

# HEALTH PLAN WEEK

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

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## With Premiums, Executive Pay and Scrutiny Rising, Insurers Must Demonstrate Value

With the possible exception of British Petroleum, few companies are under greater scrutiny from Congress, the White House and the general public than health insurers.

And with executive compensation levels and premiums both on the rise, health insurers will face continued backlash if they are unable to demonstrate the value that they bring members, employers, providers and communities, industry observers tell *HPW*.

In 2009, former CIGNA Corp. President and CEO H. Edward Hanway took home more than \$18 million in compensation (see table, p. 6) and left the company with a retirement package worth more than \$100 million. Hanway, who retired in December, was the highest paid executive among publicly traded health insurance companies in 2009, according to proxy statements filed with the Securities & Exchange Commission (SEC).

Among health plan CEOs, UnitedHealth Group's Stephen Hemsley saw the biggest year-to-year bump in compensation, from \$3.2 million in 2008 to more than \$8.9 million in 2009. Much of the increase was due to stock option awards. While Aetna Inc. Chairman and CEO Ronald Williams was the second highest paid health plan executive last year, his \$18 million in compensation fell substantially from the \$24 million he received in 2008.

*continued on p. 6*

## New Insurance Products Target Rate Hikes, Incentives to Improve Employee Health

Making premiums more affordable for employers and arming them with tools to improve the health of their employees are two of the most common features being included in new insurance products, according to several health plans queried by *HPW*.

Michigan-based Health Alliance Plan (HAP), for example, says it will launch a new "minimum premium" product in June. The product will be marketed to employers with 100 or more employees.

Rather than pay a flat premium each month, employers will receive a monthly bill that breaks down the components of the premium (e.g., administrative fees, stop-loss coverage and reserve funding). In addition, employers will receive weekly statements detailing their claims. That level of transparency, HAP hopes, will give employers a financial incentive to keep claims costs low by improving the health of employees.

The employer's claims "are not pooled with everyone else's claims, so they will be paying just for their own claims experience," explains Mark Hall, vice president of sales. "This really opens up the package and allows [employers] to see what goes into premiums. It looks like self funding, it operates a lot like self funding, but it's not self funding. Rather, it's a fully insured product with a cap on what [the employer] pays each month and annually." The rates are capped at 120% of each employer's claims projection. Hall says the product can work with any PPO or EPO (i.e., Exclusive Provider Organization) that the company sells.

The company has just begun to train its sales representatives on the new product and will formally introduce it to its agent network late this month. Conservatively,

Hall estimates between five and 10 employer clients will select the new option before the end of the year.

On the individual side, HAP last month partnered with Delta Dental of Michigan to make dental coverage available to people enrolled in its SOLO line of individual products. Delta already provides coverage to 5,000 members enrolled in HAP's Medicare Advantage plans. Cost of the coverage ranges from \$17 to \$35 per month. All plans include first-dollar preventive coverage and have a \$50 deductible on Class II and III benefits, such as oral surgery, root canals, crowns and bridges.

### Geisinger Takes 'Smart Steps'

Geisinger Health Plan's (GHP) Smart Steps program is a dual-benefit-level PPO that allows members to lower their out-of-pocket costs by maintaining a healthy lifestyle or by improving their health. GHP is part of Geisinger Health System, which includes three hospitals and a 740-member group practice.

"Employers realize that if they want to control costs long term, they need wellness...If there is a wellness program that gets employees engaged, then they are interested," says Joe Haddock, vice president of sales at GHP.

To qualify for the lower out-of-pocket costs, employees and their covered spouses must agree to a health screening. Participants who don't use tobacco and meet or exceed targets in four out of five areas (i.e., body mass index (BMI) of 30 or lower, blood pressure below 140/90) are enrolled in the "low cost-sharing" benefit. That plan design, for example, might have a \$500 annual deductible for in-network services, while the "high cost-sharing" benefit might have a \$1,000 deductible. Copayments are also lower. Employees who don't meet the goals can qualify if they agree to work with a health coach and take "smart steps" to improve over six months.

The model is labor-intensive, and members of GHP's wellness staff need to be on site to help employees understand it, says GHP spokesperson Lisa Hartman.

The program is being piloted with two employers (40 and 80 workers), but Haddock says it likely will appeal more to larger employers. The company intends to begin marketing the program in September or earlier and expects to add between 5,000 and 10,000 lives by the end of the year. GHP has about 227,000 members.

Geisinger says it also is expanding its on-site employer clinics. Geisinger's first CareWorks clinic opened in October 2009 at a regional distribution center for hardware chain Lowe's Companies, Inc. The clinic, which is staffed by a full-time physician assistant, offers free health care services to the distribution site's 800 employees. A second on-site clinic opened in March, and more are expected to open this year, says Dean Lin, CEO of CareWorks Clinics. Geisinger says it is targeting employers with 500 or more employees. The goal is to improve access to providers while reducing absenteeism and presenteeism. "Our twist on this is to manage the [employee] population by taking the primary care piece of this and work hand in hand with the health plan, which are both part of [Geisinger's] integrated system," says Haddock. The onsite clinics are an expansion of the retail clinics CareWorks operates inside five supermarkets owned by Weis Markets, a mid-Atlantic grocery chain.

### MVP Launches Hospital-Only Plan

Schenectady, N.Y.-based MVP Health Care says it has developed two low-cost products for its individual market. The MVP Basic Hospital plan covers charges for inpatient and outpatient services but doesn't cover services obtained in a physician's office. The limited coverage helps keep premiums as low as possible, says spokesperson Gary Hughes. The second plan, MVP Ba-

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sic Hospital Plus, has a higher premium but does cover physician services as well as certain technical services provided in locations other than a hospital. Hughes says the new products might be an attractive option for new graduates and pre-Medicare retirees. Both plans can be purchased for families, and both plans cover maternity care.

MVP also says it is simplifying its account-based consumer-directed health plans. The key to this simplification is a web-based tool that helps members make better decisions about using their health account dollars, Hughes says. Through a web portal, members can access their plan benefits, medical claims and health account transactions. The company also is developing new decision-support tools to help members estimate the cost of care.

### Wellness Program Aimed at Small Firms

Recently passed legislation in Colorado allows health insurers to offer discounts and financial incentives to members who meet or exceed certain biometric targets (e.g., blood pressure, BMI and tobacco use). In response to the new law, Rocky Mountain Health Plan (RMHP) says it is launching a product that will incorporate wellness-based incentives. The measures are similar to those used by Geisinger.

The yet-to-be-named product, which RMHP hopes to make available in October, will be aimed at employers with 50 or fewer employees. Neil Waldron, RMHP's chief marketing officer, anticipates enrollment of about 2,000 in the first year.

"Wellness has not really been a focus, or even available to, smaller employers...primarily because their [claims costs] are pooled with other employers," he says.

Like Geisinger's model, RMHP's new product will include two deductible levels. Employees who have healthy biometric scores will qualify for the low-deductible plan. The employer, however, won't know which employees are enrolled in that plan.

### Medica to Highlight Provider Data

Medica says it will publish cost and quality information about physicians, clinics and hospitals later this year. Spokesperson Greg Bury says Medica will be the first Minnesota-based health plan to offer customers "a broad national network where individual physicians are tiered based on quality and cost efficiency." Physicians in 22 specialties, including family practice, OB/GYN, orthopedic surgery, cardiac surgery and neurosurgery, will receive a designation based on their care patterns as compared to evidence-based quality and cost benchmarks. Quality measures are based on care variations such as lower complication rates and fewer

"re-do" procedures. Only physicians who receive a quality designation are analyzed for cost efficiency. One star will be awarded to providers who meet national quality benchmarks. Once a quality star is given, providers are further evaluated on their cost efficiency, Bury explains. Members will have access to the "Premium Designation" ratings through Medica's online provider directory.

Medica already offers its members an online tool, dubbed Main Street Medica ([www.MainStreetMedica.com](http://www.MainStreetMedica.com)), which details cost information for a variety of procedures and conditions at hundreds of clinics and facilities. Consumers also can view quality information

### HSA Enrollment Reaches 10 Million Mark

Slightly more than 10 million lives are now enrolled in a health plan that can be paired with a health savings account (HSA), according to a survey of health plans conducted by the trade association America's Health Insurance Plans. Nearly 100 health plans and their subsidiaries provided data for the survey. The enrollment figure is up 25% from a year ago. Health plans estimate that between 60% and 65% of people who are eligible to open an HSA actually do so.

A provision included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 gave birth to HSAs on Jan. 1, 2004. Health reimbursement arrangements (HRAs) were approved in guidance issued by the IRS in June 2002.

Virtually every health insurer now offers at least one product that is compatible with an HSA. According to AHIP, enrollment in the large-group market increased 33% between January 2009 and January 2010. About half of those enrolled in an HSA-qualified plan are in the small-group market. Enrollment on the small-group side jumped 22% during the same period. In the individual market, 2.1 million lives were covered by an HSA-qualified plan.

According to data compiled by HPW in March, UnitedHealth Group is the largest seller of account-based health plans. The company says 3.4 million of its members are enrolled in either an HSA-qualified plan or in a plan that is paired with an HRA (HPW 3/15/10, p. 4).

To see the full report and slides, visit [www.ahipresearch.org/pdfs/hsa2010.pdf](http://www.ahipresearch.org/pdfs/hsa2010.pdf).

for clinics and facilities pertaining to some specific conditions, Bury says.

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## Mass. Plans Report Losses, Say Rate Cap Will Add to Problems

The major health plans that serve the Massachusetts Connector insurance exchange reported net losses in their first-quarter 2010 financial reports. The information comes as the insurers are fighting a cap on premium rates imposed by the state in April (*HPW 4/12/10, p. 1*).

◆ *Harvard Pilgrim Health Care, Inc.* posted a \$27 million first-quarter net loss and a \$28.6 million operating loss. The health plan blamed the loss on “external factors” rather than on the “company’s performance,” and added that the Massachusetts Division of Insurance’s (DOI) premium rate decision contributed \$21 million of that first-quarter loss. “If the state’s mandate to use inadequate rates for the remainder of 2010 continues, Harvard Pilgrim’s financial losses will deepen,” it warned. The health plan had 1.12 million members on March 31, 2010.

◆ *Blue Cross and Blue Shield of Massachusetts* reported a first-quarter net loss of \$65.2 million. The insurer said \$55 million of the loss “is a required accounting treat-

ment” reflecting the “inadequate” individual and small-group rates “being charged for coverage effective in April, May and June 2010.” The insurer emphasized that it is not “reporting any anticipatory losses,” however. The insurer had 2.92 million members on March 31.

◆ *Tufts Health Plan* reported a \$51.9 million net loss and a \$59 million operating loss for the first quarter. It chalked up \$40 million of the net loss to the state insurance division’s premium rate decision. “The effect of an unbalanced rate regulation is a significant and unsustainable drain on our financial resources,” Tufts warned. Membership stood at 739,000 on March 31.

◆ *Fallon Community Health Plan* posted a net loss of \$8.5 million and an operating loss of \$10.8 million for the first quarter. The insurer, which has suffered losses over the past year, said it had anticipated a “return to profitability, but may now need to reassess the timeline depending on the outcome of its appeal” of the insurance division’s rate decision. Fallon had 224,000 members on March 31.

With small businesses facing double-digit rate increases, Gov. Deval Patrick (D) implemented new rules in February requiring health plans to seek approval for rate increases (*HPW 2/15/10, p. 1*). He instructed the DOI to implement temporary rules to put a hold on annual rate hikes. On April 1, DOI “disapproved” 235 out of 274 increases submitted by insurers. Several of the plans tried to fight the decision in court, but on April 12 a judge rejected their request to temporarily raise rates.

## How to Integrate FDA Risk Evaluation and Mitigation Strategy Requirements Into Formulary Management

- How can plans ensure that members have appropriate access to limited-distribution drugs under REMS programs?
- What steps should health plans and specialty pharmacies take to integrate REMS programs into their utilization management programs?
- How can the various stakeholders make sure they comply with patient privacy laws that could be compromised under REMS programs?
- What approach is needed when the FDA requires a REMS program for a drug that is already on the market?
- How can specialty pharmacies and PBMs leverage outcomes data from REMS efforts?

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"Today's financial filings demonstrate the impact of the actions taken [by the state] to artificially cap insurance rates at levels insufficient to cover medical costs," Lora Pellegrini, president of the Massachusetts Assn. of Health Plans (MAHP), said in a prepared statement. MAHP contends that prices providers are charging are fueling rising medical costs.

"I certainly would expect that after not getting the rate increases that are necessary, they would have to put up losses for the current period and premium deficiency reserves as well [i.e., preparing for what they know will be inadequate rates in future periods]," Standard & Poor's analyst Shellie Stoddard tells *HPW*.

Time will tell if the reported losses make state officials rethink the premium cap. "The insurance regulators oversee insurance solvency to the extent that these losses diminish capital and put [insurers] at risk of insolvency.... There would be some measures for the state to step in," Stoddard explains. For example, when insurers were unable to achieve rate increases in Rhode Island, the two sides "were able to achieve some level of rate increase to kind of balance those two issues — keeping premiums affordable and keeping insurers in a good financial position," she says.

Contact Harvard Pilgrim spokesperson Sharon Torgerson at [sharon\\_torgerson@hphc.org](mailto:sharon_torgerson@hphc.org), Massachusetts Blues spokesperson Tara Murray at [tara.murray@bcbsma.com](mailto:tara.murray@bcbsma.com) or Fallon spokesperson Lauren Petit at [lauren.petit@fchp.org](mailto:lauren.petit@fchp.org). Contact Stoddard at [shellie\\_stoddard@standardandpoors.com](mailto:shellie_stoddard@standardandpoors.com). ✧

## House Bill Seeks to Improve Transparency Among PBMs

A transparency bill introduced this month in the U.S. House of Representatives would be good news for retail pharmacies, but could make it difficult for pharmacy benefit managers to mandate mail-order prescriptions if the PBM has an ownership interest in such a pharmacy.

The PBM Audit Reform and Transparency Act of 2010 (H.R. 5234), introduced by Rep. Anthony Weiner (D-N.Y.) May 6, aims to limit conflicts of interest, put restrictions on pharmacy auditing practices and require greater PBM disclosure with patients and plan sponsors.

If enacted, the legislation would require PBMs to disclose the total cost of prescriptions filled at mail and retail in an annual report to plan sponsors. This would include the overall percentage of generics dispensed at mail and retail, and the percentage and number of cases in which patients were switched to a more costly drug. The bill also would prevent PBMs from mandating or even encouraging patients to use a specific pharmacy

channel — such as mail, retail or specialty — if the PBM has an ownership interest in that pharmacy.

In addition, PBMs would have to follow prompt-pay provisions that are consistent with the 14-day turnaround required of Medicare Part D plans and disclose the "methodology and resources" that they use to determine reimbursement — including to calculate their maximum allowable cost (MAC) list. MAC lists and reimbursement benchmarks would have to be updated at least once per week.

The bill is popular among independent pharmacists, who would benefit from more restrictions on audits. For example, the bill would require PBMs to give pharmacies a 15-day prior notice of audits, offer a written appeals process and limit the audit period to one year. The National Community Pharmacists Association (NCPA), which is championing the bill, says the measure will rein in what it believes are "dubious and opaque PBM practices" that help the companies profit at the expense of patients, plans and local pharmacies.

### Bill Would 'Fix Broken System'

"If this bill is enacted, PBMs would find it much harder to pad profits through hidden costs, to steer patients away from their pharmacy of choice and towards PBM mail-order pharmacies and to punitively audit pharmacies," NCPA President Joseph H. Harmison says in a statement. "Ultimately, this proposal's about fixing the complex, broken system that PBMs have put in place to make billions of dollars while leaving patients and health plan sponsors paying the bill and scratching their heads."

The Pharmaceutical Care Management Association (PCMA), on the other hand, contends that H.R. 5234 is merely an attempt by the independent drugstore lobby to limit fraud-detection efforts. "Unfortunately, the independent drugstore lobby continues to push an agenda that increases prescription drug costs for consumers and payers and limits efforts to root out fraud, waste, and abuse," PCMA says in a statement.

Former FTC attorney David Balto, now an antitrust lawyer and senior fellow at the liberal think tank Center for American Progress, anticipates the bill "will have a lot of movement behind it," as Congress seems determined to push strict transparency requirements for PBMs. "These companies make a tremendous amount of money out of the pockets of plan sponsors through an opaque and complex process," he tells *HPW*'s sister publication *Drug Benefit News*. "The more transparency, the better the market will work — it's the fundamental principle of a free market system."

*continued*

Contact NCPA spokesperson John Norton at (703) 600-1174, PCMA spokesperson Charles Coté at (202) 207-3605 and Balto at david.balto@yahoo.com. ♦

*This article was excerpted from the May 13 issue of HPW's sister publication Drug Benefit News. For more information or to order the newsletter, visit the MarketPlace at www.AISHealth.com.*

## Health Plans Must Promote Value

*continued from p. 1*

But executive compensation levels — justified or not — have little to do with the cost of health coverage. For most health plans, slicing in half executive compensation would have virtually no impact on medical loss ratios or profit margins, notes Carlton Doty, vice president and research director at Forrester Research.

“There is so much that is wrong with the health care system overall that debating the merits of executive compensation levels seems very trivial and counterproductive,” he says. “For some reason, wealth equates to evil for some. In my opinion, this shouldn’t even be an issue.”

Criticisms about executive compensation are “a red herring” in the debate over rising coverage costs, adds Fred Karutz, general manager of health plan solutions at Silverlink Communications and a former executive with Blues plan operator Health Care Service Corp. “The question is how well have they led their organizations to produce value for the customer, their providers and the communities they serve?” But health plans, he adds, often are not as effective as they could be in demonstrating value. “Telling your story — especially to consumers — needs to be proactive.”

Health insurers sometimes are more reactive than proactive. *Case in point:* In a May 9 letter to President Obama, WellPoint Inc. CEO Angela Braly said that her company spent nearly \$2 billion in 2009 to treat about 200,000 women who had been diagnosed with breast cancer. Braly also cited her company’s early cancer screening initiatives. The letter, however, was in response to a recent radio address during which the president cited a newspaper article that claimed WellPoint had cancelled policies for several women diagnosed with breast cancer.

But it might be too late to repair their brand image, says Joseph Paduda, principal at the consulting firm Health Strategy Associates, LLC. Most health plans have neglected “the care and feeding of their image” and have failed to understand how their actions impact the public’s perception of their company and its products, he says.

“As a result, instead of talking about their compensation in the context of how their efforts have helped

[thousands of] members beat cancer, deliver thousands of healthy babies and reduce the impact of diabetes,... they’re going to have to explain why they get paid so much to ration care,” he tells HPW.

A deductibility provision in the health reform law, however, could be a first step in forcing health insurers to rein in executive compensation levels, says Sam Pizzigati, associate fellow at the Washington, D.C.-based Institute for Policy Studies.

“What the deductibility limit does is advance a principal that I think is core to health reform and that is that

<b>Total Compensation for Health Plan CEOs in 2009</b>		
<b>Company</b>	<b>Name/Title</b>	<b>Total Annual Compensation</b>
Aetna Inc.	<b>Ronald Williams</b> , Chairman/CEO	<b>2009: \$18,058,162</b> 2008: \$24,300,112
AMERIGROUP Corp.	<b>James Carlson</b> , President/CEO	<b>2009: \$5,232,249</b> 2008: \$7,081,273
Assurant, Inc.	<b>Robert Pollack</b> , President/CEO	<b>2009: \$6,444,198</b> 2008: \$7,950,668
Centene Corp.	<b>Michael Neidorff</b> , Chairman/President/CEO	<b>2009: \$6,077,900</b> 2008: \$4,359,365
CIGNA Corp.	<b>David Cordani</b> , President/CEO (former Chief Operating Officer, appointed CEO December 2009)	<b>2009: \$6,593,921</b> 2008: \$7,113,945
	<b>H. Edward Hanway</b> (retired as CEO December 2009)	<b>2009: \$18,818,467</b> 2008: \$12,236,542
Coventry Health Care, Inc.	<b>Allen Wise</b> , Chairman/CEO	<b>2009: \$17,427,789</b> 2008: N/A (previously retired)
	<b>Dale Wolf</b> , CEO (resigned January 2009)	<b>2009: \$8,225,991</b> 2008: \$11,018,797
Health Net, Inc.	<b>Jay Gellert</b> , President/CEO	<b>2009: \$3,643,342</b> 2008: \$8,840,792
HealthSpring, Inc.	<b>Herbert Fritch</b> , Chairman/CEO	<b>2009: \$3,966,635</b> 2008: \$2,629,833
Humana Inc.	<b>Michael McCallister</b> , President/CEO	<b>2009: \$6,509,452</b> 2008: \$5,185,414
Molina Healthcare, Inc.	<b>J. Mario Molina</b> , President/CEO	<b>2009: \$1,866,260</b> 2008: \$2,217,645
Triple-S Management Corp.	<b>Ramon M. Ruiz-Comas</b> , President/CEO	<b>2009: \$1,318,431</b> 2008: \$1,204,227
UnitedHealth Group	<b>Stephen Hemsley</b> , President/CEO	<b>2009: \$8,901,916</b> 2008: \$3,241,042
WellCare Health Plans, Inc.	<b>Charles Berg</b> , Executive Chairman	<b>2009: \$5,074,900</b> 2008: \$14,737,758
WellPoint, Inc.	<b>Angela Braly</b> , President/CEO	<b>2009: \$13,108,198</b> 2008: \$9,844,212
SOURCE AND METHODOLOGY: Total compensation is derived from company proxy statements and includes base salary, bonuses, stock awards, options/SAR awards, non-equity incentive plan compensation, non-qualified deferred compensation earnings and all other compensation. Compiled by AIS in May 2010.		

tax dollars should not support excessive executive pay," he tells *HPW*. While the provision doesn't directly impact executive compensation, it could open the door to new rules. Health insurers, for example, might not be allowed to participate in an insurance exchange if their executives earn more than 25 times their lowest-paid workers.

"If I were a health insurer, I would be worried about what is coming down the road. As a reformer, I hope that

health plans will reconsider their corporate compensation strategies and bring them in line with what they were several decades ago...when there was less of a gap between executives and their lowest-paid employees."

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## Health Plan Executives' Pay in 2009 (ranked by salary to top-paid executive)

Company	Name/Title	Annual Salary	Stock Awards <sup>1</sup>	Option Awards <sup>1</sup>	Bonus <sup>2</sup>	Other Annual Compensation
Aetna Inc.	<b>Ronald Williams</b> , Chairman/CEO	\$1,095,785	\$4,300,011	\$9,887,895	\$900,000	\$208,659
	<b>Mark Bertolini</b> , President	\$932,414	\$7,150,030	\$3,806,838	\$612,114	\$71,692
AMERIGROUP Corp.	<b>James Carlson</b> , President/CEO	\$775,000	\$1,123,760	\$2,178,295	\$1,140,625	\$14,569
	<b>Richard C. Zoretic</b> , Chief Operating Officer (COO)	\$312,500	\$300,000	\$723,603	\$479,167	\$12,461
Assurant, Inc.	<b>Robert Pollack</b> , President/CEO	\$950,000	\$2,382,618	\$0	\$1,083,000	\$218,248
	<b>Michael J. Peninger</b> , Executive Vice President (EVP) and Chief Financial Officer (CFO)	\$500,000	\$752,391	\$0	\$804,000	\$228,301
Centene Corp.	<b>Michael Neidorff</b> , Chairman/President/CEO	\$1,000,000	\$2,878,500	\$0	\$1,750,000	\$449,400
	<b>William Scheffel</b> , EVP, Specialty Business Unit	\$595,000	\$474,500	\$391,044	\$575,000	\$32,850
CIGNA Corp.	<b>David Cordani</b> , President/CEO, former COO	\$750,961	\$0	\$811,275	\$4,948,750	\$6,593,921
	<b>Carol Ann Petren</b> , EVP/General Counsel	\$565,000	\$1,500,009	\$263,261	\$1,880,000	\$7,482
Coventry Health Care, Inc.	<b>Allen Wise</b> , Chairman/CEO	\$584,243	\$4,296,000	\$7,225,500	\$5,250,000	\$72,046
	<b>Shawn M. Guertin</b> , former EVP/CFO/Treasurer	\$594,000	\$542,100	\$1,427,364	\$0	\$2,260,051
Health Net, Inc.	<b>Jay Gellert</b> , President/CEO	\$1,200,000	\$0	\$0	\$1,587,000	\$88,395
	<b>James Woys</b> , EVP/COO	\$700,000	\$1,359,128	\$0	\$686,000	\$21,800
HealthSpring, Inc.	<b>Herbert Fritch</b> , Chairman/CEO	\$800,000	\$1,600,000	\$0	\$1,558,060	\$8,575
	<b>Michael Mirt</b> , President/COO	\$479,167	\$825,000	\$151,600	\$0	\$131,929
Humana Inc.	<b>Michael McCallister</b> , President/CEO	\$1,025,000	\$0	\$3,393,474	\$1,793,750	\$297,228
	<b>James Murray</b> , COO	\$670,000	\$0	\$1,502,824	\$837,500	\$125,466
Molina Healthcare, Inc.	<b>J. Mario Molina</b> , President/CEO	\$850,000	\$292,188	\$0	\$0	\$12,962
	<b>John Molina</b> , CFO	\$775,000	\$292,188	\$0	\$0	\$59,353
Triple-S Management Corp.	<b>Ramon M. Ruiz-Comas</b> , President/CEO	\$582,809	\$0	\$0	\$165,000	\$104,102
	<b>Socorro Rivas-Rodriguez</b> , President, Triple-S, Inc.	\$425,000	\$0	\$0	\$290,000	\$69,545
UnitedHealth Group	<b>Stephen Hemsley</b> , President/CEO	\$1,300,000	\$4,122,694	\$1,442,306	\$1,950,000	\$86,916
	<b>George Mikan, III</b> , EVP/CFO	\$700,000	\$2,748,471	\$746,605	\$1,240,000	\$321,314
WellCare Health Plans, Inc.	<b>Charles Berg</b> , Executive Chairman	\$591,346	\$2,985,000	\$719,825	\$750,000	\$28,729
	<b>Alec Cunningham</b> , CEO <sup>3</sup>	\$341,538	\$839,076	\$0	\$744,050	\$1,212
WellPoint, Inc.	<b>Angela Braly</b> , President/CEO	\$1,144,000	\$6,200,028	\$3,973,688	\$1,487,086	\$292,036
	<b>Wayne S. DeVeydt</b> , EVP/CFO	\$700,000	\$4,666,674	\$1,068,702	\$728,702	\$82,757

### Editor's note:

\*The table includes both the top-ranked executive and the second-highest paid health plan executive for each company, on the basis of salary. Changes in pension value and nonqualified deferred compensation earnings are not included.

1. Reflects the company's estimated fair value related to stock and options granted in 2008 and prior years.

2. Includes non-equity incentive plan compensation.

3. Alec Cunningham was named WellCare CEO on Dec. 28, 2009.

SOURCE AND METHODOLOGY: Compiled by Atlantic Information Services, Inc. from company proxy statements, May 2010

## HEALTH PLAN BRIEFS

◆ **At WellPoint Inc.'s May 18 annual shareholder meeting, CEO Angela Braly faced some very tough questions and criticism over the insurer's recent negative press.** At the meeting, she tried to suppress shareholder concerns about WellPoint's public feud with the Obama administration over its pricing practices and allegations that it dropped coverage for members with breast cancer, according to a news report. Braly told shareholders and critics that several factors cause premium increases, including the rising cost of care and the health of people in an insurer's risk pool. Shareholders at the meeting also voted on a resolution giving them an advisory vote on executive pay; however, final approval on the pay remains with the board, which Braly chairs. According to SEC filings, Braly made \$13.1 million in 2009, up from \$8.7 million in 2008 (see table, p. 6). Contention between the company and its shareholders continued until the meeting abruptly ended when William Bush, the brother of former President H.W. Bush and a member of WellPoint's board of directors, collapsed. Visit [www.wellpoint.com](http://www.wellpoint.com).

◆ **The National Association of Insurance Commissioners (NAIC) says it will meet the June 1 deadline to provide HHS with recommendations for calculating health plan minimum loss ratios (MLRs), but will not include the final definitions and calculation methodologies.** The reform law requires that NAIC provide HHS with recommendations for those methodologies by Dec. 31. A spokesperson for the association tells *HPW* that the finalized recommendations will be submitted well before the Dec. 31 deadline, but says no date has been set. The MLR requirements for commercial insurers take effect in 2011, but the final MLR regulations might not be out until this fall. Health plans will be required to meet an 80% minimum MLR standard for individual and small-group plans and 85% for large groups. Visit [www.naic.org](http://www.naic.org).

◆ **Aetna Inc. said May 19 that Innovent Oncology, a subsidiary of US Oncology, will deliver cancer care programs for the insurer's members and participating oncologists.** The program expands the use of evidence-based guidelines and nurse support to deliver cancer care aimed at helping patients fight cancer "with fewer side effects, less time in treatment and less financial strain," Aetna said. A recent study by Aetna and US Oncology found that evidence-

based care for patients with non-small cell lung cancer resulted in equivalent health outcomes and a 35% cost savings (*HPW* 2/1/10, p. 4). Aetna said it expects to achieve similar results in the treatment of 14 of the most commonly diagnosed cancers, including colorectal cancer and breast cancer. Visit [www.aetna.com](http://www.aetna.com) or [www.usoncology.com](http://www.usoncology.com).

◆ **Bravo Health said the Texas Health and Human Services Commission awarded it a contract to provide managed care services for STAR+PLUS members in the Tarrant Service Area.** Under the STAR+PLUS program, Bravo Health will provide health and long-term services to aged, blind and disabled Medicaid patients, allowing them "to achieve improved health and wellness access, quality, and outcomes at home or in assisted living facilities." The Tarrant Service Area includes Denton, Hood, Johnson, Parker, Tarrant and Wise counties. Financial details of the contract were not disclosed. Visit [www.bravohealth.com](http://www.bravohealth.com).

◆ **Universal Health Services Inc. (UHS) signed a definitive agreement on May 17 to purchase behavioral health provider Psychiatric Solutions Inc. for \$3.1 billion.** The deal is made up of \$2 billion in cash and \$1.1 billion in net debt. According to UHS, the acquisition will give it \$7 billion in combined pro-forma revenues and \$1.1 billion in combined 2009 earnings before interest, taxes, depreciation and amortization. On a combined basis, the company in 2009 had approximately 6.2 million patient days in 221 health care facilities across 37 states and territories, the hospital operator said. Visit [www.uhsinc.com](http://www.uhsinc.com).

◆ **Children were the leading growth demographic last year in prescription spending for one pharmacy benefit manager, with an increase of nearly four times higher than the overall population,** according to Medco Health Solutions, Inc.'s 2010 *Drug Trend Report*. In 2009, drug trend for children — a measure of prescription spending growth — increased 10.8%, driven by a 5% increase in drug utilization and higher medication costs, the report found. A corresponding analysis of pediatric medication use found that in 2009, more than one in four insured children in the U.S. and nearly 30% of adolescents aged 10 to 19 took at least one prescription drug to treat a chronic condition. Visit [www.medcohealth.com](http://www.medcohealth.com).

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