

All members of our proposed project team that are members of the Society of Actuaries are members in good standing with the American Academy of Actuaries. Because our professional staff is sufficiently large in number and diverse in experience, we can assure the Nevada Department of Insurance that we are capable of providing the appropriate resources, in terms of both skill and cost, for the proposed RFP 3509.

3.1.10 Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Oliver Wyman Actuarial has provided the services described in this RFP for approximately 4 years – since the inception of the network adequacy requirements via the ACA.

3.1.11 Financial information and documentation to be included in accordance with ***Section 8.5, Part III – Confidential Financial Information***.

The information for section 3.1.11 can be found in the accompanying Financial Information Part III document.

3.1.11.1 Dun and Bradstreet Number

3.1.11.2 Federal Tax Identification Number

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

3.2 SUBCONTRACTOR INFORMATION

Subcontractors are defined as a third party, not directly employed by the contractor, who shall provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.

3.2.1 Does this proposal include the use of subcontractors?

Yes		No	X

If "Yes", vendor shall:

3.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor shall perform services.

3.2.1.2 If any tasks are to be completed by subcontractor(s), vendors shall:

A. Describe how the work of any subcontractor(s) shall be supervised, channels of communication shall be maintained and compliance with contract terms assured; and

B. Describe your previous experience with subcontractor(s).

3.2.1.3 Provide the same information for any proposed subcontractors as requested in ***Section 3.1, Vendor Information***.

3.2.1.4 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

3.2.1.5 Vendor shall notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in ***Section 3.2, Subcontractor Information***. The vendor shall receive agency approval prior to subcontractor commencing work.

3.3 BUSINESS REFERENCES

3.3.1 Vendors shall provide a minimum of three (3) business references from similar projects performed for private and/or public sector clients within the last five (5) years.

Reference 1: ***Illinois Department of Insurance***

Contract Period: ***2011 - Present***

Scope of Work: ***We have provided assistance to the Department as they fine-tuned their rate review process in support of having an effective rate review as defined by the federal government. As part of our work with the Department, we have performed network adequacy reviews for exchange plans and have established a rate review checklist to be used with each rate increase filing. We work with the Department on issues with companies and the rate filing process, use of rates prior to formal approval and other significant issues that arise during reviews. We perform rate reviews for all non-grandfathered rate increases. In addition, we have reviewed the rates that are filed for plans seeking to become Qualified Health Plans in the Marketplace.***

Contact Information: ***Mr. Jeffrey Scott***
Illinois Department of Insurance
320 West Washington
Springfield, IL 62701
Phone: (217) 558 – 4844
Email: jeffrey.scott@Illinois.gov

Reference 2: ***Maine Office of the Attorney General***

Contract Period: ***2004 - Present***

Scope of Work: ***For this client, we review rate filings of the several different health insurance companies that offer individual ACA products. As part of this work, we have reviewed several provider networks to understand the impact on the rates, the assumptions used in the pricing and the impact to consumers with regard to availability and access to providers as issuers have moved to narrow network products. One example was a carrier that narrowed the provider network in a specific area of the state – we reviewed the information to determine whether the consumers in that area had access to an appropriate number of providers.***

Contact Information: ***Ms. Christina Moylan***
Assistant Attorney General
111 Sewall Street
Augusta, ME 04330
Phone: (207) 626 – 8838
Christina.Moylan@maine.gov

Reference 3: ***US Health and Life***

Contract Period: ***2013 - Present***

Scope of Work: ***As part of product rate development and premium pricing for this client, we were asked to compare and price various provider networks for this client. During this work, we reviewed several provider networks the client has in place and estimated the impact those provider networks have on pricing, utilization and managed care impacts.***

Contact Information: ***Mr. Mike McCollom***
US Health and Life, VP Sales and Underwriting
8220 Irving Rd
Sterling Heights, MI 48312
Phone: (248) 341 – 3011
Email: mccollom@ushealthandlife.com

3.3.2 Vendors shall submit ***Attachment E, Reference Questionnaire*** to their business references.

The reference questionnaires were sent to our references with deadlines and submission information and we have received confirmation that the questionnaires have been received by the state.

3.3.3 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in ***Section 7, RFP Timeline*** for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

3.3.4 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

Section VII – Attachment F – Proposed Staff Resumes

Company Name Submitting Proposal:	***Oliver Wyman Actuarial***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Beth Fritchen***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Partner***		
# of Years in Classification:	***29***	**# of Years with Firm:**	***28***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE
Information should include a brief summary of the proposed individual's professional experience.

Beth has provided actuarial consulting services for over 25 years. Her present responsibilities include product development for managed care and traditional plans, trend analysis, review of filings and network adequacy for state insurance departments, fee schedule analysis, financial management and forecasting, compliance, underwriting issues, provider capitation development, mental health pricing, Medicare capitation development, Medicaid capitation development, reserve analysis, and legislative analysis. She has performed forecasting and financial valuations for start-up organizations, as well as for potential mergers and acquisitions.

RELEVANT EXPERIENCE
Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

(1989 – Present), Oliver Wyman Actuarial Consulting, Inc., Chicago, IL Partner
(1988 – 1989), Wisconsin Physicians Service, Madison, WI, Analyst

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Wisconsin – Madison, B.S. in Mathematics with emphasis in Actuarial Science, 1988

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

Fellow of the Society of Actuaries (2002)
American Academy of Actuaries (1995)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference 1: Jeffrey Scott, Legislative Liaison, IL Department of Insurance, (217) 558-4844, Jeffrey.Scott@illinois.gov

Reference 2: Mike McCollom, VP Sales and Underwriting, US Life and Health, (248) 341-3011, Mccollom@ushealthandlife.com

Reference 3: Christina Moylan, Assistant Attorney General, Office of the Attorney General of Maine, (207) 626-8838, Christina.Moylan@Maine.gov

Company Name Submitting Proposal:	***Oliver Wyman Actuarial***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Shari Westerfield***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Consultant***		
# of Years in Classification:		**# of Years with Firm:**	***<1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE
Information should include a brief summary of the proposed individual's professional experience.

Broad health actuarial experience spanning nearly 30 years in both insurance company and consulting environments.

RELEVANT EXPERIENCE
Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Provided actuarial support related to various BlueCard network issues, including measurement, custom tiering, and discounts, Blue Cross Blue Shield Association, Chief Actuary, 2005-2017; Provider network measurement and pricing for various health insurance products, Trustmark Insurance Company, Assistant Actuary, 1991-1998.

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Illinois at Urbana-Champaign, BS in Actuarial Science, May 1988.

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

Member, American Academy of Actuaries (1995)
Fellow, Society of Actuaries (2001)

REFERENCES
A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Kim Holland, Vice President of State Affairs, Blue Cross Blue Shield Association, (202) 626-4810, kim.holland@bcbsa.com

Kris Haltmeyer, Vice President of Health Policy, Blue Cross Blue Shield Association, (202) 626-4814, kris.haltmeyer@bcbsa.com

Audrey Halvorson, VP and Chief Actuary, Blue Cross Blue Shield of Arizona, (602) 864-5837, audrey.halvorson@azblue.com

Company Name Submitting Proposal:	***Oliver Wyman Actuarial***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Gabriel Rivera***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Consultant***		
# of Years in Classification:	***7***	**# of Years with Firm:**	***3***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE
Information should include a brief summary of the proposed individual's professional experience.

Gabriel Rivera is a consultant with 7 years of experience. His recent experience includes network adequacy analysis for state regulator, regulatory rate reviews for various states, large group rate development and large group regulatory assistance, on-exchange rate development for individual and small group plans, MA risk score improvement and utilization management impact analysis, and commercial benchmarking.

RELEVANT EXPERIENCE
Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

(2015 – Present), Oliver Wyman Actuarial Consulting, Inc., Chicago, IL - Consultant
(2011 – 2015), Donlon & Associates, Lisle, IL - Consultant

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Roosevelt University – Chicago, IL, M.S. in Mathematics with emphasis in Actuarial Science, 2011

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

Associate of the Society of Actuaries (2017)
American Academy of Actuaries (2017)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Reference 1: Mary Buscaglia, Health Service Administrator, Contra Costa Health Plan, (925) 957-5490, Mary.Buscaglia@hsd.cccounty.us

Reference 2: Eric Anderson, Actuary, IL Department of Insurance, (217) 782-6284, Eric.Anderson@Illinois.gov

Reference 3: Amit Trivedi, Chief Actuary, Beacon Health Options, (203) 543 5060, Amit.Trived@gmail.com

Company Name Submitting Proposal:	***Oliver Wyman Actuarial***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Michael Kestler***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Consultant***		
# of Years in Classification:	***2***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE
Information should include a brief summary of the proposed individual's professional experience.

Michael Kestler's primary responsibility is to provide support on work pertaining to the health insurance industry. His experience consists of computer programming skills used to evaluate data, familiarity with running the HHS Risk Adjustment Model for purposes of estimating risk and comparing cohorts, developed ACA Cost Share Reduction reconciliation estimates, developed a tool that scraped data from multiple carrier submitted templates and combined into one large database, provided support in the health insurance rate review and compliance review regulatory process for the individual and small group markets , experience in estimating future revenue impact for provider systems in Medicare Advantage networks.

RELEVANT EXPERIENCE
Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

(2016 – Present), Oliver Wyman Actuarial Consulting, Inc., Chicago, IL - Consultant

EDUCATION
Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Loyola University, Chicago, IL B.S. in Mathematics with emphasis in Actuarial Science, 2016

CERTIFICATIONS
Information required should include: type of certification and date completed/received.

REFERENCES
A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

-LeAnn Woldt, Business Intelligence Manager, Group Health Cooperative of South Central Wisconsin, (608) 251-4156, LWoldt@ghcsw.com

-Eric Anderson, Actuary, Illinois Department of Insurance, (217) 782-6284, Eric.Anderson@Illinois.gov

-Karen Bender, President, Snowway Actuarial and Healthcare Consulting, LLC, (920) 826-2422, Karen.Bender@Saahc.com

Section VIII – Other Informational Material

Exhibit 1 – Sample Map Output

The map below represents a sample map displaying the areas where the network is inadequate for a specific specialty. In this case, the specialty is Chiropractor. For each network, the state would receive a map of Nevada for each of the specialties that are being tested. The yellow dots on the map represent a specific provider for the tested specialty. The area in green represents adequate coverage, and the areas in gray represent inadequate coverage. The borders represent both counties and zip codes.

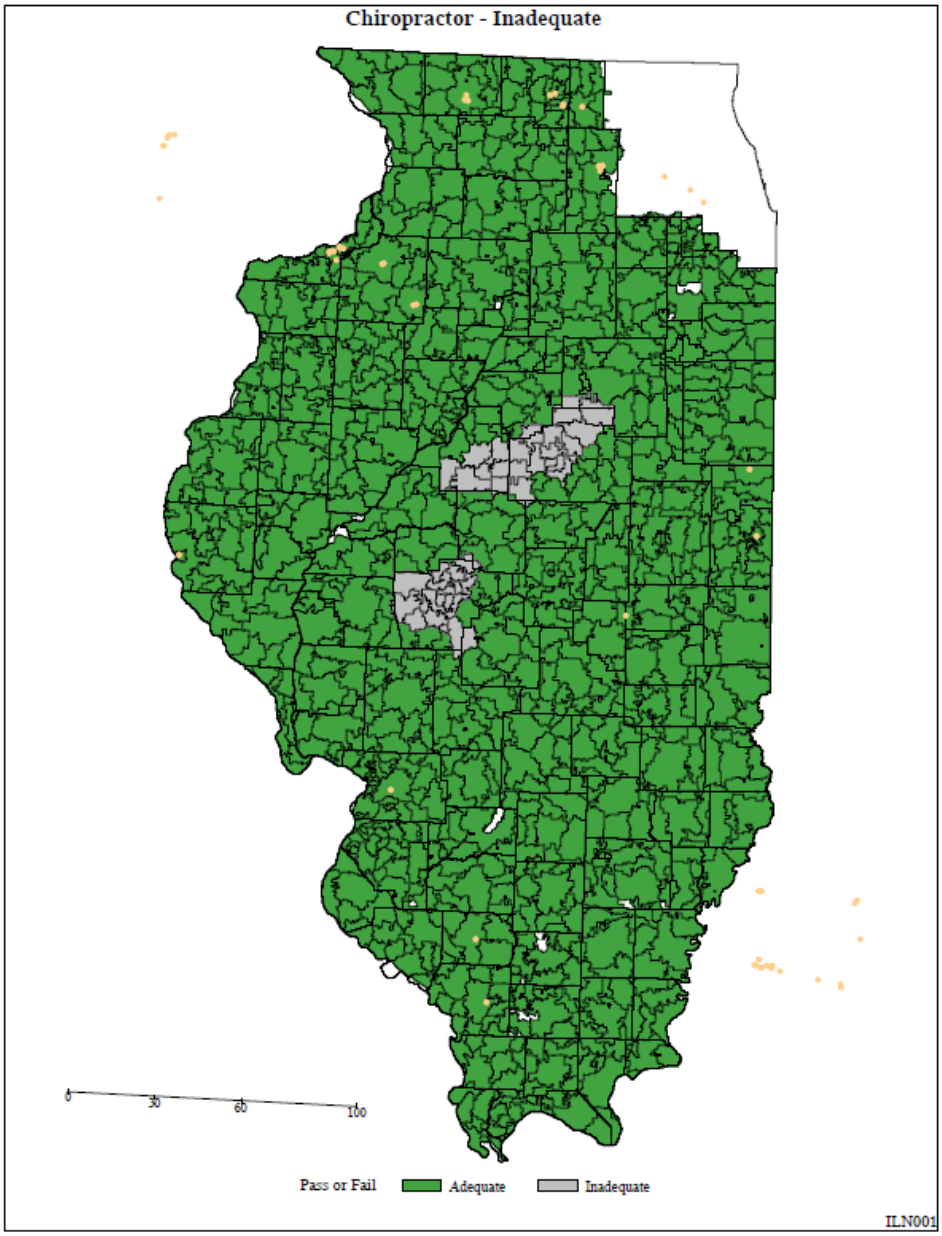

Exhibit 2 – Sample Results Letter

TO: [redacted]
DATE: July 14, 2017
FROM: Beth Fritchen, FSA, MAAA
SUBJECT: [redacted]
COPY: Gabe Rivera

This document provides a summary of the results from our analyses on network adequacy performed on the on-exchange [redacted] offered in Illinois.

Methodology

We used the proprietary Oliver Wyman Network Evaluation Tool (NET tool) adjusted for the Illinois population and benchmarks established by the Department of Insurance (DOI). Some adjustments to the analysis are sometimes necessary after reviewing some of the networks to address specific issues.

The provider directory for each network ID filed by each issuer was analyzed separately in relation to the service area the issuer assigned to the network. The providers and service area within a zip code were compared with the requirements in the Illinois Review Requirements Checklist. In addition to the time and distance requirements, there are minimum requirements of one hospital facility per county and providers to enrollment ratios. All of these were checked for each zip code within a service area.

If a zip code did not meet all of the above requirements for a specific provider or facility type, it was deemed as inadequate and is colored gray on the maps attached to this memo.

The following specialties and facility types were tested:

Specialty and Facility Types	
Family Medicine	Allergy & Immunology
Cardiovascular Disease	Chiropractor
Dermatology	Endocrinology
ENT/Otolaryngology	Gastroenterology
General Surgery	OB/GYN
Infectious Disease	Nephrology
Neurology	Neurological Surgery
Medical & Surgical Oncology	Ophthalmology
Orthopedic Surgery	Physical Medicine & Rehabilitation
Plastic Surgery	Psychiatry
Pulmonary Disease	Rheumatology
Urology	General Acute Hospital
Pediatrics	
Psychiatric Hospital	

Maps

Attached to this document are maps by network and provider type that demonstrate where the network is adequate, where it is inadequate and where the providers are located in the service area. For areas where [redacted] has demonstrated adequate providers, the map is colored green. For those areas that do not meet the DOI network guidelines, the map is colored gray. Yellow dots in the map show the location of each provider.

Overall Summary

In the analysis shown we have adjusted our benchmarking to be aligned with specialty requirements of 60 miles for urban and 100 miles for rural. There is also a check to ensure that there is at least one General Acute Hospital per county. This has been one of the more difficult criterias to meet, as there are many rural counties that only have 1 hospital. As such, special consideration was given in prior years to issuers who were not contracted with the hospital in that county, but were proactively seeking to contract with them. These special considerations were on a case-by-case basis with the expectation that it would be a one-time only exception. We have included the maps by specialty for the [redacted] networks tested that are color coded and reflect the reported "service area" for the network. The network for each map will be displayed in the bottom right corner.

For areas that failed (colored gray) in the maps attached, there was either a special consideration or one-time exceptions provided to the issuer, or we manually verified the adequacy. The special considerations and exceptions will be listed in the corresponding network section below:

Reliance and Data

We are providing this letter to you to communicate our findings regarding the filing under consideration. Distribution of this letter to parties other than the DOI by us or any other party does not constitute advice by us to those parties. The reliance of parties other than the DOI on any aspect of our work is not authorized by us and is done at their own risk.

In arriving at our opinion, we used and relied on information provided by [redacted] without independent investigation or verification. If this information is inaccurate, incomplete, or out of date, our findings and conclusions may need to be revised. While we have relied on the data provided by [redacted] without independent investigation or verification, we have reviewed the information for consistency and reasonableness. Where we found the data inconsistent or unreasonable, we have requested clarification.