VIEWPOINT

Should Health Care Systems Become Insurers?

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Incentives under the Affordable Care Act (ACA) are spurring increasing numbers of health care systems to assume the risk of paying for patient care, blurring the boundaries between care delivery organizations and insurers. New arrangements such as bundled payments, value-based purchasing, and accountable care organizations (ACOs) transfer financial risk from payers to health care systems. The union of payer and care delivery functions may engender opportunities for health systems to invest in prevention and more comprehensive, coordinated, patient-centered care.

Often, the goal of health care systems that adopt risk contracts is to contain costs in the face of mounting financial pressures. Under the ACA, Medicaid will expand and reimbursements for Medicare and fee-for-service care may shrink, creating the potential for financial losses. Meanwhile, ACO contracts have shown promise in slowing the increase in medical expenditures for public payers (eg, Medicare), as well as private payers (eg, UnitedHealth Group).[1,2] UnitedHealth, the nation's largest insurer, has said it will increase its payments contingent on quality and cost-efficiency metrics from $20 billion to $50 billion within the next 5 years. According to a recent survey,[3] 34% of hospitals and health systems already own a health plan and 21% of those expect to launch an insurance product in the next 5 years. In New York, 33 hospitals are in global capitation arrangements with 2 of the city's largest health plans, Healthfirst and MetroPlus.

> Most health care systems are ill-equipped to handle the operations of the insurance business (such as claims, appeals, and customer service)

Beyond global payment arrangements and partnerships, some health care systems hold ownership in an associated health plan. Indeed, the phenomenon of health care systems also functioning as insurers is not novel: integrated health systems such as Kaiser Permanente, Geisinger Health System, and the US Department of Veterans Affairs have bridged these roles for many years. But in the wake of the ACA, increasing numbers of health systems—in New York and elsewhere—are developing new ways of engaging with health plans (**Table**). Physicians and hospitals must distinguish between the different types of arrangements, for example contractual arrangements vs full ownership of health plans, based on the local financial and regulatory context.

Advantages of Health Care Systems as Insurers

Health systems that take on risk have several advantages. The arrangement drives integration, such that most of a patient's health care needs (and associated payments) are addressed by a single network, allowing care to be better coordinated. Some care may still be provided outside of the network but paid for by the insurer. At Montefiore Medical Center in Bronx, New York, an integrated provider association (IPA) assumes full financial and clinical risk for the delivery of health services to a given patient. Montefiore's Care Management Organization includes 300 staff members working to identify, track, and proactively manage the care of patients in the IPA. Preliminary evidence of the IPA's effectiveness from the Medicare Pioneer Accountable Care Organization model demonstrated superior performance on the tracked quality and patient experience measures, as well as a 7% total reduction in expenses compared with Medicare's benchmarked costs.

Cost savings are often realized by decreasing volume-based incentives in fee-for-service payment systems that can otherwise drive overuse. At Bronx-Lebanon Hospital Center in New York City, the hospital has a full financial risk arrangement with the Healthfirst health plan. Bronx-Lebanon Hospital Center receives a monthly per-member premium for each beneficiary. If there are savings at the end of the month, Bronx-Lebanon Hospital Center keeps a portion of them. In this way, capitation can help reduce use—particularly of expensive acute care resources—and incentivize better management of patients under its care.

Linking health care systems and payers also helps solve another entrenched problem contributing to high health care costs: a lack of price transparency. Asymmetric negotiating power between health care systems and payers contributes to higher prices and, therefore, higher costs. Integrated systems like Kaiser Permanente can bring that negotiation inside their own walls and thereby create effective price transparency.

Challenges of Health Care System–Insurer Arrangements

Accountable care organizations have already raised questions about how much health care system–insurer partnerships will create conflict with existing state and federal regulations designed to maintain a competitive marketplace.[4] These include antitrust regulations, bans on the corporate practice of medicine, and prohibitions on fee-splitting. In New York, in anticipation of these conflicts, legislation was passed in 2011 to provide safe harbor protections for care delivery organizations and payers entering into ACO contracts. Under these laws, the state department of health has the ability to issue certificates of authority authorizing health care systems to act as ACOs.

Other practical considerations present potential hurdles to greater health care system–insurer partnerships. The 2 industries are fundamentally dissimilar in terms of goals and human resources. Merging the 2 business mod-

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Table. Models of Partnership Between Health Care Systems and Insurers

Model	Description	Example
Full ownership	Joint governance between insurance plan and health care system; all participants in the health plan receive care from the associated health system	Geisinger Health System in Danville, Pennsylvania, offers group, individual, Medicare, and Children's Health Insurance Plan coverage to 290 000 members while providing care to a larger total population
Partial ownership	Health care system owns stake in the insurer, but governance and care relationships are not fully overlapping	Baystate Health in Springfield, Massachusetts, owns a majority stake in Health New England, a for-profit health maintenance organization
Partnership	Formal, documented relationship with the insurance plan preferentially referring patients to the health care system and the health care system entering into risk contracts for the insurance plan's patients.	North Shore Long Island Jewish Health System and UnitedHealth Group in New York offer a product for fully insured employer groups with 2-50 employees in Nassau, Suffolk, and Queens counties
Contractual arrangement	Health systems enter into risk-bearing contracts with insurance plans for specific populations of patients	Bronx-Lebanon Hospital Center and Healthfirst in New York have a full-financial risk arrangement; Healthfirst takes 10% to cover administrative costs and the rest goes into a pool to cover the costs of providing care; any savings are shared

els requires a significant investment of energy and capital that therefore may distract from core activities. Most health care systems are ill equipped to handle the operations of the insurance business (such as claims, appeals, and customer service). When a care delivery organization offers health insurance, it can complicate existing relationships with other commercial plans that may now view the organization as a competitor. For many facilities, having a payer function can raise uncomfortable tensions: Is it trying to generate revenue for the hospital by admitting patients or savings for the insurance plan by not doing so?

Furthermore, assuming risk is expensive, and systems must maintain adequate capital reserves to be a financially viable health plan. In the first wave of managed care in the 1990s, many health care system–based health plans could not support the financial risks associated with insurance and wound up divesting.[5] For example, in Phoenix, Samaritan Health System (now part of Banner Health) sold off its commercial and Medicaid plans to UnitedHealth. For outcomes to be different this time around, health systems must be more judicious about assuming risk and know how to manage population health and costs once they have done so.[6]

What the Future Could Look Like

Successful partnerships between health care systems and insurers are likely to have 4 key components.[7] First, the integrated arrangement must be built on a foundation of high-functioning primary care, with technology and staff supporting population health management. Second, it must incorporate organized, systemwide processes for quality improvement that include analysis and reporting of patient outcomes against evidence-based benchmarks. Third, it must fully engage patients with health outreach initiatives that support chronic disease self-management and preventive care. Fourth, integration requires systems to manage the cost of care, with a focus on avoiding preventable emergency department visits, hospital admissions, and specialty referrals.

Health systems that assume risk might apply the principles of rapid-cycle performance improvement, starting with small populations, tracking the effects of integration, and adjusting nimbly. For example, New York University Langone Medical Center, which provides care for approximately 200 000 unique hospital patients annually, has begun to transform its ambulatory services into a clinically integrated network to deliver more collaborative, accountable care. The initiative recently began to share risk through a partnership with the Cigna health plan, initially covering about 33 000 beneficiaries. Ultimately, the larger the proportion of a health system's budget that is dedicated to alternative payment arrangements, the more facile it will be to drive whole-system transformation.

Finally, the right governance structure is important for collaborations between health care systems and insurers to flourish. Paralleling the principle that care delivery transformation is the ultimate goal, health plan executive leadership should report to the health system's executive leadership in fully integrated systems. For other types of partnerships, operating relationships between the health plan and health system should be defined a priori and include sufficient funding for system restructuring, such as appropriate investments in health information technology. The ACA has already encouraged a wave of innovation to rethink the relationship between health care systems and health insurers. Now it is up to the leaders of health systems to nurture and build on that momentum in a sustainable way.

ARTICLE INFORMATION

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