Aetna jettisoned all its other lines of business to focus on being the nation’s largest health insurer. Along the way, it alienated doctors, corporate health benefits managers and patients, and found itself awash in red ink. In an industry where efficient claims processing and operations are critical, Aetna is looking to information technology to create a competitive advantage. But it won’t say how it intends to do that. Here’s the treatment Baseline advocates.
TECHNOLOGY WILL BE KEY IF CEO JOHN W. ROWE IS TO SUCCEED IN RETURNING THE HUGE HEALTH INSURER TO CONSISTENT PROFITABILITY.
But that is still a slim 1.8% operating return on $5.1 billion in revenue, in the quarter ended June 30. Rowe’s target is 6% by the end of 2003. And the company was almost stunningly successful in shrinking its membership, to focus on profitable customers. It lost 595,000 members in the quarter, leaving it with 14.4 million.

To regain its footing — and achieve its earnings goal — the M.D. is going to have to prescribe a strong dose of information systems. Rowe says improved technology is part of his regimen for Aetna. “The information technology investments we are making this year will provide us with a competitive advantage,” Rowe told an investor conference in early June. Aetna plans to spend $185 million on 192 information systems projects in 2002, plus another $100 million on related activities such as developing requirements for those systems. Overall, Aetna expects to spend 2.5% to 3% of its 2002 revenues on information technology, about level with prior years.

But while Rowe maintains information systems will provide competitive advantage, he has yet to lay out a detailed plan to show shareholders, investors, doctors, patients and corporate benefits managers how Aetna will achieve technology leadership in an information-intensive industry. Aetna cooperated on a limited basis for this article but declined to make executives available for in-depth interviews. Quotes attributed to Rowe in this article come from public statements he has made elsewhere concerning Aetna’s initiatives on business and technology. Since Rowe and his team haven’t written a prescription they’re willing to share, we’ve come up with our own. Baseline’s plan for Aetna would focus on three key areas:

— **INTEGRATION.** Aetna still has four separate health plan claims systems. After its 1996 acquisition of U.S. Healthcare, it gradually unified all HMO claims on U.S. Healthcare’s systems. Aetna’s HMO business previously used a hodgepodge of systems from other acquisitions, as well as some developed internally. Outside its HMO business, though, two of the three claims systems are incapable of autoadjudication, or computerized claim approval. The migration to an improved system for non-HMO claims is supposed to be complete in November, but it’s been a long time in coming. **Prescription No. 1:** Keep the non-HMO claims integration project on track and improve analytical tools to extract medical cost trends from claims across all lines of business.

— **AUTOMATION.** Electronically filed claims cost considerably less to process than paper claims — 80% less on average. Two years ago, Aetna set a goal of receiving 85% of claims electronically by the end of 2001. Today, analysts doubt it’s much beyond 50%. Autoadjudication also speeds processing and lowers costs. Aetna says it autoadjudicated 62.1% of the claims presented to its health maintenance (HMO) plans in April, up from 53.9% in 2001, but its most capable system for non-HMO claims is only at 34.4%.

**Prescription No. 2:** By 2003, increase electronic filing of claims to 85% and boost autoadjudication to 65% for HMO and at least 40% for non-HMO claims.

— **RELATIONSHIPS.** Aetna traditionally courted employers more than the individual consumers who are its members. Now, it’s looking to make consumers its allies in controlling costs. The company also is seeking to repair relationships with physicians frustrated with Aetna’s aggressive managed care policies. **Prescription No. 3:** Provide online tools to let consumers make—and feel comfortable making—decisions traditionally made by employers. Use technology to improve
communication with providers and treat them like partners, not adversaries.

Rowe has serious issues to deal with other than just fixing data systems. Last year, UnitedHealth Group displaced Aetna as the largest provider of health plan services to corporations. Aetna lost $187.6 million in the final quarter of last year and $280 million for all of 2001. Sales fell from $26.8 billion in 2000 to $25.2 billion in 2001. They’re still falling.

**FRAVED RELATIONSHIPS WITH PHYSICIANS AND HOSPITALS,** bloated customer rolls and staff, and rising health costs are among Aetna's biggest issues. After its $8.0 billion purchase of U.S. Healthcare in 1996, Aetna grew into the nation's largest health plan, but consumers and physicians also came to identify it with some of the worst aspects of managed care—arbitrary claims denials, meddling with medical decision-making, and poor customer service. While these complaints aren’t unique to Aetna, they put it at the top of the list of managed care firms being sued in federal court by a coalition of state medical societies and consumers. The medical societies in Connecticut, New York, South Carolina, Tennessee and New Jersey have brought similar suits in state court. The company has been sued by physicians, hospitals and patients for its payment and treatment policies.

To cope, Rowe has recruited to Aetna’s city-block-sized colonial headquarters in Hartford, Conn., a management team that includes president Ron Williams, who came from tech-savvy WellPoint Health Systems, and CIO Weh-Tih Cheng, a veteran of Memorial Sloan-Kettering Cancer Center.

In December, Aetna cut 6,000 jobs—about one-sixth of its workforce—and took a $125 million charge against earnings. In June, Aetna confirmed the phased reductions would include about 200 information technology jobs. Most data systems cutbacks will come through attrition and by eliminating contractors, in addition to 50 or 60 layoffs. The job cuts come as Aetna purposefully shrinks its membership to focus on more profitable accounts. Aetna expects to end the year with about 14 million members.

Yet Aetna needs good information if it is to cull just un-economic customers, out of all those acquired in an acquisition-fueled growth binge that began in 1996. “You really need sophisticated systems to know what the value of a customer is,” says Lori Price, a financial analyst at J P Morgan Securities. “They’ve been very disciplined on pricing, getting the price increases, but that has to chase away some economic business, too.”

Rowe says the company has been successful at cutting only the least profitable accounts. He hopes to start rebuilding membership next year, taking more care to balance growth with profitability. Aetna also has been demanding increases of as much as 20% for services it believes have been underpriced.

Aetna’s technology investments have already helped it trim administrative costs. The company wants to cut selling, general and administrative expenses by $300 million this year, partly by eliminating frills like a corporate jet, but also through more efficient claims processing and other systems improvements. One example: increased automatic adjudication helped lower real estate costs at a service center in

**THE AETNA PLAYER ROSTER**

**John W. Rowe, M.D.**

Chairman and Chief Executive Officer, Aetna Inc.

Before taking the helm at Aetna in September 2000, Rowe was president and CEO of Mount Sinai NYU Health, which he had guided through the merger of the Mt. Sinai and New York University medical centers in the city. Rowe is a physician and gerontology expert who founded the Division on Aging at Harvard Medical School.

**Ronald A. Williams**

President

Williams joined Aetna in March 2001, originally as executive VP and chief of health operations, and was named president in May 2002. Previously, he had earned a strong reputation as a top executive at WellPoint. He worked in marketing for Control Data Corp., and co-founded another consultancy, Integrative Systems.

**Weh-Tih Cheng**

Senior Vice President and Chief Information Officer

Cheng joined Aetna in April 2001 and reports directly to Rowe. Previously, he spent 15 years at Memorial Sloan-Kettering Cancer Center as VP for information systems. In addition to managing Sloan’s overall IT strategy, he led the development of systems to support the center’s disease management programs. Aetna hopes to use similar systems to help it identify members whose health, and healthcare costs, would benefit from individual attention.

**William H. Donaldson**

Board Member

Donaldson served as interim CEO after forcing the ouster of Richard Huber in March 2000. Donaldson was a co-founder of Wall Street’s Donaldson, Lufkin & Jenrette.

**Ellen M. Hancock**

Board Member

Hancock provides Aetna with high-level advice on IT strategy, based on 35 years of experience as a technology industry executive. She is the former chairman and CEO of Exodus Communications and, before that, was a senior executive at IBM, National Semiconductor and Apple Computer.

**Richard L. Huber**

Senior Director, Kissinger McLarty Associates; former Chairman, President and CEO, Aetna Inc.

After joining Aetna as CEO in February 1995, Huber executed a strategy of narrowing and strengthening Aetna’s focus on health coverage through the merger with U.S. Healthcare and a series of smaller acquisitions. One of U.S. Healthcare’s main contributions, as he saw it, was to provide information systems that would unite all of Aetna’s HMO operations. But when the company’s finances stumbled and its aggressive style of managed care backfired, he was ousted by Aetna’s board.

**Raj Jaswa**

Chairman, President and CEO, Selectica

Jaswa is a co-founder of Selectica, a software vendor that is helping Aetna create a new, unified quotation system. He previously served as president of OPTi Inc., a supplier of PC-compatible chipsets.

**Kevin Hickey**

Chairman and CEO, IntelliClaim; former Aetna operations executive

Hickey was head of claims and administration for Aetna’s Health Plans division prior to the U.S. Healthcare merger, and subsequently served in a similar role at Oxford Health Plans. As founder and chairman of IntelliClaim, he runs a service provider with health plans to improve their claims-data quality.

**Tom Blodgett**

President, ACS Business Process Solutions

With his brother, Lynn, Tom Blodgett co-founded the startup outsourcing business in 1985 that became ACS BPS, after it was acquired by Affiliated Computer Services in 1996. Lynn now serves as group president of outsourcing at ACS, while Tom is president of the BPS unit that concentrates on converting paper forms to electronic data for companies like Aetna.
AETNA: FIVE YEARS OF TOIL AND TROUBLE

- Aetna spends almost $1 billion on acquisitions and stock repurchases.
- Aetna becomes first big health plan to offer Web-based member enrollment.
- American Medical Association (AMA) challenges Aetna U.S. Healthcare over contracts doctors say give Aetna unilateral control over key aspects of their professional judgment.
- CEO Richard Huber says merger issues—including efforts to consolidate HMO information systems—have disrupted operations, causing claims to back up and making Aetna lose track of medical cost trends.
- Aetna introduces E-Pay, a program promising payment within 15 days to providers who file online.
- Aetna sets goal of receiving 85% of claims electronically by the end of 2001.
- Richard Huber fired as chief executive in February.
- Aetna turns down bid by ING and WellPoint to buy it and split it up.
- John Rowe named chief executive in September.
- The "we’re inept" defense? In responding to a lawsuit in November, Aetna claims its systems are too feeble to purposely mishandle claims.
- Aetna debuts policy-quotation system for use by internal underwriters and external brokers, based on software from Selectica.
- Aetna hires Infosys Technologies, an outsourcer in India; Chief Information Officer John Brighton sees a $12 million technology savings from March deal.
- A month later, Wei-Tih Cheng joins Aetna as CIO; Brighton is out.

AETNA'S CLAIMS PROCESSING IS GETTING BETTER ...

Aetna has become more efficient than most competitors by one measure: its percentage of clean claims, or claims that only get handled once en route to being successfully processed. Blue Cross/Blue Shield, however, sets the standard.

... BUT IT IS FAR BEHIND ITS KEY RIVAL IN OPERATING EFFICIENCY

Since 1997, Aetna's operating margin has declined every year (see chart above). This past April, however, Aetna CEO John Rowe told investors the company wants to raise operating margins over the next few years to 6% of revenues. A look at six recent quarters (see chart at right) shows Aetna has a long way to go to achieve that.

Sources: Clean-claim estimates and projections by AC Group Inc.; Operating income ratios from company financial filings
Fort Wayne, Ind., by reducing the space needed for workers, Rowe says. “That’s going to save us hundreds of thousands of dollars per year, and it’s happening in 35 service centers across the country.”

Rowe has said one reason he took the job was Aetna’s huge warehouse of healthcare data—15.5 terabytes of information, updated monthly. He believes the company has only begun to tap its potential. In particular, he wants to identify the sickest (and most expensive) patients, getting them into programs that emphasize prevention and quality care. He admits, “We’ve been slow in past years with developing some of the applications that are needed.”

There are signs that what Rowe calls a “performance-driven culture” is emerging. Aetna’s First Claim Resolution program now rewards employees for settling claims properly the first time, rather than how quickly they handle calls. Now, Aetna resolves 93.9% of claims on the first call, up from 86.5% a year ago. Rowe also praises a new executive information management system, developed under Williams, that provides “an early warning system” for business trends, such as medical cost increases that need to be reflected in Aetna’s pricing. Aetna also has assigned Business Systems Information Managers to keep technology projects aligned with business goals and track return on investment.

FOR ALL THIS, AETNA’S PACE OF CHANGE SEEMS sluggish. Analysts and former employees say the company has often failed to address the systems integration issues created by its history of mergers and has been shortsighted with its technology investments. One former consultant says Aetna talked up initiatives such as using a special model from the Software Engineering Institute to improve systems project management, but adds, “If you look at the project plans, there’s nothing to support that.”

“The first thing that gets cut is the long-term vision,” the consultant says, such as creating systems that share data. “If you look at the systems to manage the lifecycle of a claim, these are systems built years and years ago and Band-aided together. They’re not going to sit down and design a flexible system.”

Another former Aetna employee and consultant says the company’s technology managers respond to the short-sighted instincts of their business counterparts. “They will make promises to the business side that are too good to be true, and can’t be kept,” he says. Those habits are so institutionalized that they won’t be easily changed, he says.

Even if Aetna makes a strong recovery, there is no guarantee it can regain industry leadership. When former CEO Richard Huber was fired in February 2000—following a year of criticism that he had overpaid in the U.S. Healthcare acquisition—Aetna’s profits were already turning into losses. Aetna adopted the tough-guy style of U.S. Healthcare just as acquisition—Aetna’s profits were already turning into losses. Aetna adopted the tough-guy style of U.S. Healthcare just as the backlash against managed care was beginning. Huber was labeled “the poster boy for HMO arrogance” by an industry watch group after he characterized the wife of one Aetna customer who won a judgment against the company as “a weeping widow.”

Huber narrowed the focus of the company, founded in 1883, to just health care. Formerly a full-line insurer, Aetna sold its property and casualty business and bought health plans from New York Life and Prudential, among

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<th>APPLICATION, SERVICE</th>
<th>PRODUCT USED AND PURPOSE</th>
<th>SUPPLIER</th>
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<tr>
<td>Quoting and underwriting system</td>
<td>Aetna has begun the process of creating a unified underwriting, quoting and renewals system based on Selectica’s Internet Selling System. Application is live for small groups market and under development for other areas.</td>
<td>Selectica</td>
</tr>
<tr>
<td>Pricing, rating and contracting</td>
<td>Aetna is pursuing a series of projects known as Strategic Pricer, Strategic Contracts, and Strategic Codes and Rates, aimed at improving the company’s pricing and contracting processes.</td>
<td>Aetna internal development in Java and Visual Basic. Selectica also provides analytic tools targeted at pricing for policy renewals.</td>
</tr>
<tr>
<td>Scanning and verification on paper claims</td>
<td>Claims submitted on paper are scanned, turned into computer data by an optical character recognition process, and then manually checked for errors. Aetna has outsourced this process to ACS Inc., which provides mail-room services and uses offshore labor for the manual data validation.</td>
<td>ACS Inc.</td>
</tr>
<tr>
<td>Claims processing and auto-adjudication</td>
<td>An assortment of systems, mostly homegrown and running on mainframes as a mix of batch and online processes, Aetna has four distinct claims systems—one for its HMO business and three for other health plans. It plans to retire two of the three non-HMO claims systems by November.</td>
<td>Aetna internal</td>
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<td>Claims screening</td>
<td>ClaimCheck software screens claims for missing or inconsistent information and kicks out claims requiring manual review</td>
<td>McKesson HBCO</td>
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<td>Claims review</td>
<td>Fraud and Abuse Management Systems, a specialized data mining tool that targets improper and excessive claims.</td>
<td>IBM</td>
</tr>
<tr>
<td>Electronic claims filing</td>
<td>In addition to accepting claims through its Web site, Aetna partners with several EDI clearinghouses and was a founder of MedUnite, a consortium-led electronic marketplace.</td>
<td>MedUnite, WebMD, Medfax, others</td>
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<tr>
<td>Data warehouse</td>
<td>Aetna claims to have created the largest data warehouse of medical cost and quality data. The data warehouse weighs in at 15.5 terabytes, updated monthly.</td>
<td>IBM</td>
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others. But the ride was bumpy—and Aetna soon faced a $10 billion breakup bid from Dutch insurer ING and health-care rival WellPoint Health Networks. Aetna ended up selling its financial services business to ING for $7.7 billion.

Rowe took over in September 2000 from interim leader William H. Donaldson, a board member and one of the three original founders of pioneering Wall Street analytical firm Donaldson, Lufkin & Jenrette. No longer the largest insurer, Aetna is retrenching. Rival UnitedHealth is now as big as Aetna in terms of revenue (about $25 billion apiece in 2001) and, like tech-savvy WellPoint, already has the level of profitability toward which Aetna aspires.

Aetna’s ambitions may already be obsolete. “In general, I think the days of there being successful national health plans may be gone,” says Lauri Ingram, an insurance technology analyst at the Meta Group. Centralized systems struggle to achieve economies of scale in an industry heavily influenced by state insurance laws, regional hospitals and local medical practices. “It’s why the large players are kind of struggling with who are they or how can they succeed,” Ingram says.

If Aetna is to succeed on the terms it envisions, it must serve customers and process information better—not just by a little, but by an order of magnitude. Following are the three things Baseline believes Aetna must do—our prescription for Aetna’s recovery—in more detail.

**PRESCRIPTION NO. 1 INTEGRATE** (Among other things, to make sure duplicate payments cease)

**AETNA’S CUSTOMER AND PROFIT** woes largely revolve around its ability to process claims fairly, efficiently and cheaply. “Reducing the labor associated with paying claims is a critical lever with regard to being profitable,” says Brad Holmes, an analyst with Forrester Research. But Aetna’s progress is hindered by multiple claims systems.

Integrating these systems was supposed to follow Aetna’s acquisition of U.S. Healthcare, known for systems that can handle large numbers of new users. It hasn’t happened.

Former CEO Huber boasted of moving the business onto one common platform. Where Aetna truly succeeded was with its data warehouse, fed by claims data from all products. However, the integration of operational systems didn’t extend to Aetna’s non-HMO products—including less restrictive forms of managed care that customers increasingly demanded. Also, some strengths of the U.S. Healthcare systems, such as autoadjudication, relied on the relative simplicity of the HMO business model. Those systems didn’t have the flexibility to support Aetna’s more tailored benefits plans. Older systems had to be retained.

“Huber was focused on buying market share for economies of scale, but that’s theory. You have to integrate claims processing to achieve any of it, and they didn’t do it,” says JP Morgan’s Price.

Aetna also failed to make sure its prices kept pace with increasing medical costs. “They essentially mispriced for several years in their at-risk HMO business,” says Greg Crawford, head of health care research at Fox-Pitt, Kelton Inc., an investment bank in New York. Aetna should have been able to see the cost trends by analyzing claims data, and its failure to do so reflects the fragmentation of claims systems, he says.

**STUCK WITH AGING SYSTEMS**

Systems issues also have caused Aetna to overpay some accounts. “We are overpaying substantially,” Rowe said in a speech last year at a Sanford C. Bernstein & Co. investors’ conference. “And my guess is there’s more to be discovered.” Aetna was losing millions because providers who resubmitted claims for lack of payment sometimes wound up being paid two or three times. Some smaller accounts were paid even though their policies had expired.

These problems reflected the inability of its databases to share information or identify duplicate records. Aetna refuses to discuss how this has been addressed or how much waste it has eliminated.

In a November 2000 court filing, Aetna had to respond to allegations that it actually manipulated its systems to slow payments. “Aetna does not use computer software to administer claims processing in even a remotely uniform fashion,” the company claimed in its own defense. In the filing, Aetna said it maintained four claims systems. While HMO claims were processed through systems that try to automate decisions based on business rules, claims for PPO (preferred provider organization) plans were run through an older system that did little more than display claims on a screen so a clerk could make the judgment of whether to pay.

All four systems are still in use. Integration is highest in its HMO business, where all claims are handled by the system inherited from U.S. Healthcare. Elsewhere, however, Aetna continues to use two systems incapable of autoadjudication, called Aecclaims and the Managed Choice System. However, Aetna says it is moving to have all non-HMO claims managed by its Automated Claims Adjudication System (ACAS) by November. That would leave Aetna with two healthcare claims systems, instead of four.

Performance also has improved. Under the First Claim Resolution program, Aetna cut its HMO claims processing time to 4 days by April, down from 5.7 days a year earlier. Today, 62% of HMO claims are autoadjudicated, nearly double the rate of two years ago.

Holding onto existing claims systems is typical, says Ingram at Meta Group. “Companies don’t replace them very often because it’s a very disruptive, very high-risk process,” she says. Instead, they add on accessories such as fraud detection, she says, “It ends up being very piecemeal.”

Forrester’s Holmes believes Aetna will have to take the risks, however large, if it truly wants to lower administrative costs while eliminating hassles for consumers and providers. He suggests the need for a next-generation operating environment.

There are risks there, too. Although Aetna is a big user of IBM’s DB2, its claims systems continue to make significant use of Computer Associates’ IDMS, a mainframe-only data storage technology. IDMS has a reputation for being high-
performance and reliable, and CA does sell an add-on product that allows it to mimic a relational database. Still, finding experts in the base technology is becoming harder as time goes on (see story at left, “Gotcha! Downsides of Using Mainframe Databases”).

“Aetna has been working on a major conversion to DB2 and some of that has happened,” says Del Barlett, a former U.S. Healthcare IDMS administrator who left about a year after the Aetna merger. “When you have the whole system revolving around IDMS, it is a monumental task.”

Because the principles for optimizing a traditional mainframe database are entirely different for a relational database, applications have to be rethought rather than merely migrated, he says. Barlett says he remains “an IDMS bigot” because he likes its performance and reliability—even though he recognizes that DB2 has advantages in terms of flexibility for ad hoc queries and developing new applications. The trade-off is that DB2 requires more computing power and administrative manpower, he says.

KEY TO SPEEDIER PROCESSING OF CLAIMS and cutting overhead is receiving claims electronically. On average, claims cost $5 to $15 each to process manually and $1 electronically. In other words, Aetna saves at least $4 every time it convinces a provider to file electronically rather than on paper. Aetna receives about 800,000 claims per day, so every 1% increase in electronic filing ought to save upwards of $8 million a year.

The leaders in electronic filing are Blue Cross and Blue Shield. “Aetna is up to about 55% electronic claims,” says Mark Anderson, a former hospital CIO who runs an independent healthcare technology analysis business, AC Group, based in Spring, Texas. That’s an increase from 45% in 2000, but the “Blues” are both over 84%. The Blues’ advantage comes not from technical superiority per se, but because they have adopted the electronic claims format used by Medicare and Medicaid. Today, 95% of doctors are equipped to file their Medicare and Medicaid claims electronically, says Anderson. “Why can’t they do it for Aetna? Because Aetna uses a different format.”

While doctors could file claims through clearinghouses that translate between formats, most can’t be bothered, Anderson says. Instead, they print claims and mail them in, forcing Aetna to process them by hand, the costly way.

Now Aetna is faced with a government mandate to revamp its data systems as part of HIPAA, the Health Insurance Portability and Accountability Act, which dictates a standard format for electronic claims. Compliance efforts cost the company about $13 million pretax last year, with another $20 million in expenses expected in 2002.

Aetna says it is pushing for HIPAA compliance, but it has also requested a one-year extension beyond the Oct. 16 deadline. Aetna says it needs extra time to avoid the expense of modifying systems that it plans to shut down anyway, such
as the two older systems for non-HMO claims.

But electronic filing is only part of the answer. Rowe’s disclosure last year about duplicate claims payments highlights a more fundamental problem. Aetna never said exactly how much this cost, except millions of dollars a year. “That was probably an impolitic way of describing a problem that every single payer has but they just don’t talk about much,” says Kevin Hickey, a former Aetna operations executive who now serves as CEO of IntelliClaim, a claims data-cleansing specialist.

Providers who aren’t paid the first time often follow up with an amended claim, which an automated system may not recognize as a duplicate. The payer’s systems also bundle procedures together and make other changes to the claims data. All of which makes it hard to reconcile claims with payments. “The physicians may not have even realized they got paid twice, depending on how that information goes back to the physician’s office,” Gartner analyst Cynthia Burghart says.

Bad data has many other consequences. “Any time you fail from autoadjudication to manual, you have an opportunity for an error,” says Hickey. Inconsistency—and problems—result. “What really causes the most concern for providers is when they get paid one way for the same service one day and a different way the next day: When the process is automated, the likelihood that that’s going to occur is reduced.”

Right now, Aetna is left with a large volume of paper claims, many processed on its behalf by Affiliated Computer Services of Dallas. ACS scans claims, converts them into computer-readable text and then ships the results to an overseas center where workers check the electronic data against the original document. (For a profile of ACS, see p. 50.)

Tom Blodgett, president of ACS’s business process solutions, says ACS handles 2 million to 3 million claims per day overall, and expects the demand for this service to continue for years to come. “Yes, the percentage of paper claims is going down. However, the overall volume of paper claims is going up,” he says. ACS may not be able to reverse that trend, but it can help lower the cost of processing paper claims by shifting labor-intensive processes to lower-cost countries such as Ghana, Blodgett says.

Through its EPay program, Aetna also can and does entice more providers to do business online by promising pay-

MISTAKES WITH REIMBURSEMENTS ARE COMMONPLACE, AND DON’T ALWAYS WORK TO AN INSURER’S ADVANTAGE.

Changing the Rules?

With its new medical savings accounts, Aetna is embracing an idea that could turn managed care on its ear.

Introduced in September, the Aetna HealthFund isn’t about insuring against routine medical costs or controlling access to care. Instead, it’s a “consumer-driven” plan designed to give individuals more choice but also more responsibility for their health.

“We think a consumer-driven system will emerge over time,” says Aetna CEO John Rowe, calling it a “mitigating factor” against medical cost inflation. The theory is that consumers covered by employer-sponsored plans have been too insulated from the real cost of care. Conversely, educated consumers who feel they have some “skin in the game” could be a powerful force for controlling costs.

As of early summer, Aetna had eight customers for the new plan, including Levi Strauss and Toys “R” Us.

The parameters can vary, but here’s an example:

An employer gives each employee $2,000 a year in an account dedicated to paying medical expenses. Employees also receive an old-fashioned health insurance plan with a $4,000-a-year deductible. Employees get two incentives to stay healthy and manage their own medical costs. First, if they exhaust the amount in their health fund, they are personally responsible for the next $2,000. Second, except for funds earmarked for prevention, money left at the end of the year can be accumulated to provide richer benefits and less risk. (This “rollover” feature is one of several things that distinguishes medical savings accounts from “flexible” spending accounts, two funding mechanisms defined by different federal laws.)

“To the degree that people see it as their own money, we get people realizing that doctor’s visits aren’t $10, and Prilosec isn’t $15,” says Michael Parkinson, chief medical officer at Lumenos Inc., an Alexandria, Va.-based startup focused on offering consumer-driven plans.

Employers are looking for alternatives in the face of accelerating medical costs, expected to rise another 12.7% this year. In a pure “defined contribution” approach, they would give employees a flat subsidy toward purchasing health coverage. Lumenos and another startup, Definity, pioneered the model Aetna is mimicking, in which the employer’s fixed contribution to a medical savings account is backed up by traditional insurance against catastrophic illness. Other large plans use tiered co-pays that are more proportional to the real cost of more-expensive versus less-expensive drugs, or doctors, or hospitals.
Because of the way codes are assigned to different procedures, he says he continually finds himself forced to choose between getting paid quickly and getting full compensation for his services. For example, implanting a coronary stent can be a straightforward procedure that lasts less than an hour, or it can take three hours or more if he encounters complications. But he knows that if he adds a modifier to the claim, rather than sticking with the basic procedure code, “the claim gets kicked out and has to be reviewed manually,” he says. So seeking additional compensation for a difficult or extended procedure is “extremely difficult and often futile,” Seides says.

This is where systems and legal issues get tangled. Several lawsuits by providers charge Aetna and other insurers with programming their systems to “downcode” claims, resulting in reduced reimbursement. Litigants say this is a conspiracy enabled in part by the payers’ use of common systems, such as McKesson’s ClaimCheck software. The payers say their systems are simply designed to enforce discounts and other policies that are spelled out in their provider contracts.

In court, Aetna said it used ClaimCheck to spot combinations of procedures that are mutually exclusive, such as a vaginal and abdominal hysterectomy for one patient on the same day. It also blocks separate billing for a procedure that’s classified as one part of another (for example, removing an appendix during abdominal surgery).

Ultimately, prompt payment has to be balanced against avoiding claims that are inaccurate, inconsistent with Aetna policies or outright fraudulent. In addition to screening claims with ClaimCheck, Aetna can and does review claims using IBM’s Fraud and Abuse Management System, a specialized data mining tool. The tool is designed to comb through millions of claims looking for suspicious patterns. Investigators then can perform a more detailed analysis of claims from a particular provider.

**PRESCRIPTION NO. 3**

**REPAIR RELATIONSHIPS**
(its adversarial stance hath made Aetna sickly. Insurer, heal thyself)

**AUTOMATING CLAIMS PROCESSING** is an overdue solution to an old problem: The need to exchange information in smart ways. Now, that information needs to be put at the fingertips of health care customers, so they once again can pick their own doctors and hospitals, effectively.

Rowe wants to make more of Aetna’s rich store of information available to customers. “The informed patient makes better choices that result in better outcomes and, often, lower expense,” Rowe says. Aetna already provides personalized Web sites where members can check claims status, but he says much more can be done to steer consumers toward healthier habits and more economical care.

Aetna believes disease management programs, which monitor and guide behavior of the chronically ill, can reduce medical costs. As an industry average, 10% of the patients are responsible for 60% of the costs.

Still, if Rowe wants to get consumers on his side, he’ll have to convince them he’s on theirs. “We practically had to wage war with them” to get claims paid, says Betty Murphy, an Aetna member in Washington, D.C. She and her husband have been Aetna members since 1986. Both have been treated for cancer in the past couple of years. Having worked in doctors’ offices, she knows some claims problems aren’t the

> “My major concern as a physician is that we don’t really have the information on quality out there for patients to make the informed decisions we want them to make,” says Marjorie Schulman, a senior medical director at Aetna. Aetna has a head start on creating such resources because of the USQA data warehouse, successfully used to drive its preventive-care programs. For example, by identifying and educating asthmatic members it was able to drive down the frequency of asthma attacks requiring emergency room visits by 22% for children and by 13% for adults. The same sort of approach can help HealthFund members manage their health quality. But to date, USQA’s analytics have been designed for internal use and for corporate benefits managers, rather than to be accessed by consumers over the Web.

How important this market will prove to be remains uncertain. But Rowe quotes an executive at one big customer as saying, “We bought your business this year because you had this defined contribution product, and Cigna and UnitedHealth didn’t, and we thought it was time to get some experience with this—and give employees some skin in the game.”

—DAVID F. CARR

Aetna adapted a flexible-spending account claims system to support its new medical savings account. The HealthFund also leans on Aetna Navigator, which provides personalized Web sites, allowing members to monitor and manage their medical savings accounts and claims status. Aetna also sees its IntelliHealth Web site—a consumer health information portal—and its U.S. Quality Algorithms (USQA) medical data warehousing and analysis business as assets for giving consumers the cost and quality information required for informed choices.

But Lumenos CTO Chad Pomeroy thinks he has an edge in that all his systems, from the Web site to claims processing, revolve around the new business model. With no constraints from prior history, he was able to create “best of breed” systems around software from Siebel Systems for customer service and QCSI for claims processing, he says. “The nice thing about being a startup is you get to start with a clean slate.”

**The Web is fundamental to consumer-driven plans.** One of the biggest challenges is helping consumers not be overwhelmed by guiding them through the trade-offs between cost and quality. For example, you ought to be able to see whether the more expensive heart surgeon delivers a better survival rate, with fewer complications.
insurer’s fault but stem from improperly coded claims submissions. Still, the Murphys complain that Aetna routinely lost claims and that its service representatives did a poor job of explaining and resolving problems.

Aetna also has to mend fences with doctors and hospitals. Here, a basic power struggle is beyond the scope of information systems. Health care providers want better compensation, and they want to put an end to managed care meddling in decisions about what’s medically necessary for patients. Meanwhile, companies like Aetna are struggling to control costs, which means pushing for discounts and trying to discourage overuse of healthcare services.

Still, technology can reduce some hassles that add to the overhead of every doctor’s office and hospital. That means targeting the long series of phone calls doctors’ offices and consumers find themselves making to customer service before a claim is paid and eliminating unnecessary paperwork. The average cost for a physician to resubmit legitimate claims that were lost or improperly rejected is about $9.84 per claim, according to AC Group, but could be cut to less than 80 cents per claim if insurers provided a fully capable self-serve system for resolving such problems over the Web.

Rowe is intimately familiar with Aetna’s abrasiveness. In his previous job running Mount Sinai NYU Health, an organization of six hospitals in New York, he was irritated by Aetna’s slow payment and underpayment of claims and came to the brink of suing. Shortly after Aetna recruited him to help fix the company from the inside, he had to personally intervene in negotiations with the Mayo Clinic, which was on the verge of leaving the Aetna network. As he told The Wall Street Journal in 2001, he was surprised to learn his company was trying to force the clinic to provide basic primary care when he thought its services only made sense for special cases. Negotiations also had been undermined by unpaid claims, which Aetna’s systems had been rejecting for no good reason.

Rowe’s efforts to repair relationships with health care providers have been only partly successful. Aetna remains one target of a class-action lawsuit against managed care companies brought by individual physicians and the medical societies of California, Georgia, Florida and Texas. Along with Humana, Cigna, UnitedHealth, WellPoint, PacifiCare and Coventry Health Care, Aetna stands accused of conspiring to drive down medical reimbursement and reject valid claims. A series of parallel cases brought by members of these health plans also have been consolidated and are pending in U.S. District Court in Miami, but the judge has not yet certified these as legitimate class-action cases.

In recent months, Aetna has parted ways with 10 HCA Inc. hospitals in the Houston area as well as High Point Regional Health System in High Point, N.C., and Cleveland Clinic Florida in Weston, Fla. It also came close to losing Seattle’s Swedish Medical Center, which would have cost it 20% of its physician network in that area. But while the losses have made news, Rowe stresses that Aetna also has added providers. Since the start of the year, Aetna says its PPO network has grown 2.1% and its HMO network has grown 1.7%.


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**Technology to Lower Cost
A Play Every Insurer’s Making**

**UnitedHealthcare did it.** Cigna is trying to do it now, Humana is doing it in phases, and WellPoint sets the industry standard. Improving information technology performance is an imperative for health insurers as costs continue to rise—up 13.7% last year—and customers demand more choice and flexibility.

Aetna’s rivals have been making concerted efforts to rev up their means of interacting with providers and consumers. None has done so more effectively than WellPoint, which reported aggregate profits of $1.05 billion over the past three years. “The use and leveraging of technology to reduce administrative costs and improve customer service is one of our core goals,” says Marshall Jones, WellPoint’s CIO.

WellPoint’s use of Internet technology is a means to the end of enabling highly flexible health plans that WellPoint customers can tailor to their own needs. Last year, WellPoint customers got the ability to pay premiums on the Web with their credit cards, and earlier this year some Preferred Provider Organization members gained access to tools from a company called Subimo, which help them choose hospitals and research conditions and procedures.

On the provider side is WellPoint’s Provider Access site, which gives doctors and hospitals access to claims, coverage, and payment information—the same information seen by WellPoint customer service personnel. Benefits administrators at large customers can use a service called mybcclink.com that allows users to instant-

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**WellPoint also is focused on its back-office systems, and now makes automated decisions on more than 50% of claims. “Processing claims is meat and potatoes for this industry, and any company that doesn’t do it well is going to be in trouble,” says Jones, who came to WellPoint from Amoco in early 2001 and now oversees an information technology staff of about 2,000 people.**

If anyone doubts the importance of a health insurer’s core systems, the experience of Oxford Health Plans is a cautionary tale. In 1997, the HMO imploded when it botched its migration to a new claims processing system. The company couldn’t bill some customers for months. Oxford bailed itself out technologically through wholesale outsourcing of its systems to Computer Sciences Corp., but its stock went from over $80 per share to about $6, and its market cap is still only 60% of pre-disaster days.

UnitedHealth Group, which passed Aetna last year as the largest health insurer, began a big information systems upgrade in 1998, embarking on an effort to rationalize its own acquisitions by, for example, moving from multiple platforms claims-processing platforms to just two. The Minnesota insurer, which focuses its efforts through a unit called UnitedHealth Technologies, has spent $1.4 billion on technology since 1998. “Their reputation has improved,” says analyst Greg Crawford, citing the Minneap-

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**The Wall Street Journal**
and its peers have been tolerating inefficiency because they preferred frustrated claims payments to expediting them. “They’ve been doing it horribly because it paid to do it horribly,” he says, meaning they pay slowly because of the investment income they can make on the float. But now the backlash of lawsuits and lost business is forcing health companies to streamline their claims systems to survive.

Payers have their own reasons to value efficient systems, says IntelliClaim’s Hickey. “The last thing a payer wants to happen is for a phone call to come in where they have to explain where the claim is.” According to Gartner Inc., live telephone service costs about $5.50 per call. One way to lower costs is to steer customer service inquiries to a less expensive channel, such as e-mail or self-service Web sites and automated phone systems. Even better is to pay so promptly that no follow-up is required.

Insurers aren’t able to rely on investment income for profits the way they once did. Today, for every $1 a health plan makes off the float, it spends $4.50 in avoidable administrative costs—making more efficient systems essential.

A LASTING CURE
A return to profitability also requires a better approach to pricing and marketing. For example, Aetna is currently rolling out a new system for quoting health care policies based on Selectica’s Internet Selling System. Previously, this function had been scattered among many different systems. “For all the acquisitions they did, they ended up with as many systems,” says Selectica CEO Raj Jaswa.

Because it runs on IBM’s WebSphere Java application server, the system serves both independent brokers and Aetna’s own employees. A clear audit trail also is produced, replacing the spreadsheets that underwriters would previously attach to policies to document pricing adjustments. Jaswa says this is an example of Aetna overcoming what previously was an intractable problem. The Selectica implementation is complete for small group accounts and should be extended to cover other segments by the end of the year.

Along with the unification of non-HMO claims, this is a sign that Aetna is breaking the logjam on integration projects that have lingered for years.

So Dr. Rowe may have his patient moving off the critical list. But the company is not confident enough yet to talk about it. Even so, management’s probable strategy for its information systems might not vary much from the prescriptions detailed here. The real question is how effectively Aetna will execute its technology initiatives. “They understand how it can help,” says Anderson. “Now they’ve just got to see if they can get their systems updated quickly.”

Transforming itself into an information technology powerhouse could help boost Aetna back into favor with health care providers, benefits administrators and consumers. Failing to do so may lead each of those disgruntled groups to stop paying any attention at all.

Schaeffer is considered one of the industry’s best and most innovative managers. For instance, WellPoint helped persuade the Food and Drug Administration to reclassify several prescription medications, including Claritin, to nonprescription status in order to lower costs.

Using technology to good effect is more important to Jones than the technology itself. “We’re ahead of some people in terms of things like electronic funds transfer and Web technologies,” he says. Still, “the mainframe will continue for some period of time to be a very important component of our infrastructure.”

WellPoint has been sued by physicians and medical societies over claims processing and reimbursement rates. But WellPoint has managed its own skin in acquisitions with few of the problems that have plagued Aetna. Since becoming a public company, WellPoint has bought several health plans, including its March 2001 acquisition of Blue Cross and Blue Shield of Georgia and the purchase of RightChoice Managed Care, completed in January.

“We have spent a lot of time on integration, and there is no one answer on how to do it,” says Jones. “We have acquired superior technology and replaced ours with it, we’ve standardized on our systems where we could. Our rules are: First do no harm. Don’t harm the business. Systems integration is not nearly as important as business integration, so first we figure out the business.”

—EDWARD CONE