At a Crossroad

Health-care reform could destabilize the health insurance industry. Aetna CEO Mark Bertolini is giving that a lot of thought.

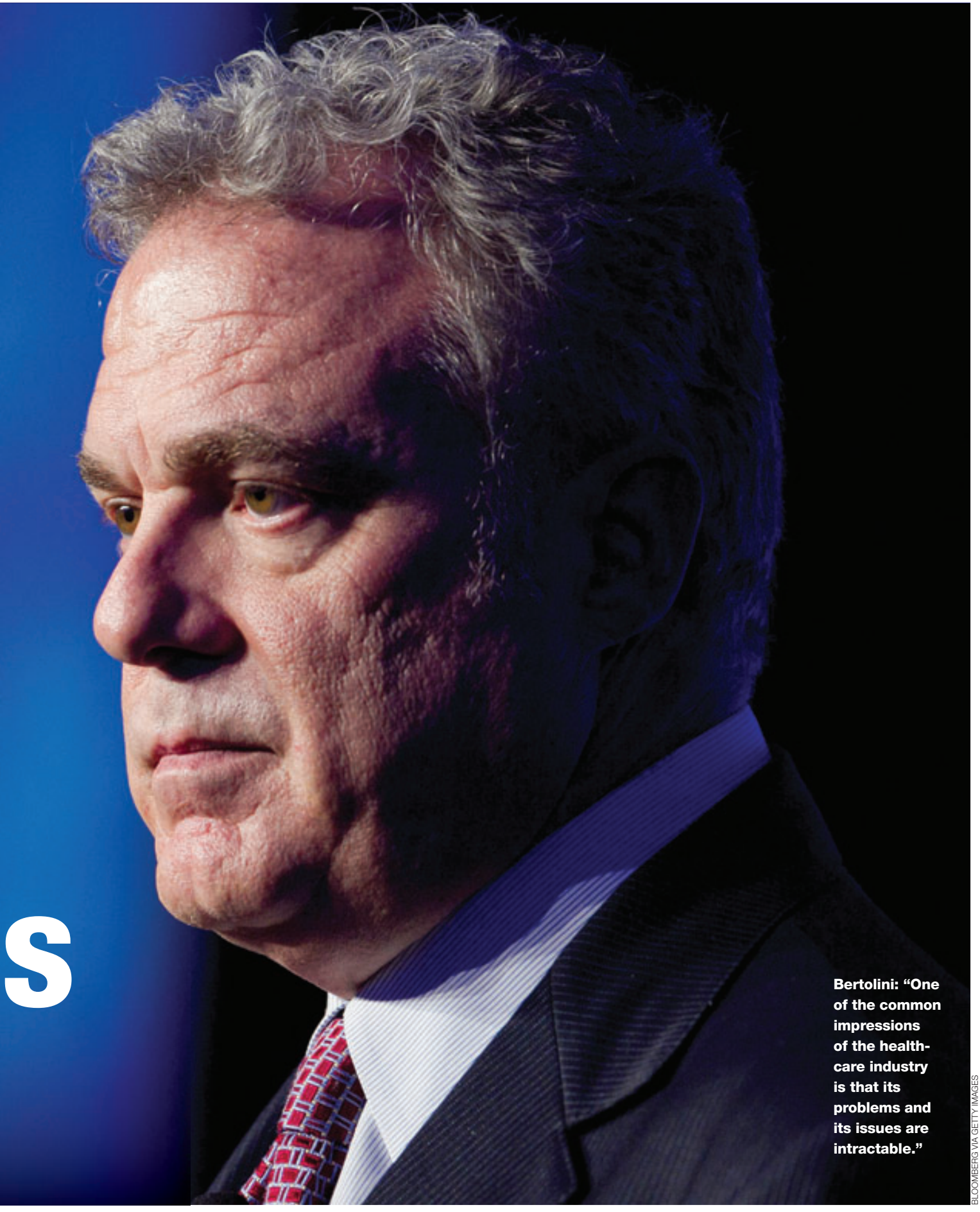
By Dylan Scott

Next year is the dawning of a new age in American health care. On Jan. 1, the major insurance reforms embedded in the Affordable Care Act (ACA) take effect. Every American will be able to get health coverage, regardless of any pre-existing conditions. At the same time, price controls will go into effect to limit how much insurers charge their sicker enrollees. States will be playing a central role by operating health insurance marketplaces where people can purchase private coverage, with some help from the feds. Between private insurance and the ACA's expansion of Medicaid, as many as 30 million people are expected to become insured over the next decade.

Nobody knows exactly what the health reform law—along with the relentless rise in health-care costs—will do to the insurance industry and to insurance premiums. Many in the private sector, however, are starting to sound the warning bell, saying that it's time for the industry to change. One of those people is Aetna CEO Mark Bertolini.

Aetna enrolls more than 40 million people in its medical, dental and pharmacy plans. It contracts with more than 1 million health-care professionals and collects more than $30 billion in insurance premiums. In short, Aetna's viability depends on the health of America's health-care system. That's why Bertolini is trying to stay ahead of the curve by re-imagining what his 160-year-old company's business model might look like in the decades ahead.

Governing spoke with Bertolini about his vision for the future and how it fits with political and economic variables. Here is that interview, edited and condensed for clarity and length.



Bertolini: "One of the common impressions of the health-care industry is that its problems and its issues are intractable."

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What do you think the health-care system of the future will look like? If we had to start all over, we would design the health-care delivery system to meet the capacity needs of the community it's serving—by understanding the demographics, the disease burden, and the economic and environmental trends of the local community.

We'd say, "Based on these inputs, here's what we think we'll need to deal with over the next 30 years and here's the capacity of the system we will need to deal with that." This would cover everything from the types and placement of facilities in the community, the skill sets necessary to operate and work in those facilities in taking care of the community, and the types of technologies that they'll need to support them. All of this is to improve the health of the population in a way that provides a more valuable input into the economy of that community. So it would be an investment in productivity. This is what we call population health management.

What do you mean by "population health management"? In that world, we would have a community-based organization that would not only be a large employer in the economy but also a key provider of the economic input. That would be a health system—a true population health system—which would meet with the community and understand the ongoing demography, disease burden and trends.

There wouldn't be plan designs. You wouldn't need them. What you would do is invest in all those things that are necessary to keep people healthy. For instance, a congestive heart failure discharge requires an office visit follow-up within two weeks to keep that patient out of the hospital again, which is one of the most expensive admissions that we have. So you might pay for the cab ride. [In another example], you might pay for diapers for a mother of three who can't afford them.

Your system would capitulate to meet the needs of that community over time. And the outcome that we would measure is, "Is this economy better off for that investment?"

What role does an insurance company like Aetna play in this community health system? A couple of things. First, we have the data to understand how that system should be constructed. [An insurance company is] the one organization in the health-care system today that actually sees everything that happens because we get all the claims. Second, we have the technology that supports the gathering of information and data. And last, we have the financing capability to make sure that that investment is well handled.

Think of an insurance company in this new world as a highly specialized bank. What we do is provide financing, risk management and reinsurance coverage. We provide intellectual property, data and technology as the intelligence side of a health-care system.

Are you already doing this somewhere? In China, we're going to be working in the Binhai area, which will be their new Silicon Valley, to set up this type of system. What we will do is create that infrastructure. We'll provide the technology platform. We'll provide the health system planning. We'll provide all that stuff—but not insurance. The government will do that. We'll show them how to finance and underwrite it.

So our role changes to an intelligence model, and we think that that's the right thing to do. We'll provide reinsurance coverage. But our role will fundamentally change, and will be very different from what we have here.

How would Aetna interact with health-care providers in a community health system? This requires us to go about our work differently. It's not a negotiation with providers over what to pay them, but a partnership with providers to understand what we're investing in and how we can both work together to make sure that investment achieves the maximum return. It requires the insurance industry to give up some of its intellectual property to the provider domain. It requires a partnership around technology, around the delivery of health care and the sharing of information, which we've long held to be proprietary. It really requires the providers to trust us in ways that they've never had to trust us—and for us to find a way to allow them to trust us.

It requires us to admit the things that we've done in the past that haven't worked and why they haven't worked. It requires us to open up and say: "Here are all the good, bad and the uglies." It requires us to show how we can make it overall better for the American health-care system, but more importantly, for the health of the nation's economy.

With reform, what kind of pressure is the health insurance industry facing? One of the common impressions of the health-care industry is that its problems and its issues are intractable. For a long time, the health insurance industry has tried various approaches to bringing health-care cost inflation under control, without much success. We've had moments of brilliance and impact, but it's been difficult. In part, I think that's because we've always confused the financing decision (how we're paying for it) with the investment decision.

It's much like buying a car. Today, you choose a car, understand its offerings and its price, and then you decide how you're going to pay for it. Whereas in the 1950s, you used to say "I can only afford X a month" and you'd get a car. So I think we've always confused the financing and investment decision in health care, and that has created this problem of what are we investing in versus how we're paying for it.

The Affordable Care Act creates an "action-forcing" event for us to focus on the investment decision, given that to some degree the financing decision is going to be constrained from a number of places. It's going to be constrained because health-care inflation is growing at twice the rate of the consumer price index. It's crowding out more and more of our budget and discretionary spending. [That cost inflation] jeopardizes the future of the country because Medicare and Medicaid are driving a vast majority of the budget deficits going forward. If left unchecked, they'll be a large part of the next $10 trillion worth of the nation's debt.

So I think those things say: "We've got to get this under control and now seems to be the time."

So the ACA is forcing you to change, and you think that's a good thing? When the health-care reform debate came along, it went from health-care reform to health insurance reform. It was easier to villainize the insurance companies and get something passed than to try to take on the entire health-care industry. So we got what we got; we got health insurance reform. And we view it this way: When somebody takes a $2.7 trillion industry and over the next decade throws $1.5 trillion into the pot, tosses it out on the table and says, "Who wants it?", there's an opportunity for people who are creative and willing to think differently about how they run their businesses.

So we've been very engaged. We're engaged in making sure we are compliant with the law, and we are engaged in the regulatory process. We believe that by doing that, not only do we help get a better bill in place—because it wasn't passed and written very well by virtue of the politics of the time—but we also create more opportunities in finding a better way to do it.

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You said you're going to be testing this new model in China. Why China? We don't have the barriers there that we have here. We don't have the entrenched interests, either politically or economically, to overcome. We don't have the technology barriers to overcome because over there they don't have landlines and fax machines. They use mobile technology and wireless. Just as we see the states as a laboratory for democracy, we think the developing nations are a laboratory for the future of health-care systems. We think we get there more quickly.

China has watched the developing nations. By the way, the United States is not unique in the crushing burden of health-care costs on its budget. You can see it in Europe. You can see it beginning in the Middle East, as they deal with one of the highest diabetes disease burdens in the world. China knows it's coming. China already has 95 million diabetics versus the United States' 26 million. So as they look forward, they say, "We can't afford what the U.S. health-care system has generated. We need to get in front of this and learn from the lessons of the West. Who can help us do that?"

How will you translate lessons learned there to the United States? The hope is that the projects we're doing in China—technology-based, intellectual property transfer, giving up the rights to having it be agnostic to the payer system—are things providers can use for any payer.

All of those things would allow us to try it here in the United States. For us, trying it with a few people who are ahead of the curve, understand where this is headed and want to be in front of the change, we believe we create a cresting wave phenomenon over time.

Are we talking about moving to single-payer, national government-run health insurance? One of the reasons we want to be in front of it is we want to be a net consolidator. We want to get in front of the change and be part of the new system. We're a 160-year-old company. We have a lot of capital invested in the current business model we have, but if we're able to reuse that capital to move us to the new world, we'll be in a good place.

I don't think we ever get to single-payer because single-payer is the government paying the bills and the government doesn't do that in any way today. Most people think the government is a single-payer in Medicare. It's not. There are dozens of payers, including us, in the Medicare space that pay bills for Medicare patients. Government doesn't even enroll a patient. We do all that. They just provide the money.

We'll see just how effective they are at putting together a significant health-care technology development to enroll people in the health insurance exchanges on Oct. 1. I think we're going to see a fits-and-starts kind of approach to health-care reform. That makes single-payer anytime soon doubtful.

What are the stakes here? Will insurance companies have to change or fade away? If you were to talk to my counterparts in the big companies, they would give you their version of what they're doing relative to changing the nature of relationships with providers. Some of them are buying practices and health systems. Others are trying to build collaborative relationships with them. So everyone is dabbling with: "What does the nature of the change need to be?" We've all done that over the years, so I think everybody does realize that it's time to change.

Whether there's an earnest investment and a willingness to really change is going to be a key driver of whether or not we're successful. This country is going to have to deal with very difficult issues about health care and about other entitlements, and if we don't get at these issues, the social and cultural ramifications are going to be difficult for everybody. At that point, I don't know what happens. I don't know if we go out of business. Take a look at what's going on in Washington today around the budget. Who would have ever thought that people would let it go on for four and a half years? But here it is.

So what does it take to have people finally say, "We can't do this anymore?" Well, there will be some point when the economics will be so compelling that we can't pay for our health-care system. Then we're going to have to make some really difficult decisions. Those difficult decisions will determine who lives or dies as a result. **G**

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