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INTERVIEW

At The Helm Of An Insurance Giant: Aetna's Richard L. Huber

Aetna's chief executive discusses the past, present, and future of the nation's largest health insurer with economist Jamie Robinson.

by James C. Robinson

EDITOR'S NOTE: One of the defining characteristics of American democracy is the central involvement of private interests in public policy making. In keeping with the intent of Health Affairs to devote greater attention to the critical role that large managed care companies are playing in the transformation of the health care system, we asked James Robinson, a health economist at the University of California, to engage Richard Huber, chairman and chief executive officer of Aetna, Inc., in conversation on his views of the changing system.

Employment-Based Insurance

James Robinson: The employment-based insurance system—the core of America's health care financing mechanism and the source of most of Aetna's business—is under stress from rising premiums, declining coverage, and rising political regulation. Yet it's also the principal source of innovation in methods of payment, product design, and provider network contracting. How do you see the future evolution of large employers' policies toward insurance coverage, benefits, and premium contributions? Will employers continue their hands-on role, or will they move toward making a defined contribution and shifting responsibility for choice and payment to employees and retirees?

Richard Huber: We're seeing several trends. One is for plan sponsors to move from what has become an unmanageable, dizzying number of health plans to greater simplifica-

tion and efficiency in dealing with one or two health plans or sometimes a single national plan with some local add-ons. Human resources departments clamor for efficiency in dealing with the huge number of differing types of health carriers. It's a nightmare. On the other hand, employers as plan sponsors feel pressured to offer more options to their employees, via either a single insurance plan that offers a cafeteria of health insurance products or different health plans. We've seen both of these trends, although I would say that in the past six to twelve months we've seen a shift to using fewer carriers.

Robinson: Do you find that employers want a single product, or do they also want to have a menu of options for their workers?

Huber: It's relatively rare to see a plan sponsor that wants only one carrier and one product. For example, one of our corporate clients is a major entertainment and publishing corporation with operations in broadcasting networks, entertainment, video and music sales and rental, theme parks, publishing, and online enterprise. Its employees range from the super-high egos, at one end, to the clerks who work at its video stores, at the other. This firm is an interesting example of the challenges we face to offer an array of product choices that satisfy all of the employees of a complex, multisite company.

Robinson: The fundamental imperative you see, then, is simplification from the point of

Richard Huber has been chairman and chief executive officer of Aetna since 1997. As vice-chairman he helped to orchestrate Aetna's \$8.9 billion acquisition of U.S. Healthcare. James Robinson is a professor of health economics at the University of California, Berkeley.

view of the employer as purchaser?

Huber: That's a very important driver right now. But as I look five or ten years out, we must be prepared for the market to move to a defined-contribution system. What if employers shifted to something like the Federal Employees Health Benefits Program (FEHBP), where in essence you get a voucher and you can choose from a menu of health plans? If the plan you want costs more than your voucher or the sponsor's defined contribution, you dip into your pocket.

Robinson: How are employers reacting to the major increases in health care costs that began to occur in 1998 and that many predict will continue to occur?

Huber: I guess if I had to use one word, I would say "stoically." They certainly are not overjoyed, which I certainly can understand. But they recognize, I think, that a number of forces are driving health costs upward, and it's largely out of our, and their, control.

Robinson: What effect might the rise in costs have on the political debate, as Congress and states debate measures that could raise costs and chief financial officers look on? Will the debate intensify?

Huber: I think so. The business community has been alerted to the dangers of some of the measures that are bouncing around the legislatures, and they're very concerned. The lobbying effort going on in Congress now is driven more by the business community than by the health insurance community.

The Managed Care Spectrum

Robinson: Which products have the greatest demand going forward, including the traditional health maintenance organization (HMO), point-of-service (POS) plans, preferred provider organizations (PPOs), and other variants?

Huber: As we argued long (and fruitlessly) with our friends at the Department of Justice, those descriptive categories are increasingly meaningless. We're dealing with a spectrum of products that flows almost seamlessly from the tightest HMO product all the way to an

indemnity product—old-fashioned fee-for-service. And there are so many hybrids around today that it's hard to say that this is a POS plan while that's a PPO. We have POS products off an HMO platform. We have a POS product off a PPO platform. We have passive PPOs. It's a mind-boggling array, which is terrific. We see our goal very clearly as working with plan sponsors to help them satisfy their employee benefit needs, using whatever products suit them the best. For example, a software giant really doesn't much care what health insurance costs. It wants the best health coverage with the least hassle for its employees. We have other plan sponsors with large groups of part-timers, such as a nationwide coffee roasting and retail chain. They're not going to invest in elaborate wellness programs for young workers who aren't going to be on the payroll very long.

Robinson: America has decided that the two ends of the spectrum, the pure indemnity plan and the staff-model HMO, are too extreme for the bulk of the population. So where is the middle ground? I would be interested in your views on the future of the traditional Aetna U.S. Healthcare HMO product, which I'll define as being a gatekeeper product with a large but closed panel, compared with your PPO and POS products.

Huber: Over the past couple of years we've seen the POS and PPO products grow more rapidly than the classic HMO. But there again, the classic HMO has become just one of a continuum of products designed to maximize choice. In some HMO products, a member may obtain services without a gatekeeper and have reduced precertification for services. Our trend is to open the utilization process. Much of our business will continue to be driven by information technology, if we have the ability for accurate and timely monitoring of how different physicians practice medicine. Like most things in this world, the distribution of medical practice ends up being a bell-shaped curve. To the extent that the bell gets narrower and higher, a larger percentage of physicians practice good medicine. They

don't deviate very much from the mean, so why do we have to waste time monitoring and precertifying them? We should concentrate instead on the two shoulders of the bell. And if we can really see who is in the middle of the bell and who is on the shoulders, we can achieve our goal of making sure that our network doctors are practicing good medicine and concentrate on the relatively few who are seriously overusing the system or, equally important, underusing it.

Rising Consumer Expectations

Robinson: How is Aetna attempting to control health care costs in the face of rising consumer demands for choice?

Huber: We succeed by responding to our customers' desires. But it is difficult to be responsive to the desire for choice without pushing the cost of basic health coverage out of the reach of cost-conscious employers and consumers. Every 1 percent increase in the cost of health care drives another 300,000 people into the uninsured category. One approach is to offer a base plan that everyone can afford, while adding options for those who want and can afford more. For example, our triple-copay pharmacy benefit plans allow members to decide how much their copayment will be, based on which drug they choose. If a member covered under this plan chooses a generic drug, for example, there's one copayment, say, five dollars. If the member and the member's physician choose a brand-name product in our formulary, the copayment is perhaps ten dollars. And if they choose a brand-name product not in our formulary, there's an even higher copayment. This is similar to the choices we all have with over-the-counter medications, whether to buy brand names or cheaper store brands.

Robinson: We all talk about the "new consumer era" in health care. What do you see as the principal elements in what we might call the revolution of rising expectations?

"It is difficult to be responsive to the desire for choice without pushing the cost of basic health coverage out of reach."

Huber: The consumer revolution affects us; it affects everyone in the industry. The bad manifestation of this is the member who goes to his or her doctor with a page torn out of *Time* magazine and says, "This is what I need." The good manifestation is that we have members who do research. They use our Web site, IntelliHealth (www.intelihealth.com), and perhaps even some others that are nowhere near as good as ours is. But they do come into a doctor's office better informed and then are better consumers of health care. The problem is keeping members from becoming their own doctors, diagnosing themselves, and prescribing their own remedies. The physician should retain a central role and not be completely displaced by the consumer.

Robinson: Americans want the best medicine that someone else will pay for. As pharmaceutical costs escalate and employers limit their premium contributions, employees now find themselves paying more and more out of pocket. The resulting system is more of a retail, less of a wholesale, model. What are the implications of this for Aetna?

Huber: One thing that drove our acquisition of U.S. Healthcare was the belief that the old Aetna lacked the capability of going down to the retail level. We foresaw a world in which the consumer would have a greater say in both the choice of health plans and the use of health services, and we felt we needed an organization that was much stronger in retail sales and marketing. I think we got what we paid for: We are much, much stronger in that area today. In the old indemnity days we made one sale to a major corporation and automatically had every employee and every dependent as a member. In the new world there is more choice. We've got to be skilled at marketing not only to the plan sponsor, but also to the individual employees.

Robinson: As managed care has become the dominant method of providing health cover-

age in this country, consumers' dissatisfaction has spread. What's Aetna doing to address consumers' concerns?

Huber: For starters, I don't agree with you. Every survey shows that the vast majority of Americans who are covered by managed care are quite satisfied with their health coverage. So I think there's been a distortion of the facts. Yet there is certainly concern about managed care as a concept. So we've got to improve the perception as well as the reality. People want to feel that they're more in control of their care, and we can help by giving them more responsibility to make decisions, along with the responsibility to cover the extra costs generated by their choices, so that we can keep coverage affordable for others. People want the assurance that they'll be able to get the care they really need, so we were the first national company to voluntarily subject our HMO medical-necessity decisions to external review by expert physicians. In fact, we have embraced virtually every component—except an enhanced right to sue—included in each of the patients' bill of rights proposals floating around Washington.

Increasing Coverage

Robinson: Aetna has launched an initiative to increase insurance coverage in the small-group market, offering products with thinner benefits but a much lower premium than that of conventional HMO or PPO products. How extensive will the demand for these products be?

Huber: We've been pleasantly surprised. We've sold quite a few of these products, and I wasn't sure we'd sell any. But it's an imperfect product. We can't offer what we should offer, which is catastrophic coverage at a low premium. State legislatures have mandated that if we offer catastrophic coverage we have to offer the whole Christmas tree of benefits mandated by every state in the union. So we had to structure the product to avoid those cumbersome, costly mandates.

Robinson: Briefly explain the difference between the new product and the traditional

Aetna HMO or PPO.

Huber: To a certain extent, this is a very old-fashioned product. It harkens back to old-fashioned hospitalization coverage with a major medical feature. It's not a great product, but it's a lot better than no product at all.

Robinson: It's an indemnity product that pays a fixed amount per hospital day?

Huber: Exactly. It's particularly attractive to small businesses that have no health care coverage. Their bosses come to me and say, "I'd like to buy a Ford Escort-style product for my loyal, trusted twelve employees." And I reply, "I'm terribly sorry, I can't write you one, because Congress knows better what's good for you than you do, so I can only give you the Cadillac." But the small employer doesn't want the deluxe model. I say, "Sorry, you have to have it because Congress thinks it's good for you." I'd love to be able to offer small employers the indemnity product plus catastrophic coverage. It would be a much better product if we could do that, but we can't.

Robinson: How does this fit into the broader effort to solve the problem of the uninsured, particularly the working uninsured?

Huber: We wish that our friends in Washington would focus on the two real health care issues that are confronting this country: the forty-three million uninsured Americans, and a Medicare system that has become so convoluted and so Byzantine that it takes thousands of pages of regulations to more or less describe how it works. There are ways to solve the problem of the uninsured, which we as a nation should try to do. And there are some very obvious ways to greatly improve Medicare. We are eager to participate in these discussions.

Robinson: Let's stay with the small firm for a moment. Experience shows that to get a lot of firms that aren't now buying insurance into the market, a governmental subsidy will be needed. How might that fit in?

Huber: Probably best via some tax credit or some tax benefit that would create an incentive for small firms that don't offer insurance now, but could tomorrow. Then there would

need to be a product that is appropriate for their needs, but I don't think that such a product exists today. And that still is only part of the problem. Whereas roughly two-thirds of uninsured Americans are working or dependents of working people, there is a residual one-third that is not working. We have to come up with some ways to provide them with health care also.

Let's be very clear. People aren't dying on the streets because they can't get any health care. They usually do get care, but in probably the most inefficient, most costly fashion imaginable. Emergency room. No preventive care. No attempt to provide preventive care. We as a society are paying for these people's health care today. Wouldn't it be better to pay for it in a way that makes more sense? We probably could save some money in the process.

Medicare Managed Care

Robinson: Let us turn to Medicare. We now witness a dialogue of the deaf. The dominant view among program administrators seems to be that Medicare HMO payment rates have been too generous. Health plans—including Aetna—claim that payments are now falling below cost trends and are responsible for HMOs' pullouts from a number of geographic areas. Given the politics of the situation, how do you see Medicare payment rates and policy evolving in the coming years?

Huber: Medicare managed care is a tough business. We wouldn't be in it if we didn't think it has great promise. But when reimbursement rates vary by a factor of three, it is irrational. Let's suppose someone arrived from Mars and asked, "How come you pay twice as much for a Medicare member in Miami as you do for one in a rural county in Minnesota? Are the people that different?" That's difficult to explain to someone who might be so naïve as to seek logic in the system. There are solu-

tions. The Breaux Commission (National Bipartisan Commission on the Future of Medicare) came up with a very constructive proposal. I didn't agree with everything they suggested, but they essentially proposed an FEHBP model for Medicare. It was sad to see poor John Breaux get his leg sawed right out from under him by the head of his own party. It's no wonder the commission disbanded without issuing a report.

"If we can't do a better job than the Health Care Financing Administration, then we don't deserve the Medicare HMO business."

Robinson: Do you find the premium-support approach, which would encourage competition between Medicare HMO plans and the Medicare fee-for-service plan, appealing?

Huber: Absolutely. If we can't do a better job than the Health Care Financing Administration (HCFA), then we don't deserve the Medicare HMO business.

Robinson: What do you think about various proposals for competitive bidding among HMOs?

Huber: The competitive-bidding proposals are so obtuse that I don't understand them, nor does anyone else that I know of. It's also unfair for traditional fee-for-service to be excluded from the bidding process.

Robinson: Some economist thought those up; they're called "game theory."

Huber: Yes. How this would work in the real world, I do not know. We strongly support the idea of competition, and we're proud of our ability to be competitive. The fact that we have 700,000 Medicare HMO members shows that we like the business, and we think that we can make a reasonable return on our capital in that bloc of business. But it's so flawed. Medicare has become so twisted, so amended, that it is nearly unintelligible. Take pharmacy benefits, for example. We offer pharmacy benefits for our Medicare members. It's a solution, right now—alive, functioning, today. Why cook up some other crackpot scheme? Of course Medicare should cover drugs. How could any sane person dispute

that? HMO products for Medicare members include pharmacy, and we do it for less than Medicare plus Medigap plans that lack pharmacy coverage. And we have to pay all of us supposedly overpaid executives at the same time.

Robinson: The bureaucracy seems to view profit as equal to fraud. Is it possible to make a reasonable return on Medicare business?

Huber: There is an ideological divide in our country and in Congress. On one side is the belief that Joe Six-Pack is not capable of handling his own money or his own health care, and we need a benevolent government to take care of all that for him.

Robinson: A government elected by Joe Six-Pack.

Huber: Exactly. Then there's the side that thinks Joe Six-Pack is remarkably savvy about his money and his health. Why doesn't the government just step aside and see what happens? The pendulum typically swings back and forth over time. But a significant body of bureaucratic opinion believes that normally functioning human beings are incapable of handling their own health and welfare. A health insurance policy is a freely negotiated, private contract between two parties. We have reached the point where we don't even question whether it's appropriate for the government to say what should be in that private contract.

Robinson: Wall Street analysts are generally bearish on Medicare HMOs. They're touting the stocks of some of your competitors, such as CIGNA and WellPoint, that have stayed away from federal government funds. Do you see Medicare as a growth area for Aetna, or are you focused more on the private sector?

Huber: We are focused on all of the above, but certainly on Medicare. We believe that we can be the low-cost producer among the large health carriers. We're able to manage this reasonably well, and we think that we can compete and produce a reasonable profit on the business. But it is a tough managerial task.

Consolidation Of The Industry

Robinson: I'd like to shift now to mergers and acquisitions. With the consummation of the Prudential acquisition, Aetna is the nation's largest managed care organization. What advantages does large scale bring?

Huber: The ability to invest in information technology is going to be the determining factor in success. Fortunately, we can invest in constant improvements. The larger the pool of members, the better our database is, and the better job we are able to do in disease management and preventive care. Clearly there are economies of scale. A company needs only one highly paid chief executive, not five or six—one set of billboards, not two. There are efficiencies in marketing and operations, and in the ability to use data more effectively.

Robinson: Wall Street analysts are of mixed minds with respect to the Prudential acquisition. That plan was bleeding financially for a number of years. What can Aetna do with that membership that Prudential couldn't?

Huber: Our administrative costs are only two-thirds of what Prudential's were, and we have better management skills in operating the whole system. Perhaps we have better provider contracts in some places. We have good utilization management tools in place. Prudential did a lot to improve itself over the past year, and they deserve some recognition for that. The Pru we're buying is quite different from the Pru of two or three years ago.

Robinson: The acquisition price per enrollee was much lower than has been traditionally the case in the industry. Some analysts say that Prudential virtually gave its health insurance division to you. But this still was a money-losing plan. You're paying for this?

Huber: Obviously, we think that it is potentially profitable, or we wouldn't have bought it. We looked at it in a number of ways. We looked at the ability to get a return on our capital. We also looked at what it costs us to build a member: What does it cost us to go out and market and create an incremental member, compared to what it cost us to buy one from Prudential? I can assure you, the for-

mer costs a good deal more.

Robinson: And Prudential was more attractive to Aetna than it was to WellPoint or United HealthCare, which had the financial means and could have purchased it.

Huber: We had the financial capability to write a check. We have the administrative, managerial capability to take it on. There are not too many out there with that capability. In fact, Prudential was confronted with a very small slate of prospective buyers.

The Antitrust Policy Perplexity

Robinson: Antitrust regulators have concerns opposite those of Wall Street, as usual, and they've questioned whether Aetna is getting monopoly power in some markets. You've agreed to divest some HMO operations in Texas as a price for approval of the Prudential purchase by the Department of Justice. Could you comment on the debate over pricing and monopoly power?

Huber: The debate goes, in part, to definition of product and geographic market. We define the product market as health insurance. As I mentioned before, the various health insurance products are increasingly part of a continuum. The Department of Justice insisted on defining the HMO as a separate product market from the PPO and defining the geographic market as a single metropolitan area. This is nonsense. If we're licensed in a state, to move into a new city is almost trivial. We can rent a network and be up and running in a couple of months.

Robinson: The antitrust enforcers seem to be unclear whether the problem is that you're going to raise the cost of health care or, rather, that you're going to reduce it.

Huber: Exactly. Let me look at this again. Where in the body of antitrust law does it say that you're supposed to protect suppliers such as physicians and their incomes? I don't seem to find it, and I've looked through the law several times.

Robinson: Perhaps you would comment on the bill to exempt physicians from antitrust law—the Campbell legislation supported by

the American Medical Association.

Huber: It would be interesting. I'm not sure whether the doctors will affiliate with the Teamsters or the United Auto Workers, or whether we're going to have Jimmy Hoffa sitting across the table from us.

Robinson: Anything could happen.

Huber: Yes, it could.

Robinson: After all, this is health care.

Huber: We obviously think it's nuts. But I have no doubt about our ability to live with whatever system comes along. We are merely a financial intermediary. If the general public thinks that doctors are underpaid at \$200,000 a year and wants them to be able to earn more money, and thinks that it's perfectly all right for them to organize, well, so be it. The end cost of health care will go up, but it really isn't my money. We can question the logic, but we'll live with it.

Contracts With Physicians

Robinson: Health plans and provider organizations today are engaged in a war of all against all. Do you see a way out of this unsustainable impasse?

Huber: Absolutely. It's harmful for us and for physicians. The physician community has played a very foolish card on the unionization issue, which has not gone over well with the general public. We should be able to build a much more constructive partnership. We have a common interest in the health of our members and the quality of their health care. We rewrote our physician contracts to make them much clearer, simpler, and more user friendly. Our E-Health initiative is another example of our dedication to improving the relationship with physicians. I want to be able to pay them quickly. There is no technological reason that we can't auto-adjudicate the vast majority of physician claims. If physicians would submit claims electronically, together we could radically transform the industry. Technology exists, and indeed has existed for some years, to enable this innovation.

Robinson: U.S. Healthcare traditionally contracted with individual physicians, rather

than with independent practice associations (IPAs) and medical groups, because it came from the Mid-Atlantic area, where the term “physician organization” is an oxymoron. But now that you’re really a national plan, what do you see as the trend in dealing on a capitated basis with IPAs, medical groups, and other provider organizations?

Huber: We very much go with regional practices. In California the relationships are primarily with IPAs and medical groups; that’s the way things are done there, but we do like to have contracts with the individual physicians who are participants in IPA plans. In other parts of the country there are few physician organizations, so we deal primarily with the individual physicians.

Robinson: Perhaps you could comment or explain the importance of the “all-products” clause by which doctors who participate in the Aetna HMO network must participate in the PPO network and vice versa.

Huber: We think that it’s against the American ethic for physicians to treat only rich people—and that’s really what happens if they limit their practice to PPO and indemnity patients. Nothing compels physicians to do business with Aetna. If they wish to do business with us, however, they must be willing to handle all of our members—whether they be Medicare, indemnity, PPO, POS, or HMO members. It astounds us that some political bodies object to this, which we think is our most consumer-friendly practice. Our members move back and forth on this spectrum of managed care products. Why should a working PPO member who retires and shifts to a Medicare HMO suddenly have to get a new doctor? We don’t think it’s defensible, and it’s one of the things that we’re passionate about.

Robinson: What lessons do you draw from the meltdown of the physician practice management (PPM) companies such as FPA and

MedPartners, with whom you had national contracts at one time?

Huber: Despair. We started three years ago with a strategy to work much more with some of the big IPAs and integrated delivery systems. We had a great contract with Allegheny, but having a significant outstanding receivable when the system went bankrupt wasn’t much fun. FPA and some of the other PPM firms were also very disappointing, but in a way predictable.

Robinson: Your view is that if the provider organizations are capable of handling financial responsibility and utilization management, you would like to have a capitated and delegated relationship with them?

Huber: We originally intended to have more of our business in those types of arrangements than we do today. Managing risk is our core strength, not theirs.

Robinson: Sometimes health insurance companies are accused by physician organizations of not wanting to capitate because there is more profit to be made by driving down fee-for-service rates and hospital utilization than by first capitating all this.

Huber: We would say quite the contrary. We would opt for the capitated model if we felt that the contracting entities were able to manage it reasonably well. We are doing new contracts with IPAs, but we have been disillusioned by the fact that relatively few have shown the capability to manage capitation.

Robinson: Many surveys have indicated broad physician discontent with managed care. What is Aetna doing to improve its relations with physicians?

Huber: Number one is trying to make it easier to do business with us. Health care is a \$1.1 trillion industry, and about a quarter of that amount is consumed by administrative costs. Our E-Health initiative is aimed at shrinking that slice of the cost pie and, most importantly for doctors, cutting the hassle associ-

“It’s against the American ethic for physicians to treat only rich people—and that’s what happens if they limit their practice to PPO and indemnity patients.”

ated with it. If we can do that, we'll go a long way toward improving doctors' satisfaction.

Robinson: Certain aspects of your relationships with physicians—contracts, for example—inevitably put your interests somewhat at odds with theirs. Are there areas where your interests are more aligned?

Huber: That's number two. We share a major interest in keeping people healthy. Our mutual goal is the best possible health outcomes for their patients—our members. We want our relationship with physicians to be a partnership. Our vast health care data can provide them with feedback on how their practice patterns and outcomes compare with those of their peers and with best practices. When physicians are armed with the right information, practice patterns tend to improve. This is the future of managed care, where its promise to improve the quality of health care can be fulfilled, and it is all based on a partnership between health plans and physicians.

Data And Quality Initiatives

Robinson: In recent speeches you've highlighted what you see as Aetna's move from traditional price discounting and utilization review toward data, information, disease management, and performance measurement. Needless to say, organizations that have the best data will succeed. Could you describe some of the key data initiatives that you're putting into place that will allow you to benefit from the new information technology?

Huber: The precedent was what we did in 1997, which was to convert all of our managed care business to a single information system platform with a single database. Not unlike the vast majority of the larger players in the industry, we were a loose confederation of acquired HMOs, each of which ran on its own system. It was impossible to use data effectively in such an environment. The systems conversion was painful, and I wouldn't want to do it again anytime soon. But now we have a single database and can begin to convert useless data into valuable information.

Robinson: Does this database also contain

claims for the non-HMO products, or will they be eventually folded in?

Huber: We have two core systems, driven separately, which feed a single data warehouse, so we can mine all of the data. But the data format is sufficiently coherent that we can mine them as a single database. However, I remind you that no insurer has health records. We have claims records, encounter records, pharmacy records, and lab records, and from those records we must infer what's going on with people's health. We've gotten rather good at it, and we get better every month.

Robinson: Traditionally, it was thought that access to clinical information was going to be a comparative advantage for staff-model health plans, which are more tightly woven, but you have a wide variety of products. Do you think that information technology will lead to narrower differences between tightly and loosely integrated health plans?

Huber: Yes. Staff-model plans have more complete information right now, but as we are more and more effective in implementing our E-Health initiative, we're going to have data that are just as good or better. When we do, I believe that our quality ratings will improve.

Robinson: America is very ambivalent. We want choice and more choice, but the fact is that clinical quality often comes from coordination and connectivity among physicians, not from broad consumer choice.

Huber: No question. We're in a business where we're damned if we do and damned if we don't. The majority of the health care bill is paid for by someone other than the user. In such a system the user will always want more because it's thought to be free. We can do some things to improve members' satisfaction, but they will always want more, since they don't pay for it.

Robinson: As you move away from utilization review in the traditional sense, and if physicians really were well organized into medical groups and IPAs, what would be Aetna's role in clinical disease management?

Huber: One approach would be an after-the-fact tracking procedure, in which we see who

fits where in the bell-shaped curve and focus on the outliers. We also have a vision of a paperless system, which our EZ Enroll initiative begins to approach. You enroll online. You choose your primary care physician online. You go to see your physician, and the physician takes your membership card, which is magnetically encoded, swipes it through a little card reader that checks your eligibility, and flashes up the type of coverage you have. You go in. You're diagnosed. Your physician says perhaps you really should see a cardiologist. Let's see, where do you live? The physician touches the screen. Let's see, you're an Aetna member—here are three cardiologists that are part of the Aetna network in your area. I know Dr. X, but Dr. Y's office is a little closer to your

home. Whom do you want to see? Touch. Done. You walk out, perhaps with a printout of the information. You have an appointment with Dr. X for next Thursday, and it's all done instantaneously. The technology exists to make this happen. The challenge is to change behavior.

Robinson: Aetna is held responsible for quality of care by the National Committee for Quality Assurance (NCQA) and others. How can you be made responsible for quality of care when you don't employ the doctors, who are out there in their private practices?

Huber: We can be held responsible for the quality of the process, but not of the treatment. We have credentialing procedures designed to weed out poor practitioners and make sure that our network physicians are qualified. We have performance measurement systems to monitor the quality of care provided to our members.

Robinson: I'm always amused by the studies that give different health plans different quality ratings, when they all use the same doctors.

Huber: I know. But there are some differences among health plans, such as in encourage-

ment of preventive care. We try very hard with our diabetes program, where we do everything possible to encourage members who are diagnosed as diabetic to have annual retinal eye exams. The best we've ever gotten is slightly over 50 percent. At some point, there is nothing more you can do.

Robinson: How interested are employers in efforts to evaluate and improve the quality of care? Or are they only interested in the cost?

Huber: They're all over the map. We have some employers who are keenly interested in analytics that allow them to evaluate the effectiveness of their employees' health care. Other employers talk to us about fractions of a penny per member per month. They are all concerned about cost, but some of the more enlightened

plan sponsors do see that if their employees are happy and healthy, they'll be more productive on the job. Through our U.S. Quality Algorithms (USQA) subsidiary, we can analyze the biggest health problems for a company's employed population and design benefit packages and health programs to address their needs. Industries whose principal asset is their people care a lot more about these types of analytics and how they can use them to design benefit packages that do improve the productivity of their workforce. For Silicon Valley companies, we actually are their largest outside supplier because they don't buy raw materials. Their two largest expense items are personnel and health care. Such companies look at health benefits as a major component of their cost structure and are concerned about ways that they can make that expenditure more productive.

Robinson: Aetna's efforts to develop clinical information systems may bring you into conflict with medical groups, IPAs, and hospital systems, many of which want to control the claims payment process and the information it generates, to build their own information infrastructure, benchmarks, and performance

"Health insurance companies can be held responsible for the quality of the process, but not of the treatment."

measurements.

Huber: Well, they shouldn't. We must have access to the data ourselves. But we're happy to give those parties access as well, and we encourage them to use the information.

Robinson: It would seem that the issue of data monitoring, which is extremely important, could be separated from claims payment, which in its purest form is a fairly routine function. Yet it seems to be the most hotly contested issue. The provider organizations in the East complain loudly that they do not have enough data, while the ones in the West insist that they be claims payers even though they lack the economies of scale. That's the only way they think they can get the data.

Huber: You're right. As our ability to parse the information improves, we can slice this any number of ways. Indeed, that's part of our business model. We use that information to differentiate ourselves with plan sponsors. Our ability to provide sponsors with detailed analytics about how their membership behaves is, I think, a competitive advantage. Also, we think we're pretty efficient.

New Markets

Robinson: You were among a handful of senior business leaders who recently accompanied President Clinton on a tour of untapped markets in both rural and urban areas. The trip was designed to promote the president's New Markets Initiative. Where did you go, and what were some of your impressions?

Huber: Well, actually, I was on two trips with the president. The first one was to Atlanta, and the second one was to Appalachia in eastern Kentucky, then to the Mississippi Delta and then to East St. Louis. It was fascinating to be part of the president's traveling flying circus. And it is an interesting initiative, one that I am actually pretty comfortable supporting. I think it's valid to focus on the pockets of poverty that persist, even though the country is enjoying unprecedented prosperity.

Robinson: Do you see the potential for businesses to find investment or market opportunities in some of these areas?

Huber: In some areas some things can be done, but in others (such as rural Appalachia) it will be much more tough going. Aetna has created a targeted marketing program in urban areas, focused particularly on small businesses that are owned and operated by Hispanics, African Americans, Asians, and women. We find that these markets are underserved for our kind of employee benefit products. Part of the secret of success, we've found, is not simply to have the right products to offer to this population, but to have people from the same community act as our representatives to this target market. So far, our results have been positive. There's real potential, and we're doing something about it.

Concluding Comments

Robinson: The U.S. system is characterized by a strong private-sector role in health insurance as well as a strong public-sector role, yet everyone seems to be unhappy. Do you see the system evolving in the next few years in a way that will increase the overall level of satisfaction among the U.S. population?

Huber: I'm not sure I'm going to live long enough to see that era, but I think we can improve things. Our steps to take out a lot of the hassle will be important to improving satisfaction of both physicians and patients, and we're dedicated to making that happen. But I see the health care arena continuing to be contentious. One of our initiatives, which I kept hoping would wait until after I retired, is to bring best practices to medical care delivery. You don't think that's going to be contentious? New York has twice as many hospital beds as it conceivably needs. The economy is not willing to pay for that excess, but as it's squeezed out, it's going to be very painful.

Robinson: There are those running for the Senate in New York who are under the assumption that it will never be squeezed out.

Huber: They may be right. Who knows?

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