brunt of a consumer backlash against network restrictions, utilization review, and bad press resulting from denials of care and abandonment of HMO markets. Rebounding from this backlash, Aetna gave up on a mission of growth at all costs, while recommitting itself to profitable growth, with prices outpacing costs. In this transition, Aetna made sharp cutbacks in its managed care plans, withdrawing from Medicare + Choice HMOs in any counties with 65 percent Medicare enrollment and leaving State Medicaid plans altogether. The company emerged from this makeover as a smaller but more profitable multiproduct insurer with more emphasis on preferred provider organization (PPO) and health savings account (HSA) products and a new culture of pricing discipline and cost vigilance. Robinson noted the downside of this turnaround, however, in his conclusion of this case study:[22]

> *"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---. 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."*

Aetna's new directors soon generated excellent returns to investors. In 2005, it was one of the industry's leading stocks, rising by 51 percent. Such success, however, remains fragile with Wall Street, as other insurers have found. When its MLR rose from 77.9 percent to 79.4 percent from the first quarter of 2005 to that of 2006, its stock fell by 20 percent as investors became concerned about slow growth in enrollment and whether premiums could keep pace with costs of care. [23] Accordingly, Aetna is aggressively marketing new products to younger and healthier enrollees where risks are low and profits higher. Here are two examples of current Aetna products:

- A limited benefit plan with a $250 in-network deductible ($350 out of network), prescription drug card covering a monthly maximum of $35, and a $10,000 maximum benefit cap[24]
- High deductible plans in California with in-network deductibles of $5,000 for individuals and $10,000 for families (double if out-of-network), plus fees beyond Aetna's allowable schedule[25]

Summary

This chapter has demonstrated the sensitivity of Wall Street analysts and investors to profits and medical loss ratios of the largest three health insurers. The Big Three are dependent on investors' expectations that big profits and healthy returns will continue indefinitely. As we saw in Chapter 1, however, the future viability of employer-sponsored health insurance has been called into question in many quarters, and the individual market is relatively small. In their efforts to keep selling insurance that delivers less and less per premium dollar paid, insurers are moving toward high-deductible, limited benefit plans of less value to enrollees. Many of these plans hardly qualify as "insurance," and health care becomes more unaffordable for more of the population every year.

Two big changes are unfolding: Growth in the private market becomes less likely and the new Democrat-controlled Congress is taking aim at assuring a level playing field in public programs without subsidies for private insurers. What do these changes portend for the future of the industry?

The private health insurance industry maintains that its *raison d'etre* is providing people with more efficiency, choice, and value than public programs. We will assess the evidence for and against these claims in the next three chapters. First, we turn to how the industry really works in everyday practice.

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