Bulletin 95-2 October 30, 1995
Contracts with health care providers

This bulletin clarifies the position of the Division of Insurance regarding compensation arrangements that individuals, employers, insurers and health maintenance organizations (HMOs) have with health care providers. The principal focus of this position is solvency. It is the Commissioner's goal to see that consumers secure the solvency protections afforded by Nevada law. Compensation or provider arrangements must ensure the continuity of care and the welfare of HMO enrollees.

The similarities between a Physician Hospital Organization (PHO) and an Association of Independent Practitioners (IPA) make them identical for the purpose of this bulletin. One may be substituted for the other.

The Division treats all provider contracts in the same manner, whether the HMO is contracting with an individual provider or an IPA. The following statutes and regulations address provider contracts: NRS 695C.090(4), NAC 695C.015, 695C.190, and 695C.195.

NAC 695C.195 allows an HMO to capitate an IPA and individual providers. An HMO is financially responsible for its entire health plan whether the HMO contracts with providers directly or contracts with an IPA that furnishes providers under its contracts. Either way, rates must reflect provider arrangements and be adequate pursuant to NRS 695C.180 and NRS 695C.090(4)(d). The expected cost of services must be based on an actuarial computation. NAC 695C.l95(1)(b).

NAC 695C.137(4)(b) adds "incurred but not reported claims and other similar claims . . . according to good business and accounting practices . . ." to the reserve requirements for HMOs. Reserve adequacy for HMO and IPA arrangements is determined on a case by case basis. Additional reserves may be appropriate for an HMO in the following circumstances:

1. The HMO's only direct provider contract is with an IPA. The obvious difference in losing one IPA when compared to losing one single provider illustrates the additional risk for the HMO. The loss of a provider network through one controlling (and unlicensed) IPA would be disastrous to consumers.

2. The IPA collects premium from enrollees pursuant to a contract with the HMO. This involvement by the IPA may require the HMO to establish an additional contingency reserve.

3. The HMO transfers funds to an IPA pooling or "withhold"

arrangement. These are funds payable to providers following a defined period based on the utilization of health care services.

An HMO's financial risk does not lessen because of its association with an IPA.

Unauthorized risk assumption

The following arrangements, when not properly associated with an HMO, involve the business of insurance and require a certificate of authority under either chapter 695C or chapter 695F of NRS:

1. A freestanding group of providers, IPA or PHO that contracts directly with anyone including employers or trusts to accept health care risk through capitation.

2. Discount medical service clubs or freestanding discounted fee-for-service organizations whose discounts are excessive or whose membership fees (contributions) are high. Providers who cannot manage the discounts without fees or dues to offset their costs are involved in a plan of insurance. (Please contact the Division for opinions on this arrangement.)

The Commissioner encourages health care providers who have entered into health care delivery agreements, or who are considering doing so, to verify whether or not the arrangement complies with Nevada laws. The Division will assist providers to bring any arrangements into compliance with the Nevada Revised Statutes. The Commissioner welcomes dialogue with the health care and insurance industries on the state of the law concerning this subject.

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