Strategic Business, Financial and Regulatory Analysis of the Health Insurance Industry

Health Plan Weekly

Sept. 3, 2018
VOLUME 28 | NUMBER 35

Senior Reporters
Judy Packer-Tursman
jptursman@aishealth.com
Leslie Small
lsmall@aishealth.com
Executive Editor
Jill Brown

Peer Grouping Drives Managed Care CEOs' Big Paydays

Generous CEO pay among major managed care companies in 2017 (see table, p. 6) — whether publicly traded or private, for-profit or not-for-profit, Blue Cross and Blue Shield or non-Blues plans — typically reflects the stock market's strong performance and the ongoing use of peer grouping to determine executive compensation levels, finance experts say. They also say that such trends are expected to continue this year.

"CEO pay was up in general. That usually follows a good year by the stock market — which 2016 was. 2017 was a better year, so I would expect pay to remain up this year," Steven Kaplan, finance professor at The University of Chicago Booth School of Business, tells AIS Health. The stock market went up 13% and 21%, respectively, in 2016 and 2017, he notes.

AIS Health collected pay data from Blues plan company documents, the National Association of Insurance Commissioners and the Securities and Exchange Commission.

As for how health care CEOs' compensation is broadly approached, "everyone basically does their compensation by peer groups, and nobody wants to be in the bottom," says Charles Elson, a finance professor and director of the Weinberg Center for Corporate Governance at the University of Delaware.

continued on p. 5

Health Insurers' Interest, Investment in Telehealth Heats Up

Amid a slew of headlines unveiling new partnerships and offerings, it's become clear that health insurers are increasingly embracing telehealth. Experts tell AIS Health, though, that payers are largely still experimenting to find the best approach to virtual care.

Most recently, Partners Healthcare said it worked with Teladoc Health to deploy a new solution for urgent care video visits, which will allow commercial members of the system's health plan to get care for minor illnesses and injuries.

"This is the kind of integrated payer-provider approach to healthcare envisioned in the affiliation between Partners and Neighborhood Health Plan, and it's part of our broader collaboration to improve health outcomes and avoid more costly care down the road by providing the right care, at the right time, and in the right place," Tony Dodek, M.D., chief medical officer of Neighborhood Health Plan, said in an Aug. 28 news release.

Then there's Cigna Corp. and Health Care Service Corp. (HCSC), which said Aug. 1 that they joined Health Velocity Capital to lead a $50 million growth investment in telehealth provider MDLIVE Inc.

MDLIVE already powers HCSC's Virtual Visits product offering, and the insurer is aiming to work with the telehealth vendor to "virtualize, automate and op-

Published by AIS Health, Washington, DC. An independent publication not affiliated with insurers, vendors, manufacturers or associations.

timize much of the care our members receive via innovative solutions, such as Sophie, MDLIVE's AI based personal digital health assistant," Tom Meier, HCSC's vice president of market solutions, said in a news release.

Tom Richards, Cigna's global leader for strategy and business development, said the insurer's own partnership with MDLIVE to offer virtual visits has resulted in a 17% decrease in total medical cost and a 36% decrease in emergency department utilization among the population tracked.

Other developments include:

✦ ***On Humana Inc.'s Aug. 1 earnings call, CEO Bruce Broussard said the company plans to integrate telehealth into its burgeoning home-based care model***. Going even further, the insurer said Aug. 27 that it will establish a center for digital health and analytics – called Humana Studio H – where it will develop new products and services to deploy across the organization.

✦ ***Anthem, Inc., said on July 23 that it would team up with telehealth provider American Well and smartphone maker Samsung Electronics America, Inc. to provide members of Anthem-affiliated plans with access to a service called LiveHealth Online (HPW 7/30/18, p. 8).*** Via the Samsung Health app on their Samsung Galaxy devices, members can use the "Ask an Expert" feature to connect with U.S.-based, board-certified health care providers to address non-emergency care needs.

✦ ***Harvard Pilgrim Health Care said in a July 31 news release that it became the first health plan in the Northeast to provide its fully insured members with access to AbleTo***, a program in which licensed therapists and behavioral coaches use a telephone and video platform to provide eight weeks of personalized, cognitive behavioral therapy and coaching for patients who are concurrently dealing with chronic or complex clinical needs and suffering from depression, stress or anxiety.

✦ ***CVS Health Corp. — which is awaiting regulatory approval to purchase Aetna Inc. — said Aug. 8 that it's collaborating with Teladoc to roll out a new telehealth offering, MinuteClinic Video Visits***, which patients can access through the CVS Pharmacy app. The offering is available for those seeking treatment for a minor illness, minor injury or a skin condition.

Mei Kwong, executive director of the Center for Connected Health Policy, tells AIS Health that there's been an ongoing interest in telehealth — but lately the subject seems to be getting more attention.

"I think there's just overall…a trend to look more toward telehealth, because of the recognition that we are working with finite resources," she says, referring to both provider shortages and spending limitations.

Demand may also play a role. As of 2017, 19% of consumers have used live video telemedicine, according to new recent survey data from the digital health seed fund Rock Health. That's up from just 7% in 2015, though down from 2016, when 22% of consumers said they'd used telemedicine.

In addition, 51% of employers say that implementing more virtual care solutions is their top health care initiative in 2019, according to the National Business Group on Health's annual employer survey, released Aug. 7.

Reimbursement Restrictions Loosen

Jay Godla of PwC's consulting practice Strategy& says that there's "definitely a spike" in insurers' interest in telehealth. "The players in the field have been performing well [and] there is definite interest from the payers — including the government payers," he says.

In fact, CMS proposed changes to the Medicare Physician Fee Schedule in July that would effectively increase the program's coverage of telehealth.

For example, it expanded coverage for services that "intrinsically involve

Health Plan Weekly (ISSN: 2576-4365) is published 52 times a year by AIS Health, 2101 L Street, NW, Suite 400, Washington, D.C. 20037, 800-521-4323, www.AISHealth.com.

the use of audiovisual technology," explains John M. Perry Jr., a partner at Bradley Arant Boult Cummings LLP. That includes virtual check-ins and interprofessional consultations — such as when a primary care physician needs to confer with a specialist.

"Those have potential for a lot of patient convenience and also potentially savings for the Medicare program," he says.

The rule also implements expansions of telehealth services included in the Bipartisan Budget Act of 2018 — including removing geographic restrictions on using telehealth for certain acute stroke services, Perry points out.

Still, "I think in some respects, CMS is behind commercial payers in this area," he says.

State Medicaid programs and private payers "have always been a little bit more advanced" than the federal government when it comes to reimbursing for telehealth, as it can be challenging for the latter to change Medicare rules that are dictated by federal statute, Kwong says.

Overall, the health care system is "definitely not regressing" when it comes to reimbursing telehealth, "but there's still that caution, I think, with policymakers because to them they feel it's still very new," she says.

Tech Advances Drive Adoption

According to Godla, technological advances are another major factor that's driving the increased focus on telehealth. After all, telehealth doesn't just mean virtual visits anymore — it can also comprise the use of wearable devices and remote patient monitoring, both of which can improve care for patients with chronic conditions.

"Things like that are now fundamentally transforming telehealth," he says. "It's provided more evidence points to say that, even though there's an upfront cost, there is value in it because it could potentially reduce medical costs long-term as well as [improve] overall outcomes."

So how are private insurers approaching telehealth?

"There's a lot of experimentation going on — I mean there is no one player that does everything really well," Godla says.

Indeed, some insurers opt for exclusive partnerships with telehealth vendors, according to a research note from Leerink analyst Ana Gupte. For example, American Well is the sole provider for Anthem, Teladoc is the sole provider for Aetna and MDLIVE is the sole provider for HCSC. UnitedHealth Group, Cigna and Humana, though, "are maintaining open architecture partnerships in telehealth consistent with their other sourcing strategies," she wrote in a research note.

Insurers Should Pick a Preferred Platform

Godla says he advises clients to evaluate the different technology platforms and pick one that is both versatile and patient- and provider-friendly. On that platform, he says, insurers can integrate a variety of providers for different virtual care functions.

Patient education, he adds, will also be an important factor. Right now, the highest utilizers of telehealth tend to be young, high-earning urban dwellers, Godla says, citing data from a 2017 survey from The Advisory Board. "As they use it and more and more proof points come out, others will move in the same direction," he adds.

Read Partners Healthcare's press release at https://bit.ly/2okynV4, MDLIVE's at https://bit.ly/2PhOyP2, American Well's at https://bit.ly/2BlQDH0, CVS's at https://bit.ly/2nkFvAb and Harvard Pilgrim's at https://bit.ly/2npjVun. View the Rock Health Survey results at https://bit.ly/2Nos1i6. Contact Kwong via Christine Calouro at Christinec@cchpca.org and Godla at jay.godla@pwc.com. ✧

by Leslie Small

Lawsuit, Legislation Reignite Pre-Existing Condition Debate

Recently, 10 Republican senators introduced a bill that would reinstate certain protections for people with pre-existing conditions if a federal judge sides with a cadre of states that aim to get the Affordable Care Act (ACA) thrown out.

Yet experts tell AIS Health that the legislation wouldn't do enough to mitigate the potential damage that could result if that lawsuit is successful. Further, it's unclear whether health insurers would be willing to embrace changes that could revert the individual market back to pre-ACA rules.

The lawsuit that prompted the new legislation, *Texas v. United States*, was filed by 20 Republican state attorneys general back in February *(HPW 3/5/18, p. 3)*, and oral arguments in the case are slated for Sept. 5. The plaintiffs claim that Congress's elimination of the individual mandate penalty renders the mandate itself — and therefore, the entire ACA — invalid. A group of Democratic state attorneys general, meanwhile, have successfully petitioned to intervene in the case and defend the ACA *(HPW 5/21/18, p. 8)*.

In June, the Trump administration filed a brief in the case that takes a less drastic position than the plaintiffs. It says that since the individual mandate penalty is set to disappear, so too should the mandate itself and the

ACA's guaranteed-issue and community-rating requirements — which bar insurers from refusing to issue policies or charging higher premiums based on health status. The rest of the law, the brief says, should remain intact, as it is "severable" from the individual mandate.

GOP Floats 'Common-Sense Solution'

Perhaps sensing that such a move could leave Republicans politically vulnerable in the 2018 midterms, Thom Tillis (R-N.C.) and nine of his colleagues on Aug. 23 introduced legislation that Tillis described as a "common-sense solution that guarantees Americans with pre-existing conditions will have health care coverage, regardless of how our judicial system rules on the future of Obamacare."

Some health policy experts, though, are not impressed.

In the unlikely event that the whole ACA ends up getting thrown out, Tillis's bill would be just "a tiny, tiny Band-Aid on a huge wound to the entire American health care system," says Washington and Lee University Professor Emeritus Timothy Jost. After all, the ACA contains a slew of provisions that have nothing to do with the individual market, such as Medicare payment rules, health care fraud and abuse enforcement, and even the FDA's authority to approve biosimilar drugs, he points out.

But what if the courts side with the Trump administration's argument and strike down only community-rating and guaranteed-issue requirements?

Even in that case, while the senators' bill would compel insurers to cover people with pre-existing conditions and not charge them more, insurers could still refuse to cover services related to those pre-existing conditions, Jost explains.

Thus, the bill would be "a little bit bigger Band-Aid for the problems that would eventuate if the United States gets what it's asking for, but it certainly doesn't address the whole problem," he says. "And in some ways makes it worse, because people could in good faith buy coverage and couldn't be excluded because they have pre-existing conditions, but as soon as they make a claim, they'd be told 'oh, well we're not covering that.'"

Chris Condeluci, principal of CC Law & Policy and a former Republican staffer for the Senate Finance Committee, says it's possible that the senators are "setting up an amendment strategy" in which they'll later add a ban on pre-existing condition coverage exclusions to the bill.

But he adds that the bill may not even be necessary, as he believes this latest challenge to the ACA will ultimately fail. While it's possible that the plaintiffs will prevail at the district court level, he says, most legal scholars agree that such a ruling would be vulnerable on appeal.

Will Insurers Turn Back the Clock?

If the courts do rule in such a way that makes the bill necessary — and it becomes law — Jost predicts insurers would start refusing to cover services associated with pre-existing conditions for individual market customers. "And I think probably once one insurer starts doing it, all of them will have to do it to remain competitive," he adds.

But Katherine Hempstead, senior adviser to the executive vice president at the Robert Wood Johnson Foundation, isn't so sure.

After all, the rest of the health insurance market — including employer-sponsored coverage, Medicare and Medicaid — already conforms to practices that protect those with pre-existing conditions, she says. Before the ACA, the individual market had always been an exception where less-robust plans that cover fewer people were common.

"From what I can tell from what you hear the [insurance] industry talking about and advocating, I feel most of the industry is ready to turn the page and adapt" to applying pre-existing condition protections across the board, she says.

Indeed, America's Health Insurance Plans said in a June 8 statement regarding the Texas v. United States case that "zeroing out the individual mandate penalty should not result in striking important consumer protections, such as guaranteed issue and community rating rules that help those with pre-existing conditions."

"Removing those provisions will result in renewed uncertainty in the individual market, create a patchwork of requirements in the states, cause rates to go even higher for older Americans and sicker patients, and make it challenging to introduce products and rates for 2019," the trade group added.

Many Have a Declinable Condition

The Kaiser Family Foundation previously estimated that 27% of adults ages 18-64 have a pre-existing condition that would have led to a denial of insurance in the individual market before the ACA. On Aug. 28, the organization published a new analysis that found the prevalence of such conditions varies considerably across the country — ranging from 41% in Kingsport, Tenn., to 20% in Logan, Utah, and Rochester, Minn.

If the ACA's protections for people with pre-existing conditions do end up disappearing, how that will affect consumers could also look different in various parts of the country.

Only four states — Colorado, Massachusetts, New York and Virginia — have incorporated versions of the ACA's guaranteed issue, pre-existing condition exclusion and community rating standards into state law, according to an Aug. 29 post on The Commonwealth Fund's To the Point blog, authored by Georgetown University researchers. Twenty-nine states, meanwhile, have not adopted any of the ACA consumer protections.

Read the senators' bill at https://bit.ly/2PwehU2 and their press release at https://bit.ly/2omJyN6. View the Kaiser Family Foundation's analysis at https://kaiserf.am/2wsltZo and blog post at https://bit.ly/2Ph4OPv. Contact Jost at jostt@wlu.edu, Hempstead at khempstead@rwjf.org and Condeluci at chris@cclawandpolicy.com. ✧

by Leslie Small

Insurance CEOs See Generous Pay

continued from p. 1

Elson explains it is not a compensation scheme relevant to the whole enterprise. "It's basically a dog chasing its tail. You'll see [generous CEO pay] because they're all trying to chase the median or higher," he says. "If you have to go outside [the company] and pay more, then everyone's pay goes up. That's the problem with peer groups — it separates the CEO's pay from the rest of the organization. The rest of the organization can't experience that growth in pay."

For 2017, the Blues plans "are all up quite a bit" with their executive compensation, Elson says, as the Blues compare themselves with each other and some public companies. "Any time you see an increase [in executive compensation] in the publicly traded plans, you'll probably see an increase in the Blues" — due to their similar sizes and the need to offer "peer pay" to stymie any competitors' attempts to lure away CEO candidates, he says.

In reviewing 2017 executive compensation, Elson describes a list of the top three dozen or so health insurers as "a mishmash" of companies. While declining to comment on specific individuals' salaries and bonuses, he says that "obviously the smaller Blues are paying a lot less. The larger Blues are paying a lot more." While executive compensation rises because nobody wants to go below the median, any decrease in an individual company's CEO pay "is not peer related," he says. "It's something within the system itself."

Overall, Centene Corp. CEO Michael Neidorff tops health insurers' 2017 executive compensation list, earning $25.3 million in total compensation last year and easily besting CEOs' pay among other major publicly traded health insurers *(HPW 5/21/18, p. 1)*. The heads of the largest Blues plans made closer to $10 million in total compensation last year, while pay for CEOs fell below $1 million — but topped $500,000 — for regional players including Health Alliance Plan of Michigan and SelectHealth, Inc.

Companies Reward Risk-Takers

Health care executive search expert Tom Giella tells AIS Health that, contrary to several years ago, companies are finding themselves now wanting to put these dollars in the pockets of executives who are innovative risk-takers, "tech savvy and more comfortable with consumerism." In a dynamic industry full of uncertainty, "creative CEOs are at a premium," says Giella, chairman of Korn Ferry International's health care services practice.

"There's a huge demand for talent," he says. "It's really trying to get the person who can be much more innovative now…and figure out new revenue streams."

In general, for-profit health care companies' CEOs are paid more than not-for-profits' executive leaders, due to equity and a higher base salary, Giella explains. But "non-competes" are "very strict, ironclad" among for-profit businesses and usually require departing executives to sit out of the job market about a year, he says, "so the talent pool is tougher."

Giella notes that some executives at for-profit health care companies are willing to give up their equity investment and shift to not-for-profits for less compensation if they are given the opportunity to become CEO. Among Korn Ferry's health care CEO searches over the past year, some candidates from for-profits were looking at not-for-profit leadership roles, he says.

Not-for-profits pay well but, similar to what's done in for-profits, the recruited CEO candidate's only guarantee is salary —which is at best one-third of total compensation, Giella says. "The rest you have to earn," he says, describing it as performance-based "incentive compensation." Another third of their pay is short-term bonuses, and the remaining third is long-term bonuses, which require executives to meet defined objectives on market share, profitability and the like.

Insurers Look Beyond Conventional

Giella points to a much more competitive health care landscape these days, full of convergence and deal-making between managed care companies and PBMs, retailers and providers — where insurers may run their own PBMs and providers may start up their own insurance companies. Payment models are changing,

and nobody wants to tread water. "So, it's not your traditional 'pure vanilla' insurance company," he says, and, as such, a company is likely not going to search for a conventional CEO candidate. "It's not going to be your traditional person. [They] need to be very strategic, someone who's tried to do a bundled, capitated plan and failed versus someone never having done it…. Boards are really interested in what you've done to try new things."

When it comes to understanding the role of technology, health care CEO candidates "don't have to be the CIO [chief information officer], but they have to be able to understand the value of data," Giella says. "You've got to be much more tech savvy. You can't just go by your gut."

Potential CEO candidates are a bit younger than previously, often in their late 40s or early 50s, according to Giella. "A couple of CEOs we placed recently were in their 40s," he says, noting his firm placed Erhardt Preitauer, the former head of a New Jersey Medicaid plan who in May began his job as Dayton, Ohio-based CareSource's new CEO; and internist Craig Samitt, M.D., a former executive at Anthem, Inc. who became Blue Cross and Blue Shield of Minnesota's president and CEO earlier this summer. Both "were leaders in what they were doing" before accepting their new roles, he says.

Given the complexity of the health-care business, "it's tough to come from financial services and become the CEO of a health plan," Giella says. Most plans are looking for

Executive Compensation Data for Top Health Insurers, 2017 (Ranked by Total Compensation)

Company	President/CEO	2017 Salary	2017 Bonus	2017 Other Compensation	2017 Total Compensation	Increase (Decrease) From 2016
Centene Corp.	Michael Neidorff	$1,500,000	-	$501,068	$25,259,468	14.98%
Humana, Inc.	Bruce Broussard	$1,272,367	-	$348,124	$19,768,525	0.23%
Molina Healthcare Inc.	Joseph M. Zubretsky	$175,000	$4,000,000	$27,858	$19,739,108	N/A
Aetna Inc.	Mark T. Bertolini	$1,200,000	-	$489,989	$18,750,816	0.47%
Cigna Corp.	David Cordani	$1,284,615	-	$229,237	$17,595,792	15.16%
UnitedHealth Group Inc.	David Wichmann	$1,162,308	-	$216,974	$17,389,976	N/A
Blue Cross Blue Shield of Michigan Mutual Insurance Company	D. Leopp	$1,537,661	$10,380,749	$1,503,453	$13,421,863	23.06%
WellCare Health Plans	Kenneth A. Burdick	$1,169,231	-	$17,525	$11,327,735	22.33%
Health Care Service Corporation	Paula A. Steiner	$1,184,813	$8,980,133	$14,422	$10,179,367	53.65%
Blue Cross Blue Shield of Florida	Patrick J. Geraghty	$1,084,616	$4,200,000	$4,860,673	$10,145,289	8.67%
Independence Hospital Indemnity Plan, Inc.	Daniel J. Hilferty	$1,271,640	$3,456,500	$71,341	$4,799,481	33.45%
Premera Blue Cross	Jeffrey Edward Roe	$882,686	$2,964,617	$152,628	$3,999,931	74.95%
Blue Cross Blue Shield of Minnesota	Michael Guyette	$1,015,016	$2,238,544	$267,758	$3,521,318	8.49%
Cambia Health Solutions, Inc. (operates Regence companies in Idaho, Oregon, Utah and Washington state)	Mark B. Ganz	$969,514	$2,291,087	$140,313	$3,400,915	21.46%
Triple-S Management Corp.	Roberto Garcia-Rodriguez	$750,000	$600	$37,996	$3,173,592	10.45%
CareFirst, Inc.	Chester Burrell	$980,000	$2,058,000	$39,960	$3,077,960	3.97%
Hawaii Medical Service Association	Michael A. Gold	$1,019,232	$1,740,180	$197,231	$2,956,643	52.95%
CareSource	Pamela B Morris	$896,579	-	$2,007,144	$2,903,723	50.93%
Blue Cross and Blue Shield of Kansas City	Danelle K. Wilson	$848,408	$1,942,944	$42,323	$2,833,675	12.29%
Blue Cross and Blue Shield of Massachusetts, Inc.	Andrew Dreyfus	$1,122,887	$1,444,405	$64,976	$2,632,268	18.15%
Anthem, Inc.	Gail K. Boudreaux	$161,538	-	$4,500	$2,166,253	N/A

someone from within the industry — whether it be a for-profit, not-for-profit or an integrated health system with an insurance arm — someone who is able to strategize and has financial acumen. "Innovation and strategic pivoting are to me the two most important" attributes in a CEO search, he adds.

"Everyone is looking for diversity across the board, not just at the CEO level but at the senior management level. They want a senior management team that mimics the market and understands the community," Giella says.

By contrast, the executive recruitment process used to be "very linear and people didn't have diverse backgrounds. People went from a director position to vice president to group president to a CEO, either from operations or network delivery," Giella says. "Now, [health care companies] would be open to someone doing more creative things, more risk-taking….[and] are looking for a more entrepreneurial, risk-seeking, ideas type of person."

Elson describes "the whole CEO pay game" as a scenario in which managed care companies all "backstop" off each other. "It's a game of leapfrog," he says. "It's unfortunately a story that's going to ultimately have to be changed. I think [CEO] pay should be designed internally, based on what others in the organization are paid."

Contact Giella at giellat@kornferry.com, Kaplan at steven.kaplan@chicagobooth.edu and Elson at elson@udel.edu. ✧

by Judy Packer-Tursman

Executive Compensation Data for Top Health Insurers, 2017 (continued)

Company	President/CEO	2017 Salary	2017 Bonus	2017 Other Compensation	2017 Total Compensation	Increase (Decrease) From 2016
Blue Cross and Blue Shield of South Carolina	David Stephen Pankau	$383,821	$1,649,530	$65,158	$2,098,509	1.53%
BlueCross BlueShield of Tennessee, Inc.	Jason David Hickey	$642,757	$1,249,714	$122,257	$2,014,728	39.36%
Highmark Inc.	Deborah Lynn Rice-Johnson	$589,621	$1,148,836	$172,352	$1,910,809	137.93%
Tufts Associated Health Maintenance Organization. Inc.	Thomas Croswell	$890,865	$706,350	-	$1,597,215	13.57%
Blue Cross and Blue Shield of Nebraska	Steven Martin	$868,018	$627,397	$39,375	$1,534,790	-33.36%
Harvard Pilgrim Health Care, Inc.	Eric H. Schultz	$899,039	-	$231,517	$1,130,556	-46.81%
Blue Cross and Blue Shield of North Carolina	Patrick H. Conway	$253,846	-	$50,804	$1,054,650	N/A
USAble Mutual Insurance Company	Curtis E. Barnett	$682,088	$282,066	$41,286	$1,005,440	71.12%
Health Alliance Plan of Michigan	Teresa L. Kline	$794,732	$25,725	$18,433	$988,890	N/A
SelectHealth, Inc.	Patricia R. Richards	$544,378	$122,296	$129,097	$795,771	-9.77%
Priority Health	Joan Budden	$513,908	$208,815	$66,452	$789,175	7.81%
UPMC Health Plan, Inc.	Diane Holder	$454,364	-	$34,053	$488,417	9.86%
Medica Health Plans	Geoffrey Bartsh	$244,336	$94,739	$50,087	$389,162	N/A
Moda Health Plan, Inc.	Robert Glenn Gootee	$200,300	$59,850	$2,801	$262,951	-1.58%
Health Partners, Inc.	Andrea Walsh	$239,642	-	-	$239,642	31.02%
Capital Blue Cross	Gary St. Hilaire	$81,054	$124,415	$1,617	$207,086	-5.01%

NOTE: N/A = Not Available. Alabama, Louisiana, Idaho and South Dakota do not disclose compensation data for specific executives at health insurance companies. Rhode Island, California and New York do not collect compensation data. Arizona did not respond to AIS's repeated requests. The compensation file submitted by Medical Mutual of Ohio is unreadable. Joseph Zubretsky was appointed CEO of Molina on Nov. 6, 2017. David Wichmann was appointed CEO of UnitedHealth Group on Aug. 31, 2017. Gail Koziara Boudreaux was appointed CEO of Anthem on Nov. 20, 2017. Patrick Conway joined Blue Cross and Blue Shield of North Carolina as President and CEO-elect on Oct. 1, 2017. He was named President and CEO on Dec. 5, 2017. Teresa L. Kline became president and chief executive officer of Health Alliance Plan and executive vice president of Henry Ford Health System in November 2016. Former Medica Health Plan President and CEO David Tilford retired in January 2017. John Naylor became President and CEO in 2017. Compensation data for Cambia Health Solutions President and CEO Mark Ganz includes payments allocated to Regence insurance operations in Washington state, Oregon and Utah but not Idaho.
SOURCE/METHODOLOGY: All data is compiled from individual health insurance company, state insurance department documents and U.S. Securities and Exchange Commission filings. Health plans were selected based on commercial medical risk enrollment as of the beginning of 2017, per AIS's Directory of Health Plans.

News Briefs

✦ ***On Aug. 29, Cigna Corp. submitted a filing with the Securities and Exchange Commission that said both the insurer and Express Scripts Holding Co., which it has agreed to acquire, have gotten approval from 14 states and require 15 more state approvals to close the transaction, which they still expect will occur by the end of 2018.*** The filing comes on the heels of another major victory for the Cigna/Express Scripts deal, as Cigna said Aug. 24 that its shareholders overwhelmingly voted to approve the acquisition. View the filing at https://bit.ly/2N-wLDkd.

✦ ***Centene Corp. said Aug. 27 its subsidiary, Centurion Detention Health Services, LLC, was awarded a contract to provide comprehensive health care services to prisoners in detention facilities in Volusia County, Fla.*** The award, subject to contract negotiations, is expected to begin Jan. 1, 2019; its base term is five years, plus five one-year renewal options. Centene has been broadening its footprint for some time in correctional health care. In March, it announced plans to acquire MHM Services, its partner on the Centurion correctional-care joint venture for several years *(HPW 3/5/18, p. 1)*; and in June, Centene's subsidiary was re-awarded a contract with the New Hampshire Dept. of Corrections. See https://tinyurl.com/ydg7nffz.

✦ ***While the Health Insurance Tax (HIT) will be suspended in 2019, if Congress doesn't enact a one-year extension of that moratorium, health insurance premiums will rise by 2.2% in 2020, according to a new actuarial analysis from Oliver Wyman.*** The analysis, which was commissioned by UnitedHealth Group, said a one-year extension of HIT relief would result in average annual savings of more than $150 for individual small business employees, nearly $500 for families purchasing coverage in the small group market, and about $250 for seniors enrolled in Medicare Advantage. Learn more at https://bit.ly/2LIlai2.

✦ ***Fully 63% of life/health insurance companies responding to a recent national survey say they intend to increase staff during the next 12 months, primarily due to an expected increase in business volume.*** That's according to the latest iteration of an insurance labor market study released Aug. 29 by The Jacobson Group, a Chicago-based insurance executive search firm, and the Ward Group, a part of Aon plc. "Expected increases in business volume and expansion into new markets are driving continued hiring," says Gregory Jacobson, Jacobson's co-CEO. "This organizational growth, coupled with a shallow talent pool and virtually non-existent industry unemployment, results in an increasingly competitive labor market." Read the summary of findings at https://tinyurl.com/y7c3bhg9.

✦ ***While the life and health insurance companies' credit ratings saw upgrades outstrip downgrades by a wider margin in the first half of 2018 than in the first half of 2017, the number of ratings that A.M. Best placed under review more than doubled year over year, according to an Aug. 22 report.*** The report also said that health insurers reported better operating results for their Affordable Care Act individual exchange business, driven by consecutive years of high rate increases and narrowing provider networks. Access the report at https://bit.ly/2PfZA6T.

✦ ***In 2017, the overall percentage of private-sector employers offering health benefits increased for the first time since 2008.*** That's according to new research from the Employee Benefit Research Institute (EBRI). "We found increases across all sizes of plans," says Paul Fronstin, EBRI's director of health research. Between 2014 and 2016, the percentage of the largest employers studied that offered health coverage rose to 96.3%, up from 92.5%; and, between 2016 and 2017, there was an increase from 21.7% to 23.5% among employers with fewer than 10 employees. EBRI also notes more workers are eligible for employer-sponsored health coverage: a number on the rise since 2015. See EBRI's issue brief at https://tinyurl.com/ydgp8fka.

✦ ***In an examination of how HHS managed the most recent open enrollment period for Affordable Care Act exchange plans, the Government Accountability Office (GAO) found room for improvement.*** The watchdog agency dinged HHS for the way it allocated funding for navigators, saying it relied on unreliable data. The GAO also suggested HHS set numeric enrollment targets and assess additional aspects of the consumer experience than it currently does. Read the report at https://bit.ly/2NfzXCt.

A Monthly Update for *Health Plan Weekly* Subscribers

The AIS Report on Blue Cross and Blue Shield Plans

HCSC's Carroll Tops List of Highest Paid Blues Board Chairs in 2017

Health Care Service Corp. (HCSC) Board of Directors Chair Milton Carroll took home more than $4.93 million for his board service in 2017, making him the highest-paid Blues board member last year. Anthem, Inc.'s George Schaefer, Jr., who was lead independent director for Anthem, came in second with $380,919, according to data collected by AIS Health from Blues plan documents, the National Association of Insurance Commissioners and the Securities and Exchange Commission (see table, p. 12).

Florida Blue Chair of the Board John Ramil followed closely behind Schaefer with $377,000, and Luis Clavell Rodriguez, chairman of the Blues licensee in Puerto Rico, Triple-S Salud Inc., earned $310,000 for fourth place in 2017 director compensation.

On the low end of Blues board of director compensation, Independence Blue Cross paid its chair, Walter D'Alessio, and other directors nothing in 2017, while BlueCross BlueShield of Tennessee, Inc.'s board chair Marty Glenn Dickens received $9,731.

"Among the Blues, we've observed that director compensation tends to correlate to key factors such as size, scope and complexity of the organization," says Rachel Grof, director, rewards, at Willis Towers Watson. "While perhaps less directly correlated than executive or management compensation, key compensation elements for board members such as board and committee chair retainers, for example, are often correlated to size of the organization."

continued on p. 11

Small Group Is Mostly Stable, but Faces Non-ACA, ASO Plans

The small-group market, which has been largely stable with single-digit rate increases for Blue Cross and Blue Shield plans despite upheaval in the individual market, could face headwinds driven by two forces: the Trump administration's moves to allow association health plans and short-term plans *(HPW 8/27/18, p. 3)*, and an increase in the number of small groups moving to administrative services only contracts.

"Our overarching concern — and the concern of most of the insurance industry, consumer advocates and state regulators — has been the creation of separate risk pools within a market that has just started to stabilize," Brett Mayfield, vice president, sales, for Independence Blue Cross, says of the moves by the administration to allow skimpier, non-Affordable Care Act (ACA) compliant plans to compete in the market.

At the same time, Michael Considine, vice president of consumer, small group and mid-size markets for Horizon Blue Cross Blue Shield of New Jersey, tells AIS Health that "we've seen some influx of self-insurance products in the small-group market, which take members away from the security of a fully insured small group and place them into a self-funded plan. These products expose employer groups to downside risk, and we caution groups to fully understand their

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.

implications before they consider any changes in product."

Still, Blues plans report consistent performance in their small-group segments. At Independence, Mayfield reports that "with more than 180,000 members, Independence Blue Cross's small employer 2-50 segment has remained strong and stable despite the legislative and regulatory uncertainty we've seen over the last few years."

Independence Touts Range of Options

Mayfield tells AIS Health that Independence's broad range of health plans has enabled the insurer to take a strong position in the small-group market. Independence also offers "benefit options that go beyond the typical medical plan," he says, including IBX Wire text message notifications for health reminders and plan information, a college tuition benefit, and online tools.

Horizon dominates the small-group market in its region, with a 62.5% market share, even as the market itself is shrinking, Considine says. In fact, he says, the small-group market has shrunk from 900,000 lives in 2006 to 350,000 covered lives in 2018, due to changes in regulations that no longer allow spousal groups to be considered as a small employer. In addition, some employers dropped coverage and others moved to the larger employment market, he says.

In Highmark Health's plans, small group represents about 4% of total health plan membership, says a spokesperson. "Generally speaking, small group is shrinking nationally, and we are seeing similar patterns in Pennsylvania, Delaware and West Virginia where we do business," the spokesperson tells AIS Health. Rule changes that re-categorized groups from small group to large group played a role in that, as did changes that came at the beginning of the ACA, when some small groups stopped providing coverage, the spokesperson says.

Plans Report Minimal Rate Hikes

For the most part, the small-group markets in Highmark's states have not been impacted by the same issues seen in the individual market, the spokesperson says, adding that on average, Highmark's small-group rate increases over the last couple of years have been in the single digits.

It's not clear how association health plans will impact the small-group market going forward, the Highmark spokesperson says. In addition, small group administrative services only "is becoming more of an option" for small groups, although "it's important for clients to understand the risks associated with going self-insured as a small group."

States vary widely in their small-group market conditions, Mayfield says, and that's why rate requests across the country also vary. "For 2019 plan coverage with Independence, we submitted for a minimal increase for the small-group ACA products. This is down from the 10.7% average increase we saw for 2018 small-group plans."

Overall, Independence has seen single-digit increases on average since the advent of the ACA, Mayfield says, similar to Highmark's Blues plans. Horizon also has limited premium increases to single digits in each of the past few years, Considine says, and expects rates to increase an average of 4.2% for 2019.

Brian Cheney, vice president, employer solutions at Health Care Service Corporation, says that small-group plans "have been relatively stable since the implementation of ACA," and adds that "while certain states may experience market corrections more than others, the trend for small-employer plan costs has been consistent."

SHOP Has 'Never Taken Off'

The Small Business Health Options Program (SHOP) exchanges have largely failed to gain any traction. Out of the Blues plans AIS Health queried, only Horizon continues to participate in SHOP, and and has enrolled a total of 131 groups through the program. "That being said, SHOP has never taken off in New Jersey," Considine says.

Independence made the decision to exit SHOP in 2017, Mayfield says. "For our small-group business, just 0.6% of groups enrolled through SHOP, while 99.4% of small groups enrolled directly through us or a broker." Meanwhile, he says, SHOP posed significant administrative burdens — enough to lead the insurer to drop out.

Highmark does not participate in SHOP, the spokesperson says. HCSC discontinued plans offered on SHOP beginning Jan. 1, Cheney says.

Small group may be a small segment of the market, but many small-business employers see providing health insurance as an integral part of their business growth strategy, Cheney says, adding, "this is even more important in the com-

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.

petitive job market we are currently experiencing."

Small-group employers in Independence's markets want comprehensive coverage — including dental and vision — plus flexibility, Mayfield says. Tiered network plans, which originated in the individual market, are now available for small and large groups, and continue to grow in popularity, he says.

Contact Mayfield via Kathleen Conlon at Kathleen.Conlon@ibx.com, Considine via Horizon spokesperson Thomas Vincz at Thomas_Vincz@horizonblue.com, Cheney via HCSC spokesperson Jori Fine at Jori_B_Fine@bcbsil.com, and Highmark spokesperson Aaron Billger at aaron.billger@highmarkhealth.org. ✧

by Jane Anderson

Blues' Boards Report Pay

continued from p. 9

Organization size and philosophy at individual Blues organizations appear to play a major role in board chair compensation, Grof tells AIS Health. "Blues organizations typically compensate within the range of other comparably sized non-Blues health insurers," she says. "For-profit organization board members will often command significantly higher pay...given the unique business and governance issues that come with managing a for-profit entity, as well as the use of equity compensation."

Still, board compensation for Blues and other not-for-profit health insurers is higher than for directors of other not-for-profit entities, such as health care providers, universities and foundations that may not compensate board members for service at all, instead relying on unpaid volunteers, Grof says.

In HCSC's case, the high compensation for Carroll reflects the greater responsibilities he assumed, according to insurer spokesperson Greg Thompson. "Following consecutive years of losses heading into 2016, a planned CEO transition was occurring against the backdrop of challenging and evolving health care industry dynamics," he explains. "In order to ensure a smooth transition amid evolving health care industry dynamics, Mr. Carroll was asked by the Board to take on a more comprehensive role."

Carroll's Pay Is 'Unheard of'

David Tsui, assistant professor of accounting at the University of Southern California, tells AIS Health that "seven-figure director compensation is basically unheard of even at the largest public companies." Meanwhile, he says, "for levels that seem unusually low, I suspect it's largely due to organizational preferences for what constitutes an appropriate level of director pay. Many directors serve for reasons other than explicit financial rewards — professional connections and sense of public service, particularly at non-profits....Higher pay levels will certainly expand the pool of potential directors, though."

Charles Elson, director of the John L. Weinberg Center for Corporate Governance at the University of Delaware, says director positions at not-for-profit Blues plans are as complex as those at private insurers, and carry the same high level of effort and potential liability. Therefore, he tells AIS Health, it's necessary to pay Blues directors more than directors at similarly-sized non-profits in order to ensure they attract and keep strong directors.

"The Blues are an odd one," Elson says. "It's not a charity — Blues compete with for-profits, and they're complicated. It's a lot of work as a director, with the time and effort involved. It's a real business, and that's why you see the compensation."

Grof says director pay across various industries and organization types continues to rise. "Director compensation levels are increasing at a modest rate and we're observing more and more organizations making changes on a more routine annual or biannual basis, rather than big increases only on an every-few-years basis," she says.

Higher Pay Buys More Attention

Paul Dorf, chairman and managing director at Compensation Resources, Inc., tells AIS Health that payments for a board chair in the $300,000 to $400,000 are high, and the compensation for HCSC's Carroll is extremely high. But he adds that the numbers by themselves don't tell the whole story for what's required to chair a board of directors for a company competing in a complex industry. "If you don't pay enough, you're going to get people who really don't spend a lot of time or energy on the job," he says.

Contact Grof at rachel.grof@willistowerswatson.com, Ellson via spokesperson Andrea Boyle at aboyle@udel.edu, Tsui at David.Tsui@marshall.usc.edu and Dorf at prd@compensationresources.com. ✧

by Jane Anderson

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.

Top Paid Directors on Blue Cross and Blue Shield Boards, 2017

Company	Director Name	2017 Total Compensation
Anthem, Inc.	George A. Schaefer, Jr.	$380,919.00
Blue Cross and Blue Shield of Kansas City	Janice C. Kreamer	$145,443.00
Blue Cross and Blue Shield of Nebraska	Allen Dale Dvorak, M.D.	$87,227.00
Blue Cross and Blue Shield of North Carolina	Frank Brown Holding, Jr.	$171,668.00
Blue Cross and Blue Shield of South Carolina	Malcom Edward Sellers	$79,241.00
Blue Cross and Blue Shield of Vermont	Charles Smith	$43,500.00
Blue Cross Blue Shield of Massachusetts, Inc.	Phyllis Yale	$120,000.00
Blue Cross Blue Shield of Michigan	Gregory A. Sudderth	$285,647.00
Blue Cross Blue Shield of Minnesota	Rita Heise	$112,300.00
BlueCross BlueShield of Tennessee, Inc.	Marty Glenn Dickens	$9,731.00
Capital Blue Cross	Kathryn P. Taylor	$156,000.00
Capital Health Plan, Inc.	John M. Hogan	$959,017.00
CareFirst Inc.	Stephen L. Waechter	$57,500.00
Florida Blue	John B. Ramil	$377,000.00
Health Care Service Corporation	Milton Carroll	$4,933,508.00
Highmark, Inc.	John Peter Moses	$145,742.00
Horizon Blue Cross Blue Shield of New Jersey	Lawrence R. Codey	$130,000.00
Independence Blue Cross*	Walter D'Alessio	$0.00
Noridian Mutual Insurance Company	David Sprynczynatyk	$49,500.00
Premera Blue Cross	Connie Renee Collingsworth Robert William Cremin Rosalio Jimenez Lopez	$131,000.00
Regence BlueCross BlueShield of Oregon	Peggy Y. Fowler	$20,200.00
Regence BlueCross BlueShield of Utah	Jake R. Nichol	$20,400.00
Regence BlueShield	Mike Koppel	$28,300.00
Triple-S Salud Inc.	Luis A. Clavell-Rodriguez	$310,000.00
USAble Mutual Insurance Company	P. Mark White	$278,800.00
Wellmark, Inc.	Daryl K. Henze	$140,430.00

SOURCE: All data is compiled from individual health insurance companies, state insurance department documents and U.S. Securities and Exchange Commission Filings.
NOTES: Several states do not disclose compensation data for specific executives at health insurance companies. Others are not required to collect compensation data. Hawaii Medical Service Association and Blue Cross & Blue Shield of Rhode Island do not compensate their boards. Blue Cross Blue Shield of Arizona did not respond to repeated requests for information by press time.
*Independence Blue Cross compensates all board members equally, and did not compensate them in 2017. Walter D'Alessio is the board chair.

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Weekly* subscribers — is published independently by AIS Health.
Not affiliated with or sponsored, endorsed or approved by the Blue Cross and Blue Shield Association or any of the independent Blue Cross and Blue Shield companies.