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HEALTH PLAN WEEK

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

Contents

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Centene CEO Neidorff Three-Peats in Topping List of Highest Paid Insurer Execs

Centene Corp. CEO Michael Neidorff easily beat his nearest competitors to win the top slot in the annual CEO compensation rankings for publicly traded health insurers, clearing $22 million in 2016. Neidorff, who's headed the rankings since 2014, saw his compensation rise 5.8% in 2016 (see table, p. 7).

Humana Inc. President and CEO Bruce Broussard took the second place on the list with total compensation of $19.7 million — nearly double his 2015 compensation of $10.3 million, and at 91.3% the biggest percentage gain for health insurer CEOs in 2016. Aetna Inc. CEO Mark Bertolini came in third, with total compensation of $18.7 million, an 8.1% increase over 2015.

The 2016 health insurer CEO compensation numbers reflect "a stronger, stable market where everyone wants to be average or above," says Charles Elson, director of the John L. Weinberg Center for Corporate Governance at the University of Delaware. Elson tells AIS Health that increasing compensation for one CEO tends to "ratchet up" pay for everyone.

Paul Dorf, managing director of Compensation Resources Inc., a consulting firm in Upper Saddle River, N.J., agrees. "There have been some very large increases. Insurers are more profitable, and as water rises, it raises all boats. Most of these companies have done fairly well," he tells AIS Health.

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In Day of Drama, Aetna Vows More ACA Exits, Molina Fires Namesake CEO, CFO

Perhaps May 2 might be best described as a day of drama for publicly traded managed care companies. During its morning earnings call, Aetna Inc. contrasted its strong government and large-group commercial business to its continuing woes on the Affordable Care Act (ACA)'s exchanges for individual policyholders, vowing further ACA cutbacks. That left many Wall Street analysts expecting Aetna's full exit from the exchanges for 2018. Later that same day, Molina Healthcare, Inc. ousted J. Mario Molina, M.D., and John Molina, its last namesake family executives, from their leadership roles, hoping to improve margins and perhaps increasing the likelihood of the company's potential sale (see box, p. 3).

Yet, despite the drama, Long Beach, Calif.-based Molina's quarter ending March 31 was mostly in line with projections. And, similar to other managed care companies' first quarterly financial reports for 2017 *(HPW 5/1/17, p. 1)*, Aetna reported a solid first quarter that beat Wall Street estimates — excluding the costs associated with its failed acquisition of Humana Inc. *(HPW 2/20/17, p. 1)*.

Hartford, Conn.-based Aetna posted a quarterly net loss of $381 million, or $1.11 per share, and adjusted earnings of $939 million, or $2.71 per share. Quarterly revenue was $15.1 billion and medical membership totaled 22.4 million as of March 31. The in-

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surer raised its full-year earnings projections to a range of $8.80 to $9 per share and projected revenue of $61 billion at year's end.

Stifel analyst Mark Kelly points out that the industry's sense of upheaval is due more to external forces than to companies' underlying financial performances in the opening quarter of 2017.

"I think while it's been sort of a chaotic earnings season, it hasn't been because results have been bad," Kelly tells AIS Health. "It's felt crazed because of uncertainty over health reform, [the court's recent ruling on] the Anthem/Cigna deal, and Molina's news. Normally we have this feeling when results are poor or inconsistent, but by-and-large they've been very strong."

"Each of the firms has been putting up better-than-expected numbers, driven by medical cost trends in line or below expectations," Kelly said May 3. "That's driving strong results across the board, and strong revenues," mostly in Medicare Advantage (MA) and Medicaid.

Aetna reported a solid quarter for its government business, growing its first-quarter 2017 premiums in the segment by more than 9% compared with the prior-year period. Quarterly revenue climbed to a record $7.1 billion, compared to $6.5 billion in first-quarter 2016. Membership grew by 107,000 Medicare enrollees, including 99,000 individuals in Medicare Advantage.

On May 3, WellCare Health Plans, Inc. also topped consensus estimates with its quarterly financial performance, reporting strong MA results and first-quarter net income of $67.3 million on total premium revenue of $3.95 billion. As expected, WellCare finalized its acquisition of Universal American Corp. April 28 and Phoenix Health Plan's Arizona Medicaid assets May 1.

Also on May 3, Humana released detailed first-quarter results in line with figures previously announced at its late April investor's day — results that President and CEO Bruce Broussard said "reinforce Humana's strength as an independent company" post-Aetna. Analysts forecast long-term opportunity for the company in the high-growth MA market.

And on May 4, Cigna Corp. posted first-quarter 2017 net income of $598 million or $2.30 per share, up from $519 million, or $2 per share, for the year-ago period. The insurer reported 15.7 million members on March 31, up from 15.1 million on the same date last year.

Government Drives Aetna's Growth

Aetna's government business is the predominant driver of its growth, the company said, noting this was the first quarter that its government premiums have exceeded its commercial premiums. In his note, Credit-Suisse analyst Scott Fidel, among other takeaways, cited Aetna's "robust group Medicare Advantage pipeline."

Large group commercial products also performed well in the quarter, Aetna said, but added that it "continues to face headwinds related to profitability" on its individual commercial business.

Aetna's Chairman and CEO Mark Bertolini didn't mention either the failed Humana purchase or the ACA during his opening remarks on the earnings call. But nearly 20 minutes into the call, Shawn Guertin, executive vice president and chief financial officer, said the insurer "expects to significantly reduce our exposure" in 2018 to the ACA's individual-market exchanges.

Aetna already had slashed its presence in ACA individual-product exchanges from 15 markets in 2016 to four markets this year: Delaware, Iowa, Nebraska and Virginia. Then in April the insurer said it will exit Iowa's exchange for 2018, making its announcement shortly after Wellmark Blue Cross and Blue Shield said it intends to leave Iowa's exchange for next year because of a net loss of roughly $90 million despite double-digit premium increases *(HPW 4/24/17, p. 1)*.

Guertin said Aetna "intends to communicate other 2018 footprint decisions when appropriate." In fact, the company subsequently said that it is exiting Virginia's

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individual exchange market for next year, according to Politico (see briefs, p. 8).

When Anthem Inc. held its earnings call April 26, CEO Joseph Swedish said that his company, too, is assessing its ACA public exchange footprint for 2018 and looking for more signs of marketplace stability *(HPW 5/1/17, p. 1)*.

Aetna believes the individual commercial risk pool "has higher cost levels than we had previously projected," and now forecasts greater-than-anticipated losses for 2017, Guertin said. But he added that this year's losses on Aetna's individual commercial line of business are expected to be "significantly less" than, or roughly half of, 2016's reported loss of $450 million.

Currently, Aetna's individual enrollment has fallen to about 255,000, down from 964,000 at the end of 2016. Guertin said the company expects the first quarter will mark the high point for its individual membership because attrition is expected throughout the remainder of 2017, consistent with its experience in recent years.

The bottom line, according to Credit-Suisse analyst Fidel, is that Aetna "continues to see a deteriorating exchange market risk pool that is driving its health insurance exchange (HIX) margins lower despite significant rate hikes for 2017. We model a full exit from the individual exchanges for Aetna in 2018."

Other analysts seem to agree. In his May 2 note to investors, Stifel analyst Tom Carroll said Aetna set up a premium deficiency reserve during the first quarter to absorb additional expected individual losses of $110 million during the rest of 2017. "This continued pain all but

Molina's Board Shows Namesake Brothers the Door

Investors cheered the decision by Molina Healthcare, Inc.'s board of directors to replace Chairman, CEO and President J. Mario Molina, M.D., and Chief Financial Officer (CFO) John Molina on May 2, with some viewing it as the equivalent of a "For Sale" sign. Shareholders drove up company shares 18% that day to close at $59.75.

Molina's board named Chief Accounting Officer Joseph White as CFO; he also will serve as interim president and CEO until a replacement is selected. Current Director Dale Wolf was named non-executive chairman of the board. The decision brought an end to the era of Molina family leadership; Mario and John Molina are sons of founder C. David Molina, M.D.

"In light of the company's disappointing financial performance..., the board determined that a change in leadership was necessary in order to drive profitability through operational improvements and other initiatives," Wolf told investors during the company's first-quarter 2017 earnings conference call, held May 2.

"While [Molina] has enjoyed significant revenue growth, it has lagged its peers in transitioning that revenue to earnings," said Stifel Co. analyst Tom Carroll.

During the conference call, Wolf told investors the decision "was merely a continuation of a process, of the board's evaluation of the road forward, and our sense that we were not keeping up with our competitors in terms of creating value for our shareholders."

When asked whether "broader strategic options [are] on the table," Wolf demurred, responding, "We've got a lot of confidence in the franchise that's here and the potential of unlocking shareholder value."

"Mario Molina and John Molina were among the largest barriers to a sale of the company to a larger MCO looking for exposure to the fast growing Medicaid managed care business model," Carroll said. But he added that "any near-term sale is unlikely given the current uncertainties at [Molina] coupled with a large number of solid assets currently available."

Cowen & Co. analyst Christine Arnold, by contrast, said, "The change in leadership increases the likelihood of a potential sale....If the new blood (with no blood ties to the business) is able to stabilize the boat, we believe [Molina] could potentially be attractive to companies with smaller Medicaid books."

Wolf, himself a veteran health plan executive, said he hoped a new CEO would be in place within six months. He emphasized that he did not want the job and added that Molina would look for "someone who is pretty damn familiar with the government business, Medicaid for sure and hopefully some Medicare."

The "new CEO will need to improve margins to justify the current valuation," said Credit-Suisse analyst Scott Fidel. When including the 17% increase in stock value on May 2 after the management change was announced, "[Molina] shares have risen by +20% over the past year even as cons[ervative] 2017 [earnings per share estimates] crumbled by -46% over the same period."

by Jill Brown Kettler

likely seals the fate of Aetna exchange products for 2018, in our view," he said.

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by Judy Packer-Tursman

As Tenet Pushes to Sell Its Plans, Other Providers Aim to Start Them

For-profit hospital operator Tenet Healthcare Corp. confirmed May 1 that it remains on track to sell or exit its health plan business in 2017: a segment that generated losses of $16 million for first-quarter 2017, down year-over-year from income of $3 million.

The news prompted industry consultant Bill DeMarco, who helps providers devise long-term clinical-integration strategies, to speculate that, while the challenges for hospitals running their own risk-bearing plans are clear, many continue to embrace this approach — especially by starting up their own Medicare Advantage (MA) products — as a competitive differentiator.

Moreover, hospitals selling their plans might have trouble finding buyers, adds DeMarco, principal at Pendulum HealthCare Development Corp. in Rockville, Ill. "What we're seeing is [that] a lot of people are saying, 'We'll just wait until you get the rate down and we'll take the fire sale rate,'" he says. "Unless you have an MA plan, people are saying they can replicate that or want to get it at the best price."

As of March 31, Dallas-based Tenet ran 80 hospitals, 470 outpatient centers, dozens of other facilities — and five health plans, according to its Form 10-Q filed May 1 with the Securities and Exchange Commission (SEC).

Tenet reported first-quarter net operating revenues of $65 million for its health plans, down sharply from $127 million in first-quarter 2016. Its 2017 outlook "excludes approximately $40 million of negative adjusted earnings before interest, taxes, depreciation and amortization (EBITDA) that the company expects to incur in its health plan business prior to the sale or exit of this business in 2017," it said.

Tenet told the SEC it had completed the sale of its health plan businesses in Michigan at a transaction price of roughly $16 million, recognizing a gain on the sale of about $9 million. As of March 31, $2 million worth of assets related to its health plan businesses in other states were recorded as "assets held for sale," Tenet said.

During its May 1 quarterly earnings call, health plan divestitures were a footnote. Tenet focused on its signing of a multi-year deal that will phase its hospitals and hospital-affiliated outpatient centers back into Humana Inc.'s network between June 1 and Oct. 1. Tenet also emphasized it is boosting its ownership stake in United Surgical Partners International (USPI) to 80% by July 3 and selling three acute-care hospitals in Houston.

In its earnings presentation, Tenet said it anticipates $65 million worth of total proceeds from multiple transactions in health plan, home health and hospice divestitures, including $6 million received in fourth-quarter 2016. Following its first-quarter sale of Harbor Health Plan in Michigan, Tenet said it expects to get about $45 million in the second quarter from selling Phoenix Health Plan and certain home health and hospice businesses, and from the expected sale of Allegian Health Plans in Texas during the second quarter.

In its SEC filing, Tenet gave more details: "On May 1, 2017, we sold the membership of our VHS Phoenix Health Plan, Inc., a Medicaid-managed health plan operating as Phoenix Health Plan in Arizona for proceeds of approximately $13 million. Also on May 1, 2017, we completed the sale of the majority of our home health and hospice businesses for proceeds of approximately $20 million." WellCare Health Plans, Inc. was the Phoenix Medicaid plan's buyer (see story, p. 1).

Tenet added in its SEC filing that it is "also continuing our strategy of selling assets in noncore markets, such as our former hospitals and related operations in Georgia and North Carolina, as well as sub-scale businesses, such as our health plans."

CHI, Others Look to Sell Plans

Tenet is not alone in vowing to exit the health plan business if it cannot find a buyer for its financially struggling unit. Catholic Health Initiatives (CHI), a major not-for-profit health system based in Englewood, Colo., also is trying to sell its QualChoice Health unit, which offers Medicare Advantage (MA) and commercial group plans, after significant losses.

"They thought they had a real jewel there," DeMarco says of CHI's health plan business.

According to DeMarco, consultants generally are advising hospital-clients to find strong partners, such as the local Blue Cross and Blue Shield insurer, as they consider future integration strategies. Or, he says, another approach is for hospitals to sponsor their own plans and try to harvest the medical cost savings — which flies in the face of hospitals' focus on fixed costs and filled emergency rooms and beds.

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Moreover, he says that a for-profit like Tenet "has shareholders looking over its shoulder all the time…and it can take 10 to 15 years or more to perfect the health plan and have sufficient scale. Tenet never got to that point."

Tenet "set up the health plan business to compete with its other businesses, and it's not a cost center," DeMarco says. "It generates dollars back and revenue and market share, but [doesn't put] heads in beds."

DeMarco says he has "gone round and round" with a major health system in Chicago, trying to get it to create its own health plan. But the provider argues that as a customer it can play plans against each other for the best costs – which it couldn't do by bringing its own plan into the mix.

Yet he says that other hospitals in Michigan, Wisconsin and elsewhere have successfully moved into risk-based commercial HMOs and the concept has taken off — especially by moving to higher-risk-arrangement accountable care organizations (ACOs) in the federal Medicare Shared Savings Program (MSSP) or diving into the MA program.

"So, if not MSSP, you can go to MA, which gives you the lock-in you don't have with the ACO and you have a commercial insurance license," he says. "Keep your profile low.…Talk to some self-insured employers about being the third-party administrator, and that's a nice place to be."

"There are a lot of provider-led plans out there, and I tell them, 'Just keep your head down and keep running,'" he says.

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by Judy Packer-Tursman

Lawyer: 'Creating Efficiencies' Won't Outweigh Anticompetitive Effects

Most eyes are turned to a May 8 hearing in Delaware Chancery Court in the ongoing legal maneuvering related to Anthem Inc.'s proposed $53 billion acquisition of Cigna Corp. The court barred Cigna from terminating the deal pending the hearing, where Anthem hopes to get an extension to the court's order prohibiting Cigna from walking away until litigation ends.

But for at least one lawyer watching the action, a federal appellate court's April 28 ruling — affirming the district court's permanent injunction blocking the megamerger — offers an interesting take on an issue that he says has been "percolating through health care antitrust cases for the past three or four years" in places including Idaho, Ohio and Pennsylvania: the defense of creating efficiencies through anticompetitive behavior.

Anthem, which said May 4 it will seek a U.S. Supreme Court review of the appeals court's decision, struck the proposed deal with Cigna, a competitor in 14 states, in July 2015.

A year later, the Dept. of Justice (DOJ) sued to permanently enjoin the combination on the grounds it likely would substantially lessen competition in at least two markets in violation of the federal Clayton Act. The district court did enjoin the merger, rejecting Anthem's argument that the transaction's anticompetitive effects would be outweighed by the efficiencies of offering the market a "new product" combining a Cigna-like benefit design with Anthem's lower rates and $2.4 billion in medical cost savings that could be passed on to consumers.

In a 66-page majority opinion written by Judge Judith Rogers, the U.S. Court of Appeals for the District of Columbia Circuit said the district court "reasonably determined Anthem failed to show the kind of 'extraordinary efficiencies' that would be needed to constrain likely price increases in this highly concentrated market, and to mitigate the threatened loss of innovation."

"This same argument is being made over and over again by hospitals and payers: Allow us to become a monopolist and trust us that we will do good for the American people," attorney Jack Rovner, co-founder of The Health Law Consultancy in Chicago, tells AIS Health. "That is a stunning argument to make."

"I can't understand why these arguments are ever accepted by the court," Rovner says. "In the Anthem opinion, the [federal appellate] court casts serious doubt whether these 'efficiency defenses' are legally viable as a way to say competition is trumped."

Dissent Sees Deal's Cost Savings

At issue is how to ascertain whether efficiencies will be passed on, especially if the dominant market player isn't being pushed to do so by competitors, he says. "We don't allow private parties to acquire monopoly power because they claim they can do the job better," he says.

In his dissent, the federal appellate court's Judge Brett Kavanaugh estimated the deal would produce annual cost savings of $1.7 billion to $3.3 billion to large employers getting insurance from Anthem and Cigna.

But Rovner questions the logic. "In the Anthem case, the argument that was stunning to me was, 'We're the Blues plan in 14 states, so allow us to acquire Cigna and drive prices down even more,'" he says, noting that this strategy would "deprive sellers [i.e., providers] of being able to sell their products."

The bottom line, Rovner says, is that the appeals court, while not outright rejecting the "creating efficiencies" argument, is "making it sound like a tough burden, and I think it should be."

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The federal appellate court 's review was limited to determining whether there was an abuse of discretion in the lower court's decision to issue a permanent injunction and whether its findings of fact were erroneous. Looking at Anthem's challenge to the district court's finding that the merger would have anticompetitive effects on the Richmond, Va., market, the appeals court said the Anthem/Cigna market share ranged from 64% to 78%. Even under the calculation most favorable to Anthem, the court said, the merger "would raise an overwhelming presumption of anticompetitive effect."

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by Judy Packer-Tursman

Compensation Is 'More at Risk'

continued from p. 1

Still, Dorf says, "compensation is increasing, but it's more at risk" since more is in the form of stock options.

Centene cited several reasons for Neidorff's compensation, which it said was higher than average for health care companies but average or slightly above average for corporations of a similar size, regardless of industry. In 2016, Neidorff integrated Health Net, Inc. after Centene acquired the company *(HPW 3/28/16, p. 7)*, drove annual revenue up 78% to $40.6 billion, and increased earnings per share 41% over 2015, the company said.

Industry Urges Certainty on Subsidies, Not Political Wrangling

Health plans beware: Industry experts predict it will take several months for final action on the Trump administration's newly revived push to overhaul the Affordable Care Act (ACA). Despite the House's narrow passage of an amended American Health Care Act (AHCA) May 4, they say the swell of insurance market uncertainty likely won't subside until year's end.

"I think it's going to take most of the rest of the year for any resolution to this," says Bob Laszewski, president of Alexandria, Va.-based Health Policy and Strategy Associates....If the Senate passes legislation, it must return to the House for reconciliation. The bad news is I don't see any clarity for plans until the end of the year," so insurers must decide 2018 pricing and products amid market uneasiness, he says.

The bill, which faces strong Senate pushback and public opposition, is not expected to become law as written. Forecasting the tough road ahead, hours before the House vote Sen. Lindsey Graham (R-S.C.) tweeted: "A bill — finalized yesterday, has not been scored, amendments not allowed, and 3 hours final debate — should be viewed with caution." Sen. Bob Corker (R-Tenn.) told MSNBC the House bill has "zero" chance of passing the Senate in its current form.

The GOP bill's latest iteration was rushed to the House floor sans scoring by the nonpartisan Congressional Budget Office (CBO). In March, CBO estimated 24 million people would become uninsured, and Medicaid would lose $880 billion in funding, over a decade under the original bill's terms — prompting House Speaker Paul Ryan (R-Wis.) to postpone the vote, make revisions and rally GOP support.

Proponents touted the MacArthur amendment, attached in April, that would give states more flexibility on essential health benefits and age-band ratings and relax protections for some people with pre-existing health conditions *(HPW 5/1/17, p. 3)*. They also promoted a revision the night of May 3 tacking another $8 billion over five years to high-risk-pool funds.

Opponents also were vocal. Blue Shield of California's chief executive called the AHCA "flawed," asserting it would make health insurance unaffordable for millions of Americans by slashing premium tax credits and provide insufficient funding for high-risk pools.

President and CEO Marilyn Tavenner of America's Health Insurance Plans (AHIP) stressed the need for "certainty now" on federal cost-sharing reduction (CSR) funds. She issued a more neutral statement than many health care organizations, saying the bill "needs important improvements" to keep private-market coverage accessible and affordable.

"I would say the bill leaves the entire individual market in great uncertainty," says national health policy expert Timothy Jost. "But the non-funding of the CSRs and the Trump administration's equivocation on them is the most immediate problem."

According to Laszewski, "Trump's not going to take cost-sharing subsidies off the table until he resolves all of this." He describes subsidy funding as likely to involve month-to-month decisions.

"Plans won't get any more direction, any clarity on cost-sharing subsidies…[and] no reinsurance subsidies for 2018 they can count on," Laszewski says. "What you see is what you get."

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by Judy Packer-Tursman

At Humana, compensation for Broussard and other executives was affected by what the company called "extremely challenging conditions" involving its proposed takeover by Aetna Inc., blocked by a federal judge in January *(HPW 1/30/17, p. 1)*. The two companies decided to abandon the merger in February *(HPW 2/20/17, p. 1)*.

Broussard's base salary grew only 3% in 2016 — from $1.2 million to $1.235 million, but the rest of his compensation rose substantially, in large part because the Humana board made an adjustment in 2016 for compensation that was granted in 2014 but where the vesting was affected by accounting issues involving the merger. His stock awards jumped from $4.37 million in 2015 to $11.89 million in 2016. He also received $4.37 million in option awards last year and $1.97 million in non-equity incentive plan compensation.

Universal American Corp. CEO Richard Barasch saw the second-highest increase in compensation out of the top 10 insurers: his overall pay rose from $2.8 million in 2015 to $4.0 million in 2016. WellCare Health Plans, Inc. finalized Universal American's purchase on April 28.

And UnitedHealth Group CEO Stephen Hemsley's total compensation rose 22.8%, from $14.5 million in 2015 to $17.8 million in 2016. Hemsley had taken a pass on additional compensation in 2015, asking his board to keep his compensation below the median for CEOs in the company's peer group. However, Hemsley owns UnitedHealth Group stock worth more than $551 million.

Hemsley's 2016 compensation increase stems largely from a conversion of his retirement plan from a cash payout to an equity payout. "This is probably a favorable thing from shareholders' perspective (increasing pay-for-performance)," says Wayne Guay, accounting professor at the University of Pennsylvania's Wharton School.

Overall, Guay tells AIS Health, "changes in health plan CEO compensation over the last few years have largely mirrored the changes for other industries: equity pay favored over cash pay, use of stock shares favored over options [and] increasing use of performance vesting and performance payouts of equity instead of simple time-based vesting."

Two CEOs saw their compensation drop in 2015:

◆ ***Molina Healthcare, Inc.*** head J. Mario Molina, M.D., who was replaced as CEO on May 2 (see box, p. 3). Molina's total compensation fell slightly, from $10.3 million to $10 million.

◆ ***Cigna Corp.*** CEO David Cordani, whose total compensation fell more than 11%, from $17.3 million to $15.3 million. The board-level compensation committee said the insurer failed to meet its financial goals.

CEO pay could be affected in 2017 by a repeal of the provision that limits companies to $500,000 in deductions for pay per executive, Dorf points out. A provision eliminating this requirement is included in the American Health Care Act (AHCA) passed May 4 by the House, but the overall bill's prospects are uncertain (see box, p. 6). Congress could include the provision in a tax reform or tax cut bill later this year, Dorf says.

Still, Guay says this might not have much effect: "Health insurers can't really afford to allow the tax restrictions on executive pay to heavily influence their compensation decisions because their executives have many outside employment opportunities in industries that are not affected by such regulations."

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by Jane Anderson

Total Compensation for Publicly Traded Health Insurer CEOs in 2016

Company	CEO	Total Annual Compensation 2016	Total Annual Compensation 2015	Full Year Increase or (Decrease)
Centene Corp.	Michael Neidorff	$22.0 million	$20.8 million	5.8%
Humana, Inc.	Bruce Broussard	$19.7 million	$10.3 million	91.3%
Aetna Inc.	Mark Bertolini	$18.7 million	$17.3 million	8.1%
UnitedHealth Group	Stephen Hemsley	$17.8 million	$14.5 million	22.8%
Anthem, Inc.	Joseph Swedish	$16.5 million	$13.6 million	21.3%
Cigna Corp.	David Cordani	$15.3 million	$17.3 million	-11.6%
Molina Healthcare, Inc.	J. Mario Molina, M.D.	$10.0 million	$10.3 million	-2.9%
WellCare Health Plans, Inc.	Ken Burdick	$9.3 million	$7.8 million	19.2%
Universal American Corp.	Richard Barasch	$4.0 million	$2.8 million	42.9%
Triple-S Management Corp.	Roberto Garcia-Rodriguez	$2.9 million	N/A*	N/A

* Roberto Garcia-Rodriguez was appointed CEO of Triple-S on Jan. 1, 2016.
SOURCE AND METHODOLOGY: Compiled by AIS Health from company financial statements. Total compensation includes base salary, bonuses, stock awards, options/stock appreciation right (SAR) awards, non-equity incentive plan compensation, non-qualified deferred compensation earnings and all other compensation.

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HEALTH PLAN BRIEFS

◆ **The Department of Justice (DOJ) filed its own lawsuit against UnitedHealth Group, alleging it overbilled the Medicare Advantage (MA) program based on false data about enrollee health problems,** the *Minneapolis Star Tribune* reports. In March, the DOJ joined a second whistleblower lawsuit alleging overbilling and said it wanted to consolidate that case with a whistleblower lawsuit unsealed in February *(HPW 4/3/17, p. 8)*. This latest suit, filed by DOJ in federal court in California, alleges that UnitedHealth worked to boost risk scores for MA enrollees, but didn't correct risk scores that were too high. UnitedHealth said it complied with the rules and will contest the lawsuit. Visit http://strib.mn/2pZ0UCq.

◆ **California Insurance Commissioner Dave Jones (D) instructed insurers to file two sets of rates for the individual market next year: one premised on continued instability in the market and a second that assumes heightened enforcement and full funding for the Affordable Care Act.** "The Trump administration and Republican leaders continue to undermine the Affordable Care Act," forcing insurers to raise rates for 2018, Jones said. Preliminary rate filings for individual market products were due May 1. Read Jones' announcement at http://bit.ly/2qAgyBd.

◆ **Aetna Inc. says it will drop out of the individual health insurance exchanges in Virginia for 2018, according to Reuters.** The insurer blamed what it called "growing uncertainty" about the future of the Affordable Care Act, plus $200 million in losses it expects in the individual markets this year. Aetna, which is selling policies in just four states for 2017, already has said it will drop out of Iowa for 2018. It hasn't announced plans for Nebraska or Delaware, the only other two states in which it sells individual policies. Read more at http://reut.rs/2pEHscI.

◆ **Prescription drug spending has increased 10% annually for Blue Cross and Blue Shield members since 2010, an overall rise of 73%, the Blue Cross Blue Shield Association (BCBSA) said in a report**. The group blamed the upward trend on "a small fraction of emerging, patented drugs with rapid uptake and large year-over-year price increases that are more than offsetting the continued growth in utilization of lower-cost generic drugs." Pharmaceutical Researchers and Manufacturers of America rebutted the findings, saying they failed to take into account the effects of rebates. "We know that private payers are receiving rebates of between 30% and 55% for medicines to treat a number of conditions," it said. See the BCBSA report at http://bit.ly/2p9W1lM.

◆ **Increases in the insured population at the local level didn't seem to reduce access to care for those who already had health insurance,** according to a study in *Health Affairs*. This finding held across eight measures of access, including receipt of preventive care. It also held among two adult subpopulations that may have been at greater risk for compromised access: people residing in health care professional shortage areas and Medicaid beneficiaries. View the study abstract at http://bit.ly/2pRsKQB.

◆ **Bundled payments in Medicaid may mean fewer women are getting long-acting reversible contraceptive (LARC) devices,** a report from the Kaiser Family Foundation concludes. The move toward bundled payments in Medicaid means that providers have little financial incentive to offer patients these devices, even though experts recommend them as a way to prevent unplanned pregnancies, the researchers found. IUDs and implants usually are reimbursed following insertion, which means providers must take a financial risk to stock the expensive devices. This may limit a beneficiary's ability to obtain an LARC, the report said. View the research at http://kaiserf.am/2p6LVkK.

◆ **Highmark Inc.'s anti-fraud efforts saved the plan and its members more than $148 million in 2016, the insurer reports.** In particular, an anti-fraud department at the insurer that seeks to identify aberrant claims behavior, such as a provider who bills many more office visits than a peer or who bills for services that exceed 24 hours in a given day, has saved significant money, the insurer said. Learn more about the program at http://bit.ly/2pGdKT2.

◆ **Blue Cross Blue Shield of North Carolina launched a campaign to educate residents on the biggest cost drivers behind rising premiums, with drug costs topping the list.** The insurer says the "prices of 30 top-selling drugs increased by an average of 76% from 2010 through 2014," and some drugs, like EpiPen, have seen even bigger price increases. View the website at http://bit.ly/2qA5xjd.

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