Volume 27, Number 30 September 4, 2017

Health Plan Week

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

Contents

Senior Reporter
Judy Packer-Tursman
jptursman@aishealth.com

Senior Reporter
Diana Manos
dmanos@aishealth.com

Executive Editor
Jill Brown

On Hurricane Harvey's Path of Destruction, Plans Ease Rules, Reach Out to Members

Health plans eased access to prescription drugs and care services for members whose lives have been upended by Hurricane Harvey's catastrophic damage to south and central Texas and beyond. Faced with the closure of some Houston-area hospitals and other providers due to widespread flooding — and with their own offices shut down and employees' lives disrupted — insurers (see table, p. 6) initiated disaster contingency measures, some at the behest of state insurance regulators.

As heavy rains continued to pummel Texas and head into Louisiana, managed care organizations and their foundations reported contributing hundreds of thousands of dollars to American Red Cross relief efforts and matching their employees' donations. Aetna, Inc. said its affected members "can seek emergency care anywhere, as needed," and opened certain services, including help finding shelters, to the community at large. Cigna Corp. launched a 24/7 telephone help line to provide personal assistance and support to all affected Texas residents through Oct. 15, staffed by clinicians able to discuss how to cope with loss, anxiety and stress.

"All but one of our major hospitals are open and operational and additional services continue to resume as the floodwaters recede. Due to the challenging circumstances in Houston, our health plan is using a back-up customer service unit out of Minnesota and an on-call designee for utilization management. To ensure that our members continue to receive easy access to pharmaceuticals, we have eased prescription fill parameters," Meredith Whittemore, a spokesperson for Memorial Hermann Health System, told AIS Health Aug. 30.

continued on p. 5

Aetna's HIV Privacy Breach Brings Legal, Regulatory Hammers Down Swiftly

In an ironic twist of fate, while sending out letters to rectify an earlier HIV privacy breach for its members, Aetna Inc. made a new mistake that launched another HIV privacy breach. The result has been an almost immediate multistate regulatory investigation that could result in fiscal penalties and a class-action lawsuit that could settle for millions. Attorneys are saying that the days of health plans failing to adequately protect privacy are over, especially when the violations could bring discriminatory attacks onto plan beneficiaries.

On Aug. 28, the Legal Action Center, AIDS Law Project of Pennsylvania and Berger & Montague, P.C. filed a proposed federal class-action lawsuit against Aetna for "its repeated failure to respect the privacy rights of people taking HIV medication by mailing its customers Aetna envelopes where their HIV medication was visible through the large transparent window of the envelopes."

The complaint, filed in a Pennsylvania district court, claims that Aetna violated several laws by revealing the highly confidential HIV information of approximately 12,000 customers in at least 23 states. A statement issued by the New York City-based Legal Action Center called Aetna "careless."

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

Center Legal Director Sally Friedman said, "Insurers like Aetna must be held accountable when they fail to vigorously protect people's most private health information." Aetna's "unprecedented HIV privacy breach" has wreaked havoc in the lives of those affected because of "the enormous stigma that HIV still carries," she said.

The groups are calling for Aetna to "cease the practice, reform procedures, and pay damages."

Ethan Slavin, a spokesman for Aetna, says the company "can't comment on pending litigation." However, regarding the breach, he has this to say: "We sincerely apologize to those affected by a mailing issue that inadvertently exposed the personal health information of some Aetna members. This type of mistake is unacceptable, and we are undertaking a full review of our processes to ensure something like this never happens again."

Aetna's letter was sent out to members who take Pre-exposure Prophylaxis (PrEP), a regimen that helps prevent a person from acquiring HIV, to tell them how to get their medications. "Recipients were stunned when they realized information about HIV medication was clearly visible through the window on the envelope," the Legal Action Center said.

Health Plan Week (ISSN: 1937-6650) is published 45 times a year by AIS Health, 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Senior Reporters, Judy Packer-Tursman, Diana Manos; Executive Editor, Jill Brown; Marketing Director, Donna Lawton

Subscriptions to *HPW* include free electronic delivery in addition to the print copy, quarterly Key Financial Indicators for major health plans (in print and posted on the subscriber Web page), e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *HPW* content and archives of past issues.

To order an annual subscription to **Health Plan Week** ($695 bill me; $595 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

According to the Legal Action Center, Aetna's letter, with its privacy-breaching window, was sent in response to HIV privacy issues filed in other cases against the company in 2014 and 2015. In those cases, Aetna wanted customers to get their HIV medications exclusively from mail-order pharmacies instead of from retail pharmacies. Customers complained that using mail-order pharmacies could breach their privacy.

Ronda Goldfein, an attorney and executive director of the AIDS Law Project of Pennsylvania, says the organization and other AIDS advocacy groups began receiving a host of complaints once Aetna sent out the letters with the clear windows in late July. Complaints rose from 23 Aetna members in nine states to 100 in 35 states within a matter of days, she says, and they are still coming in.

Goldfein says she doesn't want to say what a settlement could cost Aetna. "We are looking at what other cases have settled for," she says. "We don't know what ballpark we're in because we want to do more research. We're looking at all of the past cases."

For example, in July, Anthem Inc. settled for $115 million for a privacy breach affecting 80 million members *(HPW 7/3/17, p. 5)*.

"We have heard back-to-back horror stories of what has happened to people, and it's all avoidable; that's really the distressing thing. All of this harm and pain could have been avoided," Goldfein says. Some of the stories included cases of lost housing, threats of violence and damage to family relationships. In one instance, a member's child was able to read the information through the envelope window, she says.

Many AIDS organizations belong to a listserv that exchanges information about breach incidents, which keeps them apprised of incidents as they unfold and helps the organizations more easily coordinate responses, Goldfein says.

Regulators Respond to Breach

On Aug. 29, the day after the lawsuit was filed, the District of Columbia Department of Insurance, Securities and Banking (DISB) said it had opened an investigation of Aetna in response to the breach, which affected 390 District policyholders. DISB will reach out directly to the policyholders to provide them with details of the breach and of the investigation, said Commissioner Stephen Taylor in a statement.

"The Department also plans to review Aetna's policies for data privacy and safeguarding of medical information of its customers and its compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state laws," DISB said. "The department will also share the results of investigations with other state regulators to ensure that a compre-

hensive, coordinated corrective plan is implemented by the health insurer."

According to Tanya Bryant, public affairs specialist at DISB, the length of the investigation will depend on what is revealed as it unfolds. "As our examiners begin their work, new issues could arise," she tells AIS Health.

Bryant says DISB will work with insurance regulators in other states to investigate Aetna's privacy practices. The collaborative investigation is somewhat unique. "These types of situations, fortunately, do not occur frequently," she says.

"It is too early to determine what the worst-case scenario could be for Aetna," Bryant says. "The investigation could result in fines or requirements for Aetna to make changes to prevent something like this from occurring in the future."

Contact Goldfein at goldfein@aidslawpa.org and Bryant at tanya.bryant@dc.gov. ✧

by Diana Manos

Tufts Joins MassHealth's New 'Transformational Paradigm Shift'

Massachusetts has hammered out the details and nailed down Medicaid accountable care organization (ACO) contracts with 17 health care organizations that include existing ACOs and networks of physicians, hospitals and other community-based health care providers, moving ahead on its 1115 waiver to overhaul the MassHealth Medicaid program. Exclusivity between providers and a single health plan in the ACO contract is a new element meant to optimize care and lower costs. Hopes are high for the players to achieve these goals, but transitioning members to the new program might prove to be a challenge, ACO participants say.

On Aug. 17, the Massachusetts Executive Office of Health and Human Services (EOHHS) said the health care organizations will form ACOs to enact "a major restructuring" of MassHealth, the state's Medicaid program, which covers 850,000 members.

According to EOHHS, the new program, which will launch March 1, will include efforts to improve quality and member experience and integrate the full spectrum of care including medical care, behavioral health and long term services and supports. Last year, six ACOs piloted the program, covering approximately 160,000 members.

Dan Tsai, assistant secretary and director of the MassHealth program, says the overhaul represents a "significant change" in the way the state Medicaid program will work. It has operated mainly on a fee-for-service basis, but will now move to a risk-based model, paying for value-based care.

The ACO program is a major component in the state's five-year 1115 Medicaid waiver, bringing in $1.8 billion in new federal investments to restructure the current MassHealth system, according to EOHHS.

Partners Have 'Similar Missions'

Tufts Health Plan was among the 17 organizations that signed contracts with the state to form Medicaid ACOs. Some of the 17 organizations have not finalized their ACO partnerships, but Tufts has, according to EOHHS. Tufts will participate with Atrius Health, Beth Israel Deaconess Care Organization, Cambridge Health Alliance and Boston Children's ACO. The ACO provider partners working with Tufts will only see Medicaid patients covered by that insurer.

Hyunsook Song, vice president of product management and community relations for public plans at Tufts Health Plan, says the plan selected its ACO partner organizations from among those that shared its objectives when it comes to health care. "We were looking for those with similar missions and values, high quality service and care, and driven to look at the costs," Song says. "We also looked for partners with a strong track record in driving those values. We aligned really well with our partners, and they were looking for the same."

Song calls the new MassHealth ACO program "a transformational paradigm shift," in which the state is using ACOs as a vehicle to improve quality and lower costs. "That's the whole underlying premise here," she says.

According to Song, the transition shouldn't be difficult with the provider organizations in the ACO because most of them already have a relationship with Tufts. The change is that the relationship will now be exclusive between the providers and Tufts for Medicaid patients.

The difficulty will be in getting members to transition to the ACO. It will take a lot of education and communication, to be executed with guidance from the state and partnering efforts with the provider organizations, she says. "The goal here is pretty obvious. We don't want to create any confusion."

Beth Honan, chief contracting officer at Atrius Health, one of Tufts' ACO partners, says the MassHealth shift to ACOs is the most substantial change to the state's Medicaid program in decades, in terms of reform around payment and care delivery. "It's very much in line with other Massachusetts and national reform efforts to move away from fee-for-service toward value-based care," she tells AIS Health, calling the state "ahead of the curve in the Medicaid space."

Atrius, a large multi-specialty independent group practice, is somewhat unique in Massachusetts in that it is not affiliated with any hospital or health plan. Atrius prides itself in being at the forefront of the value-based care movement, Honan says. The group has been operating under a risk and capitation model for decades. Currently, 80% of the group's gross revenue is capitated and risk-related, she says.

Honan agrees with Song that the big focus now is on the beneficiaries and how to communicate with them about what is happening. Atrius has 30,000 Medicaid beneficiaries that will need to be alerted as to the new ACO arrangement.

There is guidance coming out on a daily basis from the state, Honan says, on how to communicate with the Medicaid beneficiaries.

Honan adds that the requirement for participating health care providers to be exclusive with their health plan in their ACO is very new — "unlike today, in the Medicaid environment, where you have a hodgepodge of providers, health plans and delivery systems, with some providers participating in all of them." The exclusive relationship will make it easier to accomplish value-based care, she says.

ACOs Eligible to Split $1.8 Billion

ACOs in the program will be eligible to receive a portion of $1.8 billion over five years in Delivery System Reform Incentive Program (DSRIP) funding to improve integration of care, outcomes for members with serious mental illness and comorbid conditions or long term services and supports, according to EOHHS.

The DSRIP funding "is enormously important to us," Honan says. Atrius is considering using its DSRIP funding to add pediatric and/or mental health facilitators to assist clinicians, she says. School-based care is also under consideration. And Atrius is evaluating ways it could use data to better understand the social issues that can be alleviated to improve a patient's health outcomes.

At this point, Massachusetts' Medicaid ACO program is just launching and details are still being worked out, Jim Lloyd, a program officer at the Center for Health Care Strategies, tells AIS Health.

"Regarding how payment works, it depends on which model the ACO is a part of," he says. "In the first model, the payments flow to the plans, which then manage the ACOs. In the second, MassHealth contracts directly with the ACO outside of managed care, and in the third, the payments flow through the plans to the MCOs [managed care organizations] with which they have contracts. Massachusetts designed the program with flexibility to allow multiple types of arrangements to operate."

In a December blog, Lloyd wrote that "[t]he Commonwealth of Massachusetts' new accountable care organization (ACO) program — a central part of its $52.4 billion Section 1115 waiver — goes well beyond traditional Medicaid ACO models and, in our view, is headline worthy. The Massachusetts Medicaid ACO program offers an innovative mechanism to integrate community partners and social service organizations into the health care system with the goal of addressing members' social determinants of health, improving access to care, and bending the cost curve."

Contact Honan via Jackson Murphy at jmurphy@solomonmccown.com and Lloyd at jlloyd@chcs.org. ✧

by Diana Manos

Medica Inks Deal to Acquire Mayo Clinic's $15M TPA Line of Business

Nonprofit Medica Inc. is acquiring Rochester, Minn.-based MMSI, a division of Mayo Clinic doing business as Mayo Clinic Health Solutions, the managed care organization said Aug. 17. Financial terms of the transaction were not disclosed.

MMSI, a physician-led health benefits management company and licensed third-party administrator (TPA) with offices in Scottsdale, Ariz., provides plan administration services and health care products to 260,000 members through 28 self-insured employer customers.

The firm posted $15 million in third-party administrative revenue for 2016, down from $18 million a year earlier, according to Mayo Clinic's consolidated financial report dated Dec. 31, 2016.

Minnetonka, Minn.-based Medica says the move represents a new business arrangement for the two organizations, a deal that may afford opportunities to help improve access for patients with serious, complex medical conditions.

"For many years, Mayo Clinic and Medica have each worked to advance health care, improve the consumer experience and drive innovation in health care delivery, technologies and tools," John Naylor, Medica president and CEO, said in an Aug. 17 statement.

"This new arrangement offers technologies and opportunities to explore that can benefit patients and clients," said Kedrick Adkins, Mayo Clinic's chief financial officer.

By selling its MMSI product to Medica, Mayo is sure to be included in Medica's network, explains Larry Bussey, director of Medica communications. Bussey recently provided more answers to AIS Health on the significance of the deal:

AIS Health: Is this a new business area for Medica?

Bussey: This will be a new business unit for us, but it provides the services (benefits administration, network development, product development) that are core capabilities of our current business.

AIS Health: Is it part of an ongoing partnership with the Mayo Clinic?

Bussey: Yes. We have a strong relationship with Mayo. This acquisition builds on that by more effectively leveraging each of our strengths — we provide the administrative services and Mayo provides care for complex cases through these products.

AIS Health: Is it part of a larger strategy for Medica?

Bussey: TBD [To be determined]. It is certainly part of our efforts to grow our membership.

AIS Health: Is the deal finalized?

Bussey: No. The deadline for finalizing is the end of the year, but we hope to have it finalized before then.

Karl Oestreich, Mayo Clinic's director of media relations, tells AIS Health that approximately 200 employees are in the MMSI division. He says Medica was the only entity interested in acquiring MMSI; it was not a competitive negotiation. Mayo Clinic has run some iteration of this TPA business for about three decades, he notes.

"This decision is part of a strategy for Mayo designed to help support broader access to Mayo Clinic in an environment where a narrowing network of health insurance products could eliminate Mayo Clinic as an option for some patients," Oestreich says.

No individual-market plans being sold in the Twin Cities include access to Mayo Clinic on an in-network basis, according to the *Star Tribune's* report on the deal.

"Mayo Clinic continues to explore opportunities with multiple potential collaborators to help improve access to Mayo Clinic for patients with serious and complex medical conditions," Oestreich says.

Contact Bussey at larry.bussey@medica.com and Oestreich at oestreich.karl@mayo.edu.

by Judy Packer-Tursman

State Issues Hurricane Guidance

continued from p. 1

Such front-line efforts were taking place amid local officials' talk of a long, slow recovery period and years of rebuilding for the ravaged region.

At a state level, the Texas Department of Insurance issued a series of bulletins Aug. 26 to the insurance industry related to Hurricane Harvey. The bulletins provide guidance to insurers on grace periods for premium payments, health coverage and other issues.

Given the level of personal hardship in hurricane-hit areas and the fact that many individuals will be away from their homes and health care service areas, the department says in one guidance that "all health insurers and health maintenance organizations that provide prescription medication coverage as part of any policy… should, through the duration of the governor's [disaster] proclamations, authorize payment to pharmacies for up to a 90-day supply of any prescription medication for individuals regardless of the date upon which the prescription had most recently been filled."

Another bulletin says health plans should "authorize payment for necessary medical equipment, supplies, and services regardless of the date on which the service, equipment, or supplies were most recently provided." And, more broadly, the department says in guidance that insurers "should waive penalties and restrictions" on enrollees when they get "necessary emergency and non-emergency health and dental services out-of-network as a result of the disaster."

"We anticipate sending Consumer Protection staff to the storm damaged areas once it is safe to do so and multi-agency Disaster Recovery Centers are established," department spokesman Ben Gonzalez told AIS Health on Aug. 28.

Plans Try to Contact Members

At this point, plans are reaching out and trying to connect. Blue Cross and Blue Shield of Texas estimates about 1 million members are affected by the massive storm, spokesperson Chris Callahan told AIS Health. He said the Texas Blues' operations have been minimally impacted. "Our offices in Houston, Beaumont and Corpus Christi remain closed, however, and the work usually conducted in those offices is being handled from other locations," he said Aug. 30.

The Texas Blues insurer knows multiple employees have been affected by this disaster, Callahan said, and efforts are underway to identify and stay in contact with those most severely impacted and make them aware of available resources. "The BCBSTX team is also promoting donations to our company's employee relief fund to help our employees in their time of need," he said.

Humana Inc. spokesperson Ross McLerran said the insurer's customer service staff "is in the process of contacting by telephone or separately by email more than 300,000 members who are identified as being in the storm's path."

"More than 117,500 telephone calls have already been placed checking on member health and welfare," he said Aug. 30. "An e-mail outreach campaign is also underway" — and Humana's free crisis intervention

hotline is available 24/7 to members and the community at large.

On another front, Humana has completed telephonic and email outreach to 3,000-plus employees identified as working in the region affected by Hurricane Harvey, McLerran said Aug. 30. "In addition, supervisors in all areas of operation were asked to ensure the safety of individuals within their team," he said. "Human Resources began 'well-being' checks to employees over the weekend. Humana has responded to affected employees with financial aid, lodging, food and transportation. Employees were notified of the availability of 24-hour Employee Assistance Program crisis intervention and guidance counseling."

Thus far, Humana has identified 800 employees dealing with the potential of flooding, he said, and three associates in need of immediate assistance got Helping Hands grants from a Humana program designed to support its workers facing unexpected hardship.

According to McLerran, Humana has implemented disaster plans for members in Texas and Louisiana, waiving all requirements for primary care physician (PCP) referral, thus easing prior authorization requirements. "Members seeking medical care at an out-of-network emergency room, physician or urgent care center will pay the same cost-sharing they would get at an in-network facility," he said. "Humana has removed prescription drug limitations such as 'refill too soon' notices that prevent replacing lost medications," he said.

Top 10 Texas Health Plans Impacted by Hurricane Harvey

Blue Cross and Blue Shield of Texas serves a quarter of all Texas residents with plans in all sectors across the state. About half the insurer's lives are via self-insured employers, and it provides national BlueCard access to another million residents. A total of 65 insurers operate in the state, with two leading plans, Texas Children's and Community Health Choice, headquartered in hard-hit Houston.

Insurer	Total in State	Market Share
Blue Cross and Blue Shield of Texas	4,473,225	24.84%
Aetna, Inc.	2,946,030	16.36%
Cigna Health and Life Co.	1,558,429	8.66%
Centene Corp.	1,243,853	6.91%
Anthem, Inc.	851,126	4.73%
UnitedHealthcare	831,705	4.62%
Humana Inc.	665,713	3.70%
Molina Healthcare, Inc.	493,000	2.74%
Texas Children's Health Plan, Inc.	430,676	2.39%
Community Health Choice, Inc.	422,734	2.35%

SOURCE: *AIS's Directory of Health Plans: 2017*. To order visit https://aishealthdata.com/dhp or email Sales@AISHealth.com.

Humana also has been in contact with individual physicians, medical groups and the Texas Medical Association, "offering our assistance and providing background on our efforts supporting our membership and the communities we serve," he said.

McLerran noted that Humana has had a presence in Texas for nearly 40 years.

Insurers Prepare for Emergencies

Every new Humana employee is enrolled in an emergency preparedness training course, Humana conducts hurricane drills, and all of Humana's executive and operational teams participate every six months in crisis exercises "across a vast array of scenarios," McLerran said. Humana's Enterprise Tropical Storm and Hurricane Plan includes specific actions for operations and supporting functional areas in each phase of a storm — from the indication of a weather event to resumption of normal operations. "Each year before hurricane season starts, the plan is reviewed, updated and distributed to business leaders, stakeholders and departments involved in preparing for and recovering from hurricanes and tropical storms," he said.

Cigna spokesman Mark Slitt made it clear that insurers' emergency planning, while helpful, can only go so far. "We have a robust business continuity planning process for all of our sites nationwide to minimize business interruption during natural disasters and other events," he told AIS Health on Aug. 29. "Having an established and tested process certainly helps. However, each situation that arises is unique, and events as massive as a category 4 hurricane are especially challenging even with advance planning."

Asked whether Cigna's offices are up and running in the hurricane-ravaged region, he said Aug. 29: "Not yet. We have three sites in the Houston area and all are currently closed….Our Houston sites will be closed until at least Sept. 5," though "my understanding is there is power and computer servers are working."

Slitt noted that "tens of thousands" of Cigna members were in the storm's path. Asked whether the carrier has implemented short-term policy changes for those members who are hardest hit, he replied: "We will assess the needs of individual customers, in particular with access to care. Their safety and well-being is our highest priority."

He added that the insurer has nearly 800 workers based in the Houston area, who are being helped through Cigna's employee assistance program and other corporate resources.

In addition, Cigna has been in direct contact with employer group customers "who may need our assistance with on-site Critical Incident Response Services

and other services once their workplaces reopen," Slitt said.

He also cited challenges for the insurer's participating hospitals, physicians and other providers.

"We are letting our network providers know that we're lifting the 'too soon to refill' restrictions and the prior authorization requirements," he said. "One of the biggest challenges right now is that providers have also been displaced by the hurricane, just like their patients, and their workplaces are closed."

Cigna said it has lifted prescription refill restrictions in South and Central Texas counties and waived prior authorization requirements for acute medical care and behavioral health services in affected areas. The insurer noted that these areas may expand based on the path of the storm.

Among other health plans' responses in the affected region:

◆ ***Amerigroup Texas,*** which covers about 850,000 low-income Texans, revised pharmacy and health care guidelines to make it easier for its Medicaid, Medicare and dually eligible members to gain access to needed services and supports. The insurer said Aug. 28 that affected

Top Compensated Directors for 2016 Blue Cross and Blue Shield Boards

Like many health insurers, Blue Cross and Blue Shield companies vary widely in how they pay the members of their boards of directors (see story, p. 9). AIS Health collected compensation data for Blues plans' boards from Blues plan company documents, filings to the National Association of Insurance Commissioners and the Securities and Exchange Commission.

Company	Director	2016 Total Compensation
Anthem, Inc.	George A. Schaefer, Jr.	$395,938
Arkansas BlueCross BlueShield	Sherman Tate	$515,000
Blue Cross and Blue Shield of Florida, Inc.	Catherine P. Bessant	$310,500
Blue Cross and Blue Shield of Kansas City	Melvin Glazer, M.D.	$249,292
Blue Cross and Blue Shield of Minnesota	Rita Heise*	$98,200
Blue Cross and Blue Shield of Nebraska	Todd Shepard Sorensen, M.D.	$142,931
Blue Cross and Blue Shield of North Carolina	Frank Brown Holding, Jr.*	$128,000
Blue Cross and Blue Shield of Vermont	Charles Smith*	$39,350
Blue Cross Blue Shield of Arizona	Robert B. Bulla	$613,275
Blue Cross Blue Shield of Massachusetts	Phyllis Yale*	$120,000
Blue Cross Blue Shield of Michigan	Gregory A. Sudderth*	$293,879
BlueCross BlueShield of South Carolina	Malcom Edward Sellers*	$79,646
BlueCross BlueShield of Tennessee	Betty Walters DeVinney*	$10,000
Capital BlueCross	Kathryn P. Taylor	$154,420
CareFirst BlueCross BlueShield	Stephen L. Waechter*	$57,500
Health Care Service Corporation	Milton Carroll	$4,924,624
Highmark, Inc.	John P. Moses	$143,949
Horizon Blue Cross Blue Shield of New Jersey	Vincent J. Giblin	$119,000
Independence Blue Cross (IBC)[1]	Walter D'Alessio*	$1,000
Noridian Mutual Insurance Co.	Dale Klein, M.D.	$53,400
Premera Blue Cross	Kathryn Langlois Munro	$152,000
Regence BlueCross BlueShield of Oregon	Luis Machuca	$14,480
Regence BlueCross BlueShield of Utah	S. Fred Beck	$17,420
Regence BlueShield	Mark C. Adams, M.D.	$19,860
Triple-S Management Corporation	Luis A. Clavell-Rodriguez*	$310,000
Wellmark, Inc.	Daryl K. Henze	$140,069

*Board Chair/Leader
[1]Independence Blue Cross (IBC) compensates all board members equally.
SOURCE: Compiled by AIS Health.

members can see in-network and out-of-network physicians and service providers.

Amerigroup noted that it is donating and transporting portable USB solar chargers and power banks to the greater Houston area in an effort to ensure that individuals coping with the flooding can access assistance via their mobile phones.

◆ ***Aetna, Inc.*** is offering services to members in nearly 50 Texas counties and all of Louisiana's parishes. "If needed, affected Aetna members may refill their prescriptions early. Those who use Aetna's mail-order pharmacy can either get a prescription at an alternate delivery location or refill a prescription that may have been lost, damaged or destroyed," the company said Aug. 27. "In addition to helping with prescription refills, Aetna can help members who have been evacuated from their homes find care and behavioral health support, among other services. Aetna is also extending claim and appeal filing times."

Asked whether insurers anticipate any sort of financial hit or long-term impact from Hurricane Harvey, Cigna's Slitt replied: "We expect all businesses will experience a financial impact due to this catastrophe. Our focus is on the safety and well-being of our employees and customers."

Contact Whittemore at meredith.whittemore@memorialhermann.org, Callahan at chris_callahan@bcbstx.com, Slitt at mark.slitt@cigna.com and Gonzalez at ben.gonzalez@tdi.texas.gov. ✧

by Judy Packer-Tursman

HEALTH PLAN BRIEFS

◆ **CareSource agreed to cover the last bare Affordable Care Act (ACA) exchange county in Ohio.** The Ohio Department of Insurance (ODI) said Aug. 24 that CareSource will step in to fill the last of 20 counties that had no insurer operating on the state's exchange in 2018. "Making sure coverage is available has been our goal through this process, but this is a temporary solution and one that only applies to 2018," ODI Director Jillian Froment said in a statement. See http://bit.ly/2xPtNkg.

◆ **Medicaid officials slapped Kaiser Permanente with a notice of intent to impose a $2.2 million fine** for failing to deliver Medicaid patient care data to the state by the designated deadline, *California Healthline* reported on Aug. 28. The data is used to set rates and ensure that patients are getting adequate care. This is the second such fine this year for Kaiser, which was notified of the state's intent to fine it $2.4 million in January. The company said the sanctions were in no way related to the quality of patient care or access to treatment, *California Healthline* reported. Kaiser does not collect its patient data in the format required by the state, but it is working to fix that, according to the *Mercury News*. Read the *California Healthline* story at http://bit.ly/2wLJ1Kb.

◆ **Canopy Health officially launched a new provider-sponsored plan in the San Francisco Bay area, according to an Aug. 24 statement from the company.** The alliance is composed of nearly 4,000 providers, 15 hospitals and numerous care centers across seven counties. Canopy Health was incorporated in March 2015 as an affiliation between University of California, San Francisco (UCSF) Health and John Muir Health. "We're really dedicated to the idea of transparent care and coverage," said Denise Vance-Rodrigues, director of business development for Canopy Health. See the Canopy statement at http://prn.to/2glOai6.

◆ **UnitedHealth Group is acquiring The Advisory Board Co.'s health care business.** The deal joins the Advisory Board's research and advisory services with UnitedHealth subsidiary Optum's data analytics and technology capabilities to help customers adapt to the changing health care environment, the companies said Aug. 29. Optum, whose clients include 300-plus health plans, said the transaction will "preserve the objectivity and enhance the range, impact and value" of the Advisory Board's research for its 4,000-plus members. It will close by the end of 2017 or early 2018, contingent on stockholder and regulatory approvals and other conditions. UnitedHealth said the deal won't affect earnings per share in the first year. See http://tinyurl.com/y9tdv6e9.

◆ **The Maryland Insurance Administration on Aug. 29 unveiled approved 2018 premium rates for small-group and individual health plans.** About 257,000 Marylanders are enrolled in the small-group market, where rates will rise by an average of 1.7% versus the originally filed 4.2%. Rates for individual-market plans will rise by an average of 33% versus the original 43.1%. Enrollment will run from Nov. 1 through Dec. 15. See http://tinyurl.com/yb65o4fe.

A Monthly Update for *Health Plan Week* Subscribers

*The AIS Report on Blue Cross and Blue Shield Plans**

Contents

Board of Director Pay at Blues Plans Tends to Line Up With Industry, With a Few Exceptions

There is broad variation across Blue Cross and Blue Shield companies in how they pay the members of their boards of directors. In 2016, annual compensation ranged from a low of just $72 for one director at Blue Cross Blue Shield of Michigan to a high of $4.9 million for a director at Health Care Service Corp., data compiled by AIS Health reveals. Meanwhile, board chair compensation for chairs not also serving as CEOs ranged from $1,000 at Independence Blue Cross to $310,000 at Triple-S Management Corp.

But when examined more closely, compensation experts say, board pay for Blues plans generally falls into line with director pay for comparable non-Blues insurers, especially when accounting for differences between for-profit and non-profit entities.

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

Paul Conley, a consultant with the U.S. executive compensation practice at Willis Towers Watson, says that board pay appears to follow what he views as a typical pattern of higher pay for larger entities and lesser pay for smaller entities. "That said, there is variability across organizations at a given size, generally reflecting local market circumstances and/or individual company philosophies regarding pay," he says.

continued on p. 10

Radiologists Push Back as Anthem Alters Coverage Policy for Some Hospital Imaging

Close on the heels of its controversial policy aimed at placing constraints on emergency room visits *(HPW 7/24/17, p. 4)*, which has met with resistance, Anthem, Inc. is implementing another coverage policy based on "medical necessity." This time it's for hospital-based outpatient imaging across its Blue Cross and Blue Shield plans in 13 states. The upshot is that the Indianapolis-based health insurance giant won't pay for certain imaging tests done on an outpatient basis in hospitals that the insurer asserts could be done in less costly settings. The move is getting strong pushback from radiologists amid their concerns that other insurers may follow suit.

"Our Imaging Clinical Site of Care program, administered by Anthem subsidiary AIM Specialty Health, started in Indiana, Kentucky, Missouri and Wisconsin on July 1 for our individual and employer-sponsored members in fully insured programs," Lori McLaughlin, Anthem's communications director, tells AIS Health. "It will roll out to Ohio, Colorado, Nevada, Georgia and New York on Sept. 1; California, Oct. 1; and Connecticut, Maine and Virginia on Mar. 1, 2018. The review will be offered to local, self-funded accounts to add to their members' benefit package on Jan. 1, 2018."

Under Anthem's new coverage policy, the doctor or medical practice must submit a prior authorization request for outpatient MRI or CT services at the hospital. The imaging service will be covered at the hospital only if Anthem deems the request to be medically necessary. According to Anthem, an advanced radiologic imaging procedure in the hospital outpatient department is considered medically necessary when the services being provided are available only in the hospital setting; the individual requires

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Week* 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.

an obstetrical observation; the individual is receiving perinatology services; or there are "no other geographically accessible appropriate alternative sites" for the individual to undergo the procedure. Anthem says the last category includes, but isn't limited to: when moderate or deep sedation or general anesthesia is required for the procedure and a freestanding facility providing such sedation is unavailable; when the equipment for the size of the individual is unavailable in a freestanding facility; or when the individual has "a documented diagnosis of claustrophobia" requiring open magnetic resonance imaging unavailable in a freestanding facility.

If a member chooses to go to an outpatient hospital facility and that in-network facility provides the imaging service, then the provider, and not the patient, would be responsible for the cost, according to Anthem. Members would bear the cost only if they sign a waiver.

ACR Calls Policy 'Arbitrary and Unwise'

McLaughlin tells AIS Health that "the program covers CTs and MRIs only." But the American College of Radiology (ACR), in an Aug. 29 statement, considers the policy to be more broadly applicable. "The new Anthem cost-cutting policy of not covering advanced imaging (MRI, CT, PET, etc.) performed in hospital outpatient departments is arbitrary and unwise," ACR says.

ACR says "economically motivated steerage of patients compromises the physician-patient relationship" and "sets up another nontransparent preauthorization process that moves medicine backward." Inner-city and rural patients may be most adversely affected, it says, since they live in places where the local hospital outpatient setting "may be the only immediate access point."

Anthem insists that its primary concern "is to provide access to quality and safe health care for our affiliated health plan members. We are also committed to reducing overall medical cost where possible when the safety of the member is not put at risk."

McLaughlin explains Anthem's rationale in this way: Clinical research shows the safety of providing imaging services in free-standing imaging centers. The program helps identify when hospital outpatient services for certain imaging tests are medically unnecessary. In such cases, members can get needed services in a clinically appropriate setting, such as a freestanding outpatient clinic, which is often less costly. Members could save up to hundreds of dollars for each imaging test and have more affordable premiums.

She cites "huge cost disparities" for imaging services, depending on where members get diagnostic tests. At a free-standing clinic, patients "can save close to $1,000 out-of-pocket for some imaging services for those who haven't met their deductible and up to $200 for those whose plans require only a copay," she says.

Anthem members in high-deductible plans who haven't met their deductible may be responsible for the full cost of the service, she says. In those cases, the member saves the difference between the hospital imaging cost and the non-hospital cost. For other members with coinsurance, "the lower the cost of the service, the more affordable the cost is to members and plans," she says.

Under Anthem's imaging program, its AIM subsidiary collects data on imaging providers, both hospital-based and free-standing, in areas such as facility specifications, clinician qualifications, accreditation and equipment. Information is used to determine conformance to industry-recognized standards and to assign a site score. Providers can use AIM's portal to see each facility's site score and find facilities with equivalent scores.

Contact McLaughlin at lori.mclaughlin2@anthem.com. ✧

by Judy Packer-Tursman

Blues' Director Pay Varies Widely

continued from p. 9

There's "no meaningful difference in pay for board members at Blues organizations when compared to non-Blue health insurers after adjusting for company size," he tells AIS Health. "From a trend perspective, we do see organizations evaluating and making modest upward adjustments to board pay on an annual basis. This practice aligns to that followed when evaluating manager pay, and is seen as preferable to waiting several years for a review and then making more sizable adjustments."

Almost all Blues organizations have some variation between their highest-paid and lowest-paid directors (see table, p. 7). For example, Anthem, Inc.'s lowest-paid director receives $300,000 annually, while the company's highest-paid director receives $395,938. But some companies see a much broader spread in director pay than others. For example, Blue Cross Blue Shield of Michigan, which at $72 has the lowest-paid director reported, provided its highest-paid director with $161,386. Blue Cross and Blue Shield of Nebraska paid its lowest-paid board member $7,678 and its highest-paid member $142,931.

Board chair compensation also varied considerably, ranging from just $1,000 for Independence Blue Cross chair David Hilferty to $310,000 for Luis Clavell Rodriguez at Triple-S Management Corp., the parent company of Blue Cross Blue Shield of Puerto Rico. Of course, chairs also serving as CEOs or company presidents, such as Anthem CEO Joseph Swedish and Florida Blue CEO Patrick Geraghty, earned much more.

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Week* 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.

David Tsui, assistant professor of accounting at the University of Southern California, says the director compensation looks about how he would expect it to look, although he notes "there are a few organizations with unusually low director pay — less than $25,000 per director is quite low even for organizations of modest size."

For example, BlueCross BlueShield of Tennessee, which says it had 3.4 million members in 2016, paid its board chair $10,000 per year and paid its directors between $3,500 and $9,000. Cambia Health Solutions, Inc., which operates Regence companies in Idaho, Oregon, Utah and Washington, paid its board members for all states except Idaho between $12,760 and $19,860. And Independence Blue Cross, which has more than 8.5 million members, compensated its chair and directors at a flat rate of $1,000.

> **"Compensation at the per-director level for the non-profit Blues is in most cases somewhat below what a comparable corporate director could expect to receive.**

Still, Tsui adds, "Organizational size is the primary determinant of director retainers and most of the major public insurers are substantially larger than the non-profit Blues organizations — and hence pay their directors more....Even after accounting for size differences, though, compensation at the per-director level for the non-profit Blues is in most cases somewhat below what a comparable corporate director could expect to receive."

It's possible that non-profit Blues plans pay their directors less because they have different organizational goals than the for-profit companies, he says. "For example, non-profits may view minimizing administrative costs as a high-priority objective, while [for-profit] corporations may be more willing to incur greater costs if they ultimately lead to greater profits."

Differences in the director compensation between relatively similar organizations also could be due to differences in those directors' type or qualifications, Tsui says. And some may be less willing to pay for "professional directors."

There's another key distinction between non-profit Blues plans and for-profit plans, Tsui points out: "Non-profits tend to have much larger boards than public corporations. For example, many of the non-profit Blues have boards with 15 to 20 or more directors, while the typical corporate board has around nine or 10. This means that in many cases, the total compensation paid to the board as a whole is the same or greater at non-profits, despite lower per-director pay."

For the non-profit Blues plans, Tsui notes that there's plenty of variation in director pay within the same organization, compared to a typical publicly traded corporation. For example, at Blue Cross and Blue Shield of Nebraska, the lowest-paid director received $7,678 while the highest-paid director received $142,931 for 2016.

"This might indicate that some directors at these non-profits carry much more responsibility than others — e.g., some might bear substantial operational responsibility, which is not unusual in non-profit organizations, while others serve a more nominal role," Tsui says. It also could mean that some directors at non-profits are willing to forego some compensation to serve, he says.

For-Profit Directors Face Liability

Charles Elson, director of the John L. Weinberg Center for Corporate Governance at the University of Delaware, notes that liability issues are different between for-profit insurers and non-profit insurers. "That's probably why compensation is a little bit lower" for the non-profit board members, he tells AIS Health. To determine compensation, he says, "you've got to factor in the time and potential liability differences for non-profits."

Tsui adds that the trend for increasing board pay most likely will continue: "Director compensation has been steadily rising for at least the past couple of decades. This trend is pretty consistent across industries — directors often serve on or move between boards in a variety of different industries or business environments, so industry-specific factors are less likely to play a huge role in compensation decisions."

Paul Dorf, managing director of Compensation Resources Inc., a consulting firm in Upper Saddle River, N.J., agrees, especially for the larger, public companies: "The public boards are raising their comp up to the $300,000 to $500,000 levels as are most of the Fortune 500 companies. There is a lot of literature suggesting that because of public liability and complexity, that is what they need to recruit new board members. Also, they are saying work has gone up exponentially."

Typically, the board chair will receive up to $90,000 more than regular members, Dorf tells AIS Health. "When we market price we choose peers that are one-half to double the size" of the company in question, he says. Although generally speaking only a small number of non-profit companies pay their boards, most Blues organizations do have paid boards, Dorf says. Some states may have caps on compensation, he adds.

Contact Conley at paul.conley@willistowerswatson.com, Tsui at David.Tsui@marshall.usc.edu, Elson via spokesperson Andrea Boyle at aboyle@udel.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 Week* 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.

Blue Cross Blue Shield Organizations by Medical Enrollment and National Market Share

BCBS Licensee	Total Medical Enrollment	BCBS Market Share	National Market Share
Anthem, Inc.	34,982,000	32.55%	10.32%
Arkansas BlueCross BlueShield	693,604	0.65%	0.20%
Blue Cross & Blue Shield of Mississippi	603,191	0.56%	0.18%
Blue Cross & Blue Shield of Rhode Island	406,807	0.38%	0.12%
Blue Cross and Blue Shield of Alabama	2,878,141	2.68%	0.85%
Blue Cross and Blue Shield of Florida, Inc.	3,638,841	3.39%	1.07%
Blue Cross and Blue Shield of Illinois	8,199,314	7.63%	2.42%
Blue Cross and Blue Shield of Kansas	685,374	0.64%	0.20%
Blue Cross and Blue Shield of Kansas City	733,369	0.68%	0.22%
Blue Cross and Blue Shield of Louisiana	1,533,206	1.43%	0.45%
Blue Cross and Blue Shield of Montana	293,291	0.27%	0.09%
Blue Cross and Blue Shield of Nebraska	707,794	0.66%	0.21%
Blue Cross and Blue Shield of New Mexico	458,549	0.43%	0.14%
Blue Cross and Blue Shield of North Carolina	2,526,856	2.35%	0.75%
Blue Cross and Blue Shield of Oklahoma	816,591	0.76%	0.24%
Blue Cross and Blue Shield of Texas	4,626,390	4.31%	1.37%
Blue Cross and Blue Shield of Vermont	215,109	0.20%	0.06%
Blue Cross and Blue Shield of Wyoming	105,969	0.10%	0.03%
Blue Cross Blue Shield of Arizona	772,025	0.72%	0.23%
Blue Cross Blue Shield of Massachusetts	2,880,279	2.68%	0.85%
Blue Cross Blue Shield of Michigan	4,386,563	4.08%	1.29%
Blue Cross Blue Shield of Minnesota	2,647,023	2.46%	0.78%
Blue Cross Blue Shield of North Dakota	362,666	0.34%	0.11%
Blue Cross of Idaho Health Service, Inc.	510,759	0.48%	0.15%
Blue Shield of California	3,925,603	3.65%	1.16%
BlueCross BlueShield of South Carolina	815,264	0.76%	0.24%
BlueCross BlueShield of Tennessee	3,372,672	3.14%	1.00%
BlueCross BlueShield of Western New York and BlueShield of Northeastern New York	556,379	0.52%	0.16%
Capital BlueCross	767,070	0.71%	0.23%
Capital Health Plan, Inc.	134,850	0.13%	0.04%
CareFirst BlueCross BlueShield	3,232,635	3.01%	0.95%
Excellus BlueCross BlueShield	1,402,281	1.30%	0.41%
Hawaii Medical Service Association	734,075	0.68%	0.22%
Highmark Health	4,130,255	3.84%	1.22%
Horizon Blue Cross Blue Shield	3,824,479	3.56%	1.13%
Independence Blue Cross (IBC)	1,805,971	1.68%	0.53%
Premera Blue Cross	2,083,013	1.94%	0.61%
Regence BlueCross BlueShield of Oregon	755,691	0.70%	0.22%
Regence BlueCross BlueShield of Utah	490,277	0.46%	0.14%
Regence BlueShield	1,037,193	0.97%	0.31%
Regence BlueShield of Idaho	140,085	0.13%	0.04%
Triple-S Management Corporation	1,026,788	0.96%	0.30%
Wellmark Blue Cross and Blue Shield of Iowa	1,258,371	1.17%	0.37%
Wellmark Blue Cross and Blue Shield of South Dakota	306,589	0.29%	0.09%

SOURCE/METHODOLOGY: *AIS's Directory of Health Plans: 2017*. Visit https://aishealthdata.com/dhp for more information, or contact Sales@AISHealth.com to order.

The AIS Report on Blue Cross and Blue Shield Plans — a monthly update for *Health Plan Week* 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.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)