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From Managed Care To Consumer Health Insurance: The Fall And Rise Of Aetna

Aetna has taken steps to ensure that it is never again portrayed as an entity standing between consumers and the services they wish to use.

by James C. Robinson

ABSTRACT: This paper documents Aetna's fall as the nation's largest managed care plan and its subsequent reemergence as a smaller but more profitable multiproduct insurer. The paper emphasizes the transformation in corporate goals, product design, organizational structure, information technology, product mix, premiums, cash flow, net income, and share prices. Disciplined underwriting and pricing have restored the firm to profitability and set the foundation for new growth. The implications for the health care system as a whole are less unambiguously positive.

Throughout the turbulent 1990s Aetna was the poster child for the aspirations and failures of managed care, channeling patients and physicians into health maintenance organizations (HMOs); holding down premiums so that enrollment would grow; acquiring competitors to penetrate new markets; and then floundering in adverse publicity, economic shortfalls, and investor disenchantment. Aetna's near-death produced a thoroughgoing change in executive leadership, product and network design, pricing policy, organization, and operating model. Emphasis now is placed on profitability over growth; a balance of HMO, preferred provider organization (PPO), and health savings account (HSA) products; increased reliance on underwriting to limit risk; organizational restructuring based on customer size, not geography; refocusing of information systems and incentives; and a culture of pricing discipline and cost vigilance.

Aetna has redefined its mission to be one of helping clients make informed, cost-conscious choices and has abandoned the mission of overriding cost-unconscious choices in the name of managed care. The new Aetna and the industry of which it again is a bellwether now offer customers more choices at higher prices, more information on quality, more responsibility for cost, and a range of insured and self-insured funding mechanisms that further erode the social pooling of risk and the implicit subsidies from perennially healthy to chronically ill citizens.[1]

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Fall Of A Managed Care Giant

In its foray into managed care, Aetna had bad luck, made worse decisions, and had the worst of timing. Through the early 1990s Aetna was a venerable and profitable commercial carrier, providing indemnity services for employees and retirees of large, self-insured corporations. It avoided the individual insurance market, Medicare and Medicaid, capitation, utilization management, primary care gatekeeping, and network-based managed care products. It watched with dismay as diminutive HMOs converted to for-profit ownership; loaded up on equity capital; and launched into a self-reinforcing cycle of enrollment growth, better provider contracts, lower premiums, and further growth. Everyone from Wall Street to the White House believed that the future of health insurance would be everything Aetna was not. After nibbling at managed care through local acquisitions and lackluster HMO start-ups, the firm bet its balance sheet on the biggest, most expensive, and, in retrospect, most fateful acquisition in the history of the industry.

U.S. Healthcare was the antithesis of Aetna in every respect. Whereas Aetna was focused on nationwide scope, large accounts, self-insured indemnity products, and fee-for-service payment to providers, U.S. Healthcare was focused on regional market dominance, small accounts, fully insured HMO products, and capitation payment to primary care providers. In 1996, when Aetna acquired, merged with, or was acquired by U.S. Healthcare (depending on which version of the story one prefers), the talk was all about complementarities, synergies, and economies of scale. The reality quickly turned out to be one of incompatible product designs, operating systems, sales forces, brand images, and corporate cultures. To make the merger succeed, the newly renamed Aetna U.S. Healthcare would have needed to stop, analyze, and integrate its products, customer segments, information technologies, and cultures. Instead, it pursued a flight forward to even greater scale and ever broader scope.

■ **One-size-fits-all perspective.** The conventional health insurance wisdom during the 1990s was that one size fit all or could be made to fit all. According to this perspective, which imbued President Clinton's Health Security Act and continued to influence public and private decision making for several years thereafter, all citizens should be enrolled in the same type of health plan, with uniform benefits and provider networks, purchased on an open-enrollment basis and managed with attention to increasing primary and decreasing specialty utilization.[2] Aetna U.S. Healthcare embraced and came to embody the private-sector version of this public policy perspective. It sought to move as much enrollment as possible into the fully insured HMO, counting on aggressive provider discounts to control medical costs, and offering comprehensive benefits with minimal consumer cost sharing to encourage primary care and preventive services. Slice business, in which large and midsize employers offer multiple plans to their employees, was pursued even though it brought uncertain and transient enrollment, high administrative costs, and the potential for adverse selection. HMO provider networks were expanded through

"all-products" contract clauses that required primary care physicians who treated Aetna's indemnity patients also to accept the firm's HMO enrollees. Similar benefit designs were offered to small firms, whose first priority was low price, and to large accounts, whose first priority was hassle-free access to services. Primary care gatekeeping for specialty referrals, prior authorization for procedures, and retrospective denial of payment for hospital days were used to control medical costs in the face of rising antipathy from physicians, patients, and politicians.

■ **Reliance on massive enrollment.** The Aetna U.S. Healthcare managed care strategy relied above all else on massive scale, on millions in enrollment and billions in revenue to pressure physicians and hospitals to participate at low payment rates; cover the administrative overhead of utilization management; dilute adverse selection from weak underwriting; and spur continuous rounds of lower costs, lower premiums, and further growth. The firm took the HMO product to places it had never been before, aggressively pursued the small-group market, took on Medicare risk contracts, and committed itself to being not only the largest health plan nationally but a dominant plan in the most populous regions, including New York, the mid-Atlantic states, Florida, Texas, and California. By the end of the decade, after absorbing the health business of New York Life and Prudential, Aetna U.S. Healthcare was at the top of its curve.[3] With twenty-one million enrollees and nationwide all-products contracts, it was the biggest player in an industry committed to decreasing costs for purchasers and increasing earnings for shareholders. By then, unfortunately, everyone from Wall Street to the White House believed that the future of health insurance would be everything Aetna U.S. Healthcare was not. The consumer backlash against network restrictions and utilization review was reaching a fever pitch, and Aetna offered a perfect target for a populist culture that distrusts big business as much as big government. Providers were in full revolt, consolidating their local markets and demanding rate increases, litigating over delays in payment and denials in authorization, and, in some instances, simply walking away from HMO networks.[4]

■ **The roar of investors' criticism.** The capital markets had supported Aetna's growth strategy during the late 1990s under the principle that major economies of scale were achievable, but they retained a worry as to the earnings potential of overdiversified conglomerates, especially those built through acquisitions rather than internal growth. Many firms in other industries had undergone excessive growth in the previous decades, only to falter and be dismembered through leveraged buyouts in the 1980s.[5] Criticisms of Aetna's strategy rose to a roar as the company reported severe difficulties in integrating the Prudential accounts into the Aetna core products and networks. The hedge funds and other institutional investors called for the head of the chief executive officer (CEO) and dismemberment of the company, arguing that the whole of an overbuilt conglomerate is worth less than the sum of its parts, and obtained from the Aetna board of directors most of what they demanded.[6] The CEO and most of senior management, including all of the top executives

"The merger with U.S. Healthcare retains the glory of having paid the highest price per covered enrollee in the history of the industry."

brought over from U.S. Healthcare, left the company, and the international and financial services business lines were divested to focus the firm on domestic, health-related activities. After a chaotic interregnum, the board hired a new CEO and, with him, radically altered the firm's organizational structure, operating principles, and market strategy.

Rethinking And Repositioning

The prospect of a hanging wonderfully focuses the mind. The new executive team at Aetna considered the fate of its predecessor and found it prudent to expeditiously abandon the assumptions about the firm, its products, and its market environment that had undergirded the managed care strategy. The survival imperative quickly produced a new principal objective, new strategy, and new operational model; implementation, of course, took longer.

■ **A bias toward profitability.** The first and most important treasure to be tossed overboard by the newly renamed Aetna Inc. (U.S. Healthcare is never mentioned now) was the guiding principle that growth in market share was the basic measure of success and the means to all other ends. In the new thinking, economies of scale exist in health insurance, but they are modest and do not bring major cost reductions sufficient to support low premiums, further growth, market domination, and eventual profits. Instead of growth driving profits, promotion of growth as an overriding objective is now seen as threatening profitability. (Profitable growth, with prices outpacing costs, remains a goal.) In pursuit of growth, premium trends had been held below cost trends in the ever-optimistic expectation of costs following prices down. The corporate emphasis on Aetna's regional managers to expand enrollment was particularly dangerous in an industry whose underlying costs were driven by unpredictable and uncontrollable factors such as the rate of introduction of new clinical technologies and where claims were incurred by providers one to three or even five months before being submitted and recognized by the insurer's information system. Weak underwriting skills at U.S. Healthcare became a serious problem as Aetna pursued slice business, based on the principles of managed competition, instead of continuing to insist on serving each employer's entire workforce as an antidote to adverse selection.

The more serious symptom of the erstwhile managerial orientation was the focus on mergers and acquisitions, which proved the worst way to pursue sustainable growth. The merger with U.S. Healthcare retains the glory of having paid the highest price per covered enrollee ($3,300) in the history of the industry, but even the more modestly priced acquisitions of NYLCare ($520 per enrollee) and Prudential HealthCare ($188 per enrollee) were horribly dilutive to Aetna's value once

the smoke cleared and enrollee retention could be measured.[7] The acquisitions of NYLCare and Pru were rationalized as bulking up enrollment in particularly attractive markets (for example, Texas and the mid-Atlantic states) rather than as mergers of equals, and so the managerial and cultural clashes engendered by the U.S. Healthcare merger were not anticipated and did not occur. But the product designs, provider networks, and, especially, information systems were duplicative or incompatible. Most importantly, in retrospect, these firms had been holding down their premiums to expand enrollment as a prelude to sale, knowing that the sale price would focus on their size. Once Aetna reset premiums on NYLCare and Pru accounts at sustainable levels, most former customers simply went elsewhere. Aetna does not report or comment on where the eight million enrollees who left the firm during the turnaround had come from, but gossip speculates that the firm would be lucky to still have 30,000 of the 5 million it acquired from Prudential.

Aetna now proclaims a "bias toward profitability" and an interest in scale only to the extent that it is compatible with that objective. Over the past two years the firm has repriced its entire book of business, with aggressive double-digit increases that resolutely outpaced cost trends and a willingness to endure the consequences in enrollment. In 2002, for example, it achieved a "premium yield" of 19 percent, compared with an average for the industry of 13 percent. Enrollment was expected to fall and did so, but the company was able to steer successfully through an inevitably perilous set of rapids. Attempts to downsize insurance firms through premium increases are endangered by a likelihood that the best risks (that is, the healthiest customers) will be wooed most aggressively by competitors, leaving the downsizing firm with a worsening risk profile. Aetna was able to improve, rather than worsen, its risk mix through detailed case-by-case evaluation of past claims costs and the repricing of particular accounts based on their particular experience. It withdrew altogether from some market segments, such as the small-group market in Colorado, the Medicaid program (except for administrative services), and much of the Medicare HMO program.

The success of the repricing focus was evident in the comparison of the medical cost ratios of the "lapsed" accounts that went to competitors versus the cost ratios of those that stayed with Aetna (a difference of four to five percentage points in 2002, for example). The bias toward profitability is not merely a pricing orientation for the turnaround phase but also reflects a fundamental reassessment by Aetna of the industry of which it is a part. For twenty years managed care was viewed as a growth industry by entrepreneurs and investors, and individual firms were valued based on scale and increases in scale. The market share, "penetration pricing" phase of the industry is over, and, in the eyes of the investors, what matters is return on investment now, not later. Growth industries absorb funds from the capital markets to generate growth; mature industries generate profits to release funds back to the capital markets.

■ **Costs and cost control.** A guiding principle of the managed care era was that

"U.S. Healthcare was a one-product HMO, and Aetna U.S. Healthcare made the mistake of falling in love with that one product."

health care costs are driven by unnecessary utilization, excessive provider prices, and administrative waste and hence that inflation could be controlled without damage to clinical quality or consumer convenience. The focus on avoidable expenditures, amply bolstered by evidence on geographic, organizational, and professional variations in practice patterns, prices, and costs, inspired public initiatives to achieve universal coverage without tax increases and private initiatives to raise profits without raising premiums. Cost trends now are seen as driven by changes in technologies, regulations, litigation, provider consolidation, labor shortages, cultural expectations, and other factors that are largely outside the control of health insurance companies. Health plans will continue to struggle with providers over unit prices and volumes, but they no longer see themselves as able to promise premium stability to purchasers. Private insurers are poorly positioned to fight back against the many sources of medical inflation, as the public is only too willing to perceive a concern for profits rather than a concern for limiting inflation as underlying their cost control initiatives. The strategic implications of this new understanding led Aetna to move away from an attempt to manage risk itself to a decision to share risk with its various stakeholders.

Since 2000 Aetna has allowed a considerable amount of risk to be shifted from itself onto purchasers, by facilitating a transfer from insured products to self-insured health benefits. Although the administrative-services-only (ASO) fees that Aetna receives for managing these self-insured accounts are much lower than the revenues obtained on insured accounts, they hold almost no risk for medical cost inflation. A finely grained matrix for measuring and pricing experience-rated insured accounts provides the firm another mechanism for shifting predictable, demographic risk back to those purchasers who do not want full self-insurance. More generally, the firm has buffed its "funding options" for clients, ranging from self-insurance at one end to nonexperience "manual" rating at the other, each with appropriate adjustments for the amount of risk Aetna retains. Insurers are willing to bear insurance risk, but they need to get paid for doing so. Aetna also is sharing risk with its enrollees. By increasing the deductibles, coinsurance, and other cost-sharing provisions available with its products, Aetna provides employers and employees with choices between paying on a fixed monthly basis (premium) or paying at the time of care (copayment). Traditional HMO products with low cost sharing protected enrollees from the financial consequences of their utilization decisions, whereas newer designs require the enrollee to bear more risk (but with a lower premium than otherwise would be necessary to cover costs).[8] Aetna's benefit buy-down has been modest (3.5 percentage points in 2002) but has laid the basis for more substantial design changes if and when purchasers become willing

to face the resulting backlash from beneficiaries.

Aetna has addressed its claims costs and provider relationships through a good-cop-bad-cop combination of flexibility and discipline. It has abandoned the all-products clause and allowed primary care physicians to elect fee-for-service over capitation payment. It has reduced the extent of capitation for hospital services and narrowed the range of capitated services for medical groups.[9] It has taken a tough line on provider rates in some markets, however, especially with consolidated hospital chains. It has reduced the annualized rate of growth in medical expenses from 17 percent during the last three quarters of 2001 (compared with the industry average of 11 percent), to 8 percent in 2003. Aetna's commercial HMO medical cost ratio declined from 90.8 percent in the second quarter of 2001 to 81.6 percent by the end of 2002 and then to an industrywide low of 78.0 percent in the fourth quarter of 2003.[10]

■ **The HMO as a product in transition.** U.S. Healthcare was a one-product HMO firm, and Aetna U.S. Healthcare made the fundamental mistake of falling in love with that one product. In the new regime, Aetna is not in love with any product and is focused on offering "solutions," not any particular product, to its customers. The HMO is viewed as suffering from endless bad publicity, litigation, provider resistance to capitation, consumer resistance to gatekeeping, and journalistic appetites for something to blame for the ills of U.S. health care. The Medicare HMO product is viewed with special skepticism, and Aetna is devoting most of its Medicare-related energies to the demonstration projects on PPO options and the discussions of "consumer-driven" possibilities. Aetna sees the backlash against managed care fading with the economic recession and reignition of cost inflation but never again will allow itself to be portrayed as an entity that stands between the consumer and the services the consumer wishes to use.

■ **Organizational structure and incentives.** The most important operational change implemented by the new management team was to restructure Aetna according to the size of its customers, with information technology and managerial compensation restructured accordingly. The firm now is made up of separate business lines for large corporate accounts, midsize accounts (subdivided into those with 50–300 and those with 301–3,000 employees), small firms, and governmental entities. Regional general managers no longer exist. Product design, network design, pricing, marketing, and sales are coordinated with market business units (segments) and are allowed to vary by segment. Profit-and-loss responsibility now resides principally with the senior segment executives, with regional managers reporting to their respective national segment manager rather than directly to the president of the corporation. Performance-based compensation has been driven throughout the firm, with profit-and-loss being measured and compensated for thirty-three executives (segment, region within segment, and specialty services). The organizational and incentive restructuring along customer segment lines is supported by a new executive management information system, which provides seg-

ment-level data on revenues, enrollment, medical claims (sixteen categories), and administrative costs (by function); all of these can be broken down by product, funding (for example, insured or ASO), region, time period (monthly, quarterly, or annual), budget (forecast or realized), and dollar (total, per member, or per employee) basis. The segment-structured information system proved crucial for Aetna's repricing and downsizing (avoidance of adverse selection), ability to maintain premium trends above cost trends, and selective recontracting of network providers.

The Turnaround, By The Numbers

■ **Enrollment and earnings.** Exhibit 1 presents trend data on the two competing measures of performance at Aetna: enrollment and earnings.[11] By 1997 Aetna had emerged as the largest firm in the managed care industry, measured by an enrollment of 13.7 million, and maintained a pretax profit margin of 6.7 percent. Over the next two years it surged to its enrollment peak of 21.0 million but then plunged downward, shedding two million enrollees in each of the two succeeding years and

EXHIBIT 1
Enrollment And Earnings At Aetna And Its Principal Competitors, 1997–2003

	Aetna	United	CIGNA	WellPoint	Anthem
1997					
Enrollment	13,734	13,552	11,707	6,638	5,261
Pretax earnings	6.65%	6.29%	8.23%	7.77%	–[a]
1998					
Enrollment	15,666	14,008	12,686	6,892	5,167
Pretax earnings	13.87%	4.94%	9.38%	7.49%	–[a]
1999					
Enrollment	21,058	14,434	12,491	7,300	6,265
Pretax earnings	4.07%	4.82%	9.08%	7.32%	–[a]
2000					
Enrollment	19,337	15,031	13,376	7,869	7,270
Pretax earnings	2.29%	5.68%	8.44%	6.87%	4.10%
2001					
Enrollment	17,170	16,510	13,413	10,437	7,883
Pretax earnings	–0.76%	6.68%	8.04%	6.62%	5.08%
2002					
Enrollment	13,678	17,680	13,091	13,223	11,053
Pretax earnings	3.15%	8.74%	5.97%	7.10%	6.74%
2003					
Enrollment	13,002	18,690	11,535	14,421	12,583
Pretax earnings	7.15%	9.85%	6.85%	7.66%	7.26%

SOURCE: Lehman Brothers' Global Equity Research. These data are adjusted to ensure comparability across firms and among years; they do not match exactly the statistics published by Aetna itself.

NOTES: Enrollment figures are in thousands. Earnings include investment income but are prior to interest and taxes (EBIT margin).

[a] Earnings data for Anthem are not available prior to the year of its initial public offering (IPO).

almost 3.5 million in the come-to-Jesus year of 2002. Pretax profits collapsed, with a negative margin of −0.8 percent in 2001, followed by a rebound to industry-average performance in the latter part of 2003. After six turbulent years Aetna was back to the same size it had been in 1997. The firm's major competitors spent those years growing earnings and enrollment, often at Aetna's expense, and by 2003 Aetna had fallen from first to third in enrollment after United and WellPoint.

■ **New product mix.** Exhibit 2 documents Aetna's purposeful flight from what once was its flagship product: the future of U.S. health insurance, the fully insured HMO. Between 2000 and 2003 total enrollment at Aetna fell by six million, but the losses were concentrated in product lines where medical costs and costs of adhering to regulatory requirements exceeded the value of the revenues received. The insured, commercial HMO shed more than half of its membership, four million enrollees. Aetna sharply limited its exposure to governmental programs, withdrawing from the Medicare+ Choice program in counties accounting for 65 percent of Medicare enrollment and withdrawing from state Medicaid programs (aside from self-insured) completely. The PPO and point-of-service (POS) products, especially the PPO, now lead Aetna's portfolio, making up half of the total, up from 40 percent two years earlier. The decision to shift insurance risk from the insurer back to the in-

EXHIBIT 2
Changes In Enrollment And Product Mix At Aetna, 2000–2003

	2000	2001	2002	2003
Enrollment in insured products				
HMO	7,778	6,712	3,948	3,327
POS	341	183	101	127
PPO	905	907	753	824
Indemnity	243	204	106	75
Medicare	549	255	117	105
Medicaid	131	15	0	0
Total insured enrollment	9,947	8,276	5,025	4,458
Enrollment in self-insured (ASO) products				
HMO	869	1,086	1,349	1,385
POS	3,397	2,820	2,514	2,160
PPO	3,100	3,168	3,171	3,554
Indemnity	1,930	1,691	1,517	1,331
Medicaid	94	129	102	114
Total self-insured enrollment	9,390	8,894	8,653	8,544
Total enrollment	19,337	17,170	13,678	13,002
Insured products as percent of total enrollment				
All insured products	51.4%	48.2%	36.7%	34.3%
Commercial HMO	40.2	39.1	28.8	25.6
Medicare HMO	2.8	1.5	0.9	0.8

SOURCE: Lehman Brothers' Global Equity Research. These data are adjusted to ensure comparability across firms and among years; they do not match exactly the statistics published by Aetna itself.
NOTES: All figures are in thousands except percentages. HMO is health maintenance organization. POS is point-of-service plan. PPO is preferred provider organization. ASO is administrative services only.

sured is evident in the decline in insured enrollment as a percentage of the total, falling from 51 percent in 2000 to 34 percent in 2003. Aetna's residual reliance on risk enrollment is similar to United's (34 percent) and CIGNA's (30 percent) but falls short of Anthem's (49 percent) and WellPoint's (61 percent) because of the historical Blue Cross concentration in the individual and small-group markets.

■ **Operating cash flow.** Exhibit 3 disaggregates the revenue, cost, and earnings data to highlight the times and the places where Aetna made its money, lost it, and found it again. Between 2000 and 2003 health care premium revenues followed insured enrollment downward but on a less steep gradient, falling 39 percent compared with 55 percent (Exhibit 2), as the firm partially compensated for declines in quantity by increases in unit prices (premium per member per month). As seen in Exhibit 3, ASO fees (a decline of 2 percent) and nonhealth business (a decline of 11 percent) cushioned the fall in insurance sales. The increases in health insurance pre-

EXHIBIT 3
Revenues, Expenses, And Earnings At Aetna, 2000–2003

	2000	2001	2002	2003
Revenues (millions of dollars)				
Total	26,819	25,097	19,812	17,911
Health premiums	21,747	19,940	15,004	13,236
ASO fees	1,926	1,835	1,843	1,885
Other revenues	3,146	3,322	2,965	2,791
Premiums (dollars per member per month)				
Commercial HMO	151	168	206	233
All insured products	191	202	248	279
ASO fees	16.9	16.7	17.2	18.0
Expenses (millions of dollars)				
Total	26,768	24,872	19,059	16,426
Health claims	18,768	17,897	12,580	10,348
Nonhealth claims	2,154	2,458	2,246	2,091
Administration	4,751	4,517	4,233	4,039
Cash flow EBITDA (millions of dollars)				
Total	1,040	225	755	1,434
Health care	701	(49)	591	1,144
Earnings (millions of dollars)				
Total	139	(275)	347	828
Health care	96	(365)	307	727
Profit margin (percent)				
Total	0.52	(1.09)	1.75	4.63
Health care	0.40	(1.65)	1.80	4.74
Earnings per share (dollars)	1.20	(1.96)	2.26	5.22

SOURCE: Lehman Brothers' Global Equity Research. These data are adjusted to ensure comparability across firms and among years; they do not match exactly the statistics published by Aetna itself.

NOTES: Figures in parentheses indicate financial losses. Nonhealth claims include disability, life, long-term care, dental, and other specialty products. Figures for 2000 are restated to exclude Aetna's pension business, subsequently divested, to facilitate comparisons with subsequent years. ASO is administrative services only. HMO is health maintenance organization. EBITDA is earnings before interest, taxes, depreciation, and amortization.

miums are evident as revenues per member per month for the commercial HMO rose from $151 to $233 and for all insured products, from $191 to $279. Expenses declined both as the firm shrank and as it shifted much of the remaining enrollment from insured to self-insured products. While total expenses declined 39 percent in 2000–2003, the medical claims paid out to physicians, hospitals, and other providers declined by 45 percent. Administrative costs declined as the firm shuttered operations and eliminated a quarter of its workforce but rose as a percentage of revenues. The limits of downsizing in pursuit of profitability lie in the inherent difficulty in reducing core staffing and functions, and Aetna will be able to reduce administrative costs to industry levels only if it can grow enrollment after stabilizing in 2003.

Exhibit 3 shows the numbers of greatest concern for Aetna's investors. Operating cash flow—the difference between the revenues obtained and costs incurred in the regular course of business (without accounting for balance-sheet adjustments, interest on reserves, and taxes)—plunged from $1 billion in 2000 to $225 million in 2001, with negative cash flow of $49 million in health care. Net earnings (bottom-line profits) for the firm were a negative $275 million (1.09 percent) in 2001. The financial success of the Aetna turnaround, in the short term, is evident in the rebound on all the earnings measures during the past two years. Cash flow tripled from 2001 to the end of 2002, and almost doubled again in 2003, while earnings surged by $622 million and by another $481 million in 2003. Earnings per share, which had collapsed from $1.20 in 2000 to a loss of $1.96 in 2001, jumped to $2.26 the following year and reached $5.22 in 2003.

■ **Stock market value.** Aetna's trials and tribulations have generated a volatile stock price as investors have stampeded from confidence to skepticism, then to despair, then back to optimism, and now on to exuberance. The firm's share price peaked at $82 in the middle of 1997, when investors and policy pundits believed that the future lay in managed care, and then plunged in two steps to $25 in early 2001, as the rising tide of consumer backlash and red ink made Aetna the country's least-loved insurer.[12] With share prices that low and the arrival of a new management team, investors were willing to give Aetna another look, and the turnaround in share price preceded the turnaround in earnings. From the second quarter of 2001 through the fourth quarter of 2003, Aetna generated the highest return on investment of any stock in the managed care sector, passing $72 per share in 2003, and greatly outperformed marketwide indices such as the Standard and Poor's (S&P) 500. These short-term gains were possible only because of the very depressed baseline prices. Until 2002, Aetna had delivered investors a dismal long-term rate of return, with a 50 percent return over the entire 1992–2002 decade (compared with an S&P 500 return of 175 percent). Going forward, of course, anything could happen.

Insurance System Implications

The purpose of market insurance is to protect consumers from fluctuations in expenditures by charging each covered group a premium equal to its expected

costs and then using the profits earned from lucky customers, who incur claims costs lower than the premiums they paid, to cover losses from unlucky customers, who incur claims costs above their premiums. There is no subsidy from customers known to be at low risk to customers known to be at high risk, but only from the lucky to the unlucky within each risk class. The purpose of social insurance, on the other hand, is to make coverage affordable to those with high expected claims costs, and hence it charges similar premiums to those with quite different levels of risk. Instead of redistributing income from the lucky to the unlucky within risk groups, social insurance redistributes income from the predictably healthy to the predictably unhealthy across risk groups. Managed care, with its emphasis on controlling health care costs rather than differentially pricing risk, constituted a private-sector means to the public-sector goals embodied in social insurance. The backlash against managed care is driving the industry back toward traditional insurance principles; variations in health status across the privately insured population now are being reflected ever more precisely in premiums, benefits, and product designs.

THE TURNAROUND AT AETNA illustrates the increasing industrywide emphasis on underwriting, pricing discipline, exit from unprofitable markets and customer segments, sharing of risk with employers through self-insurance, and sharing of risk with employees through coinsurance. While the future is always uncertain and new disasters could strike, it appears that Aetna has stanched the financial hemorrhaging and is poised for new growth.

The implications of its turnaround are less unambiguously positive for the health system as a whole, however. The employment-based health insurance system is proving to be less willing and able to perform the redistributive functions of social insurance in addition to the risk-spreading functions of market insurance. The nation appears unenthusiastic about any prospect of pursuing social insurance through explicit taxes and subsidies, continuing to prefer implicit transfers that do not raise the specter of big government (even as an alternative to big business). In the absence of adequate governmental subsidies for less healthy citizens, however, Aetna's improved ability to predict and price risk will expose it to obloquy as a failure at social insurance rather than to praise as a success at market insurance. In the health care sector, where no one agrees on the appropriate division of labor between the public and private sectors, no good deed goes unpunished.

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NOTES

1. Material for this paper was obtained over the course of eighteen months through a case study of Aetna, including extensive interviews with current and former management at the corporate and regional levels with responsibilities for overall strategy, operations, market business units, provider contracting, marketing and sales, disease management, data warehousing and analysis, quality improvement, legal affairs, and product development. Additional information was obtained from competing health insurers, provider organizations, purchasers, brokers, and investors. The financial data were collected with the help of Josh Raskin and Greg Nersessian of Lehman Brothers' Global Equity Research. Insights into financial trends were obtained from a variety of investment banking (sell side) and hedge fund (buy side) analysts, plus weekly, quarterly, and annual reports on Aetna and its competitors from Lehman Brothers and Salomon Smith Barney (investment banks).
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11. For an overview of Aetna and the entire sector, with historical data, see J.R. Raskin, G. Nersessian, and K. Bullymont, *2003 Managed Care Guidebook* (New York: Lehman Brothers' Global Equity Research, 22 January 2003).
12. The $117 equity price peak on 4 August 1997 is adjusted downward to account for the subsequent one-time dividend of $35 per share, made after the firm divested its international and financial services businesses, to ensure comparability to subsequent share prices.