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Health Plan Week

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

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Wal-Mart Bucks Trend in Declaring Jump in Insurance Uptake; Most See Flat Response

When Wal-Mart Stores, Inc. informed investors on Aug. 14 that it expects to take a $500 million hit in 2014 from an unexpected rise in the number of its own employees buying company health insurance, the news was taken with surprise by analysts who have seen no such trend in the general employer benefits segment. In fact, researchers at Mercer say their data show employees have not shifted in great numbers to employer plans from 2013 to 2014. This is a surprise of its own because of sentiment that the reform law's individual mandate would likely spur more individuals to take advantage of employer offerings and avoid being penalized.

"We were surprised [by the research]. We thought when the provision went into effect, we would see a big jump," Beth Umland, Mercer's director of employer research for health and benefits, tells *HPW*. Another possibility at work is that employers are tracking hours worked a lot more closely these days to keep part-time workers part time and full-time workers full time, she says. "This is all about managing employees better. If they are supposed to be working 25 hours per week and end up working 31," that has an impact on their insurance status under the Affordable Care Act since part-time workers under 30 hours do not have to be offered coverage, Umland adds.

Another factor is that some workers just don't take health benefits, period. "There is always going to be a percentage of employees who will opt out for whatever reason. The typical opt-out rate is 15% and that is typically people who have coverage elsewhere, through their spouse, through their parents. So they don't need their employer's coverage because they have other coverage," Tracy Watts, senior partner and national health care reform leader at benefits consulting firm Mercer, tells *HPW*. "It is possible that some go without coverage because of financial reasons or they think they don't

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Health Plans Monitor What Works in Mobile App Space as Aetna Passes on CarePass

Despite health insurers touting how they have become more digital in their consumer outreach and wellness efforts, not all such programs work. A case in point is Aetna Inc.'s recent decision to shut down its CarePass personal health platform by the end of this year. The company calls the move part of a learning experience as it and other carriers try to untangle the age-old riddle of how to motivate positive consumer behavior, albeit these days through the use of high-tech mobile apps, incentivized computer games, wearable tracking gadgets and Web portals.

Industry consultants say insurers need to be on top of the digital business, since the space is important to employer clients who want attractive wellness and other engagement offerings for employees like for administrative or team-building experiences. The tools also promise a return on investment (ROI) in the form of healthier members, who have a better chance of dodging costly chronic diseases by using apps and other programs to undertake and sustain weight loss, smoking cessation and a more active lifestyle.

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Examples of this were apparent with the CarePass model, which worked with popular wearable tracking devices developed by San Francisco-based Fitbit Inc. to sync and record exercise and sleep patterns. CarePass also interfaces with scores of other apps, like LoseIt, RunKeeper, Fooducate and GoodRx, creating a virtual smorgasbord of tools to help Aetna members in their individual daily exercise and health programs. Aetna tried to attract members to this broader idea of a "personal health cloud," promising a storage vessel allowing the movement of health-related data between CarePass-enabled apps *(HPW 7/30/12, p. 1)*.

But what may come to be successful in the future may not work today. As one leading consultant says, "There is a growing level of skepticism about the efficacy of tools to improve behavior. And as a friend of mine at a major carrier says, 'behavior improvement is not rocket science, it is much more difficult.' And it's true. What's going to motivate you or what's going to motivate me are likely different things," Jay Savan, a partner at Mercer LLC, a unit of Marsh & McLennan Companies, tells *HPW*. "Similar people have much different health needs."

He calls the apps and other tools focused on improving healthy behavior "somewhat monolithic…and when they presume a monolithic nature among particular demographics like 'all employees of Mercer who are 40 to 45 and male and living in the three double seven ZIP code must act this way,' that is folly." The skepticism about the ability to measure and track ROI from the marketing of devices, tools and communications to members is real, and behavior change may only work in certain cases. "Unless those tools are tied directly, very linearly to an economic consequence or some other likewise consequence for the participant, then generally speaking you are not going to get sustained, adjusted behavior," Savan says. An example would be members getting a cheaper premium if they maintain weight loss. "Aetna's decision is not necessarily a trend, but it is going to be something we won't see the last of," he adds.

Costs Rule the Roost for Carriers

In a bottom-line business, the issue of apps, mobile platforms and tech wizardry is really about costs, stresses Steve Zaharuk, senior vice president for Moody's Investors Service in New York. He tells *HPW* that this overarching health industry concern about costs, particularly medical claims, is at the root of the push for digital success in wellness and engagement programs. "Reducing costs helps the bottom line and it helps the top line as well. And it attracts more sophisticated buyers like employers," Zaharuk says.

Even if there is skepticism about the ROI on these apps and device tie-ins, insurers see the process of finding what works as a win-win effort. "They've been experimenting with a lot of these programs. There have always been these programs that measure heart care and weight programs. And now they are moving into a space where everybody is online and has smart phones and likes to get apps to do things in a more interactive way with the employer population," he continues. But, as with the wider retail world, there are going to be successes and failures in these insurer experiments. "I don't see them as selling them to be money generators in and of themselves, but basically a means to achieve their ultimate goal of reducing costs," Zaharuk adds.

Aetna Says No More to CarePass

For its part, Aetna spokesperson Ethan Slavin concurs that CarePass is not a revenue generator. And he says ending the program will help the carrier evolve. "CarePass has provided us valuable experience in important areas such as the use of open APIs [application program interfaces] for health data, helping people use their data to power health goals, and collaborating with innovative companies who are developing popular health care apps," he says. "As we improve the mobile experience for consumers through enhancements to tools like iTriage, we will use this experience to help engage people in their own health care and empower them to

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live healthier lives." Aetna acquired mobile app developer Healthagen in December 2011, which created iTriage as an app to help consumers evaluate their symptoms and find local health care providers *(HPW 12/26/11, p. 8)*.

Slavin says beyond CarePass, Aetna is a champion in the use of mobile health as a meaningful channel for its members to improve their health. He adds, "Specifically, we will be investing more in:

◆ "A renewed and improved consumer experience through our mobile channel.

◆ "Significant new features in iTriage like cost transparency, telemedicine and secure messaging between patients and providers.

◆ "Working with physicians to offer condition-specific interventions to help people be healthier."

Tools Can Work, if Efforts Are Widespread

In providing some longer-term perspective, Josh Michelson, associate partner in Oliver Wyman's health and life sciences practice, tells *HPW* that consumer engagement over the past decade centered on throwing resources at wellness initiatives and often involved arms-length coaching over the telephone or nurse navigators reaching out to individuals. "People were calling reminders to members," he says, but they seemed to miss the boat on modifying human behavior. "It was hard to tap into because insurers are not ingrained in people's daily lives." But now, there is innovation with more personal and better-curated tools in play and the economic motivation of the Affordable Care Act to improve quality. "A few billion in venture capital has been raised on consumer-powered health to allow consumers to make better decisions, have greater awareness and [be] much more conscious of how they can improve," Michelson says.

One such emerging force in the business of online consumer management is Minneapolis-based Novu, whose CEO Tom Wicka tells *HPW* that his company uses repeated digital messaging, like is seen in the financial services sector, to aid insurer clients in getting positive results from members. Without being hung up on the debate over "our science is better than your science," Novu seeks to increase the efficacy of its work by remembering consumers are all over the lot on what motivates each individual. "Our platform approach is broader and based on need and interests," Wicka says.

So far the company has attracted 10 payers as clients, including major carriers, regional plans and smaller entities, and will grow that number by eight in January for 2015, he adds. Novu is also branching beyond the commercial space to extend its platform to Medicare and

Medicaid payers, which have been "underserved" in helping people manage health digitally, Wicka says.

Savan does say some behavior-change tools can be quite effective, with caveats. "But they are situational. They are probably not going to be something that a large mass of employers will be adopting [in conjunction with their carrier], because they can be expensive, and require pretty major data transmission [from an insurer]. They are not for the average Joe," he explains.

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Calif. Adds Abortion Services to Mandated Coverage for State Plans

It takes nearly two computer screens to scroll through the list of state-mandated medical services that health insurers in California must cover. And on Aug. 22, a clarification of an existing state law added one more when the Department of Managed Health Care informed carriers that abortion services are a basic health service in the state and must be covered.

The directive should not cause too much of a ripple, according to a health insurance broker in California, and another consultant says unlike most mandates this one technically could be less expensive for insurers.

Putting aside the sensitive religious and political issues tied to abortion, industry sources said it is unclear if many health plans were writing benefits for employers specifically forbidding payments for abortions or saw a backlash for including such services. "I have not seen it before," Henry Loubet, chief strategy officer for Keenan, a California-based health care consulting and brokerage firm, and former CEO of UnitedHealthcare's Western operations, tells *HPW*.

There were, however, two Catholic universities in the state that did oppose their insurance plan and reacted. In fall 2013, both Santa Clara University and Loyola Marymount University informed their employees that abortion services would no longer be covered under the universities' health benefits. If they wanted, employees could pay for abortion procedures through supplemental coverage, provided by a third party. Objections arose when opponents of the decision pointed out that the two schools received public funds and therefore were obliged to offer coverage of basic health services *(HPW 7/15/13, p. 1)*.

In her Aug. 22 letter, Department of Managed Health Care Director Shelley Rouillard told insurers that the state had "erroneously approved" provisions in the two universities' plans that excluded abortion services. Under the state's Knox Keene Act, a law that guarantees basic health care services, the two schools must have abortion services covered for employees, she said.

Reproductive Services Are a Hot Topic

For insurers, Loubet says, the coverage of abortion services is a well-established practice. "[Reproductive coverage] has gotten a lot of publicity of late, but I think abortions are kind of part of the landscape and I don't see it as having a big overall financial impact like Sovaldi will have," he says, referring to the concerns of insurers about paying for the new hepatitis C drug *(HPW 3/17/14, p. 1)*.

Most recently, abortion and contraceptive issues have become news because of the U.S. Supreme Court decision on June 30 siding with employer Hobby Lobby and its refusal to offer coverage for certain contraceptive services to workers. And just this past Aug. 22, HHS outlined a workaround that may allow employees at companies like Hobby Lobby to have their birth control paid for by insurers as outlined in the Affordable Care Act.

As for paying for abortion services, Jim Reschovsky, senior fellow at Mathematica Policy Research, tells *HPW* that most times mandates for a new benefit in the reproductive space, like in vitro fertilization, would increase costs for insurers. But not necessarily for abortions. "Mandates for such things as birth control and abortion actually might reduce health care costs. It is a lot cheaper to do an abortion than to pay for a pregnancy and delivery and pediatric care. That is the same with contraceptive coverage," he says.

In a more general sense, the economics are fairly predictable in that most mandates increase premiums. "At the same time there is another economic rationale for mandates, which has to do with the adverse selection

Additional News of the Week

Coverage of these health plan developments was included in this week's issue of *Spotlight on Health Insurers:*

- Noble Picks IBC for Accountable Care
- United, ConnectedHealth Team on Exchange
- United to Expand Exchange Reach in 2015
- Compass Healthcare CFO Pleads Guilty to Fraud
- Highmark Nixes Claims of Anti-Competitive Pricing
- MBS Sticks With Highmark for 2015
- RMC Extends Contract With Blue Cross
- Aetna to Recoup $8.4M for Inflated ER Billing

Links to these additional news stories can be accessed at www.AISHealth.com/enews/spotlightonhealthinsurers.

in insurance markets that most pertains to the pre-ACA world. This is to the extent that you have clients that don't cover mental health benefits or things like that and it gives rise to selection," Reschovsky says. "The more freedom that plans have to deal with the benefit package, the greater risk that clients will experience favorable or adverse selection — and insurance markets cannot function as well if that happens."

As for the insurer reaction to the California decision on abortion services, Darrell Ng, spokesperson for WellPoint Inc.'s Anthem Blue Cross of California, the only insurer to respond to *HPW*'s request for a reaction to the abortion services decision, said simply that it would "comply with our regulator's letter."

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Generic Prices Soar; Plans May Need to Review Formulary Tactics

As health plans and PBMs continue to grapple with rising drug expenditures due to recently inflated compound medications, new high-cost specialty agents such as hepatitis C treatment Sovaldi and fewer generic opportunities due to the patent cliff leveling off, payers have a new thorn in their side: retail generic drug inflation. PBMs, health plans and industry observers recently interviewed by *HPW* sister publication *Drug Benefit News* agree that this is a new phenomenon that should not be ignored, and may lead payers to revise their formulary strategies around generic promotion.

According to a recent analysis of National Average Drug Acquisition Cost (NADAC) data from July posted to the Drug Channels blog, Pembroke Consulting, Inc.

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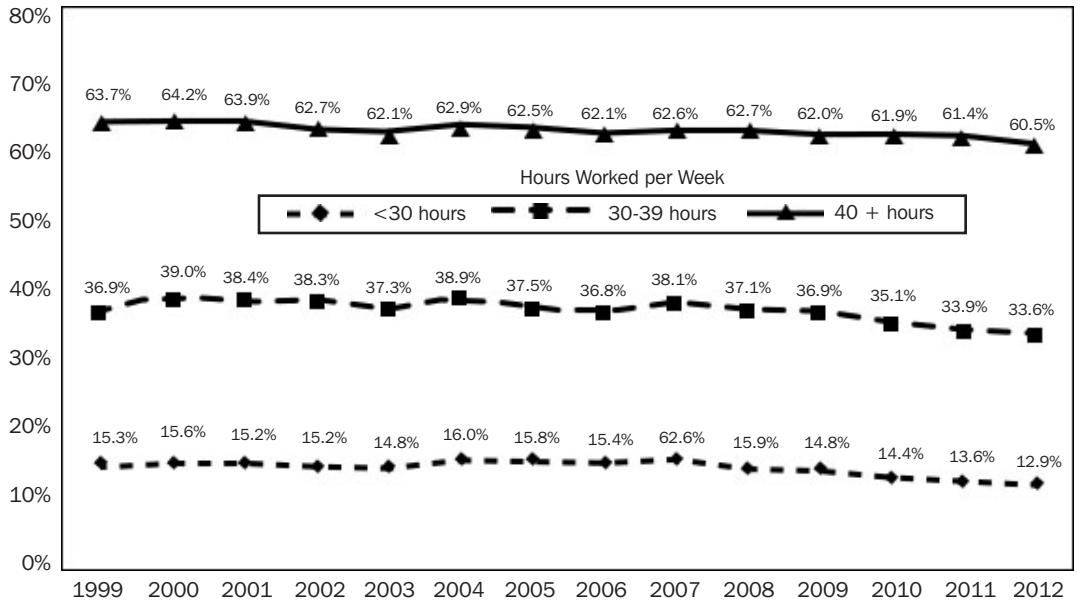
Percentage of Workers With Health Coverage Through Their Own Job, By Hours Worked, 1999–2012

Research by the Employee Benefit Research Institute (EBRI) shows that full-time workers were much more likely to obtain health insurance coverage through their employer than part-time staffers. In the most recent data, EBRI said 60.5% of workers employed 40 hours or more per week had job-sourced coverage, but only 33.6% of workers employed 30-39 hours per week had such coverage. The numbers go even lower with the fewer number of hours worked. For example, only 12.8% of workers employed fewer than 30 hours per week had insurance through their employer.



SOURCE: Employee Benefit Research Institute estimates from the Current Population Survey, March 2000–2013. Visit www.ebri.org.

finds that half of all retail generic drugs rose in price over the last 12 months. Nearly 50% of drugs dropped in price; 19% of the sample experienced cost decreases of less than 5% and only 3% had declines greater than 25%. Meanwhile, one out of 11 drugs — or 9% of the sample — rose in price by more than 100%. When Pembroke analyzed the data last fall, comparing November 2012 to November 2013 figures, only one-third of generic drugs had increased in price.

"Generic inflation will force payers to rethink their formulary strategies," Pembroke President Adam Fein, Ph.D., says. "The priciest generic drugs are still less expensive than brands. However, these products have exploded in price due to shortages, which leads to generic-to-brand substitution. Some older brand-name drugs are experiencing a sales boost from the combination of high generic prices and shortages."

Payers See Generic Costs Rise

To determine the changes in generic drug costs over the last year, Fein looked at recent NADAC data that are collected by CMS as part of a voluntary monthly mail survey of chain and independent pharmacies. After eliminating duplicate National Drug Codes, since the NADAC data report the same price for all NDCs of the same product, he identified 2,376 unique generic products and computed the simple percentage change in the NADAC per unit for each product, he explains. Because the survey collects only invoice costs and not off-invoice discounts, rebates and price concessions, the NADAC data do not reflect a pharmacy's net actual acquisition costs, he adds.

The products that experienced "mega-increases" of more than 1,000% in NADAC per unit were antibiotic tetracycline, antidepressant clomipramine and high blood pressure treatments captopril and doxazosin mesylate, Fein observed in an Aug. 12 Drug Channels post. He explained that the "primary culprit" for the sharp rises was shortage. Tetracycline, for example, which skyrocketed from 5 cents per 500 mg capsule in 2013 to $8.59 per capsule in 2014, was unavailable due to a "raw material shortage," according to drugmaker Teva Phamaceuticals.

Mesfin Tegenu, R.Ph., president of PerformRx, LLC, the wholly owned PBM subsidiary of the AmeriHealth Caritas Family of Companies, suggests that if NADAC data were available prior to October 2012, when CMS began publishing its survey results, similar calculations might show that "this trend in generic drug pricing actually started some time ago, we believe as early as 2011." Since the PBM has been tracking that trend using its own drug acquisition cost competitive intelligence, Tegenu says, "We've been educating our clients for some time that the anticipated reduction(s) in the cost of generic drugs year over year has pretty much come to an end."

One limitation of the Drug Channels analysis, Tegenu points out, is that it isn't a weighted calculation based on actual utilization of the specific drugs that either rose or dropped in price, so it "doesn't really give you a feel for the actual impact of these challenges." But using the NADAC drug list to compare the utilization of generic drugs for a specific client from January 2013 to January 2014, PerformRx finds that "the overall cost of the January '14 utilization has stayed flat or in fact has ticked up a percentage point or two (dependent on the client type)," he says via email. "In essence, what we are finding is that any potential overall savings associated with the reduction in specific generic drug prices is being offset, and in some cases more than offset, by the cost increases in other products."

Several Outliers Are Moving the Needle

A handful of high-volume products have seen price hikes in a short amount of time, observed ISI Group LLC Senior Managing Director and Partner Ross Muken during a July webinar unveiling the firm's new Generic Drug Price Inflation Tracker tool. In 2013, those outliers were thyroid hormone levothyroxine (58.3%), corticosteroid prednisone (116.4%) and Klor-con, a potassium chloride tablet used to treat low blood levels of potassium (412.6%). When ISI removed drugs that increased 50% or more to compare year-over-year trend, inflation changed from 4.4% to a decrease of 1.8%. "What it basically shows is when you get these massive, high one-off inflations, it really moves the needle," said Muken.

Prime Therapeutics LLC says its generic costs have gone up 8.4% from the second quarter of 2013 to the 2014 comparable quarter, primarily due to three trend drivers:

(1) A "flattening" or no longer continuing decrease in overall generic costs that plans have enjoyed in the past few years, which is "likely a market response to the end of the post-patent era," remarks David Lassen, Pharm.D., chief clinical officer for the Blues plan-owned PBM.

(2) New market entries such as generic antidepressant Cymbalta (duloxetine). Although other generic products are down in the class, the generic price overall for antidepressants is now up, says Lassen.

(3) Some lower volume existing generics are experiencing large price hikes. For example, the price of pravastatin for cholesterol is up 25% over the same time period last year, he observes.

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

Wal-Mart Sees Benefits Rise

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need it. And the penalty from the individual mandate is not that much for this year. So we have yet to see a change in the enrollment."

Other industry observers think the data provided in the Mercer report better reflects the market reality than does the Wal-Mart development. "I would be surprised if much has changed [in employee benefits buying]," Tom Miller, resident fellow at the American Enterprise Institute, tells *HPW*, citing evidence from multiple sources that show no uptick whatsoever.

Mercer's survey of more than 700 employer clients (26% with fewer than 500 employees, 49% with 500 to 4,999, and 24% with 5,000 or more) put the average number of workers enrolled in a company plan for 2014 at 69.3%. This is only slightly above the 69.1% level of 2013. And when asked to project to 2015, the survey respondents told Mercer they expect a very small increase in employee uptake to 69.8%.

Wal-Mart Stands Apart From Most Employers

Weighing what the Wal-Mart news means is made difficult by the very fact the company is so large and has been integrating more health care delivery into its operations, sources say. "Wal-Mart has clinics in stores now.… Whatever they are doing is not pure employer benefits; a lot of it is customer-facing," John Graham, senior fellow, National Center for Policy Analysis, tells *HPW*.

What is known is that during an Aug. 14 conference call to discuss second-quarter 2014 earnings, Wal-Mart executives said that the "most notable headwind" to its operating earnings was health care costs. Specifically, the retailer said health care costs increased $180 million in the second quarter versus the same period of 2013, well above internal company estimates. The primary cause was increased associate enrollment and cost inflation. The company said it expects the trend to continue through 2014 and anticipates more than $500 million in year-over-year expense growth in the benefits segment for the year when compared to 2013.

Graham says even if Wal-Mart is unique in many ways, all employers are in a state of flux on how to provide health benefits to employees, given the uncertainty about the employer mandate and even the individual mandate. The Obama administration has delayed implementation of the employer mandate, for instance, until 2015 *(HPW 2/17/14, p. 1)*. And without mandates to make businesses and consumers act, then rates of insurance uptake are not going to be predictable, he adds.

"Whether they [HHS] will ever clamp down on the employer mandate is increasingly doubtful. And if you have a low-income workforce, like a Wal-Mart, the fact is you look at your workforce and say, 'even if we pay the fine, they will get a subsidy in the exchange and it's kind of a win-win situation for the employee.' The other thing, with the economy fully recovering, we should see an increase in employer-based benefits," Graham says.

The reform law mandates that all employers with 50 or more full-time-equivalent employees offer coverage that includes mandated essential health benefits. Employers that opt not to offer coverage must pay an annual $2,000 per-employee penalty. Employees are considered full time under the law if they average 30 hours or more a week on a monthly basis. This stipulation has caused some employers with large numbers of part-time, often lower-wage, workers, to weigh the idea of cutting back hours to prevent workers from hitting the 30-hour-per-week threshold.

Employers Stay the Course for Now

Beyond Mercer's survey, there is much anecdotal evidence that employers are not seeing higher take-up rates among employees, Paul Fronstin, director of the Employee Benefit Research Institute's Health Research and Education Program, tells *HPW*. "So it is curious to see what is going on with Wal-Mart. It may be unique and limited to the retail sector," he adds.

Changes in employers' benefit designs or distribution strategies also do not seem to be major factors moving employees to enroll in company plans, Fronstin says. "We've had consumer-directed health plans for over a decade now.…That is a trend that is certainly accelerating. But that is not a major benefit change, it is an acceleration," he says. Private exchanges are newer and attracting much interest from employers, but some employees may not even know their employer made a switch. "I know of one employer that offered a private exchange last year but employees did not know. The name of the exchange was not used, and workers would only know that they have more choices, from three plans to 20 to 25 now," Fronstin says.

Shari Davidson, a vice president at the National Business Group on Health, tells *HPW* that her group actually asked members, which include Wal-Mart, during a January conference whether more people enrolled in employer-sponsored health plans than expected. "Most employers were in the category of 'increased a little' but within the realm of what might be expected," she says.

For more information, contact Fronstin at fronstin@ebri.org, Graham at john.graham@ncpa.org, Umland and Watts via Bruce Lee at bruce.lee@mercer.com, Miller at tmiller@aei.org and Ed Emerman for Davidson at eemerman@eaglepr.com. ✧

HEALTH PLAN BRIEFS

◆ **Two GOP senators sent a letter to the head of CMS on Aug. 27 asking for a more thorough report on how many people are enrolled in public exchanges ahead of the second open-enrollment period that starts on Nov. 15.** Sens. John Barrasso (R-Wyo.) and Lamar Alexander (R-Tenn.) wrote to Marilyn Tavenner, CMS administrator, seeking information on the number who have signed up as well as the number of plan cancellations that have occurred since the initial open-enrollment period ended in April. Visit http://tinyurl.com/ntarb6x.

◆ **Aetna Inc. and Banner Health Network in Phoenix, Ariz., on Aug. 27 said their accountable care organization (ACO) generated roughly $5 million in shared savings in 2013 for Aetna Whole Health fully insured commercial members and produced a 5% drop in medical costs.** The ACO, which was announced in 2012 *(HPW 7/2/12, p. 5)*, also helped improve medical quality. Aetna said for example that ACO members experienced better cancer screening rates, positive blood sugar management for diabetics, decreased numbers of radiology services and lower avoidable hospital admissions. Visit http://tinyurl.com/jwlb7qm.

◆ **The Affordable Care Act's payroll tax requirements for top health insurance executives generated an additional $72 million in federal revenue from the 10 largest publicly traded carriers in 2013,** according to a report by the left-leaning Institute for Policy Studies on Aug. 27. The reform law imposed a $500,000 limit on the tax deductibility of health insurance executive pay, starting in 2013. Visit http://tinyurl.com/oatqp9f.

◆ **Blues plan operator Hawaii Medical Service Association (HMSA) is pulling out of the small-business side of Hawaii's troubled state-run insurance exchange,** the Associated Press reported on Aug. 15. That means that small employers that opt to buy coverage through the Hawaii Health Connector will see options from just one carrier — Kaiser Permanente. HMSA President Michael Gold told AP his staff is spending too much time and money dealing with the Connector's technical problems. Visit http://tinyurl.com/nzo3u7y.

◆ **Software-as-a-service (SaaS) technology provider Zywave, Inc.'s 2014 Broker Services Survey released on Aug. 22 finds a disconnect between what employer clients want from their health insurance brokers and the information these agents provide.** The survey said businesses want more services added to the traditional execution of insurance benefits. "Most of us will agree this is positive, as it moves the broker to more of an adviser role, supporting business issues such as compliance, HR, risk management, wellness, etc. Agencies and brokers who excel at positioning themselves this way have enjoyed significant growth in recent years," said Dave O'Brien, CEO at Zywave. Read more at www.zywave.com.

◆ **A majority of people are concerned that their employers will stop offering health benefits and move them to public exchanges instead,** according to a new poll in Morning Consult released on Aug. 19. In a party-affiliation breakdown, the poll found 72% of Republicans worried about moving to an exchange, with Democrats and Independents less fearful that a change would have a negative impact on their insurance coverage. A majority of Republicans (62%) and Independents (52%) said they would consider searching for a new job if they were shifted onto an exchange. Only 42% of Democrats said they would look for another job. Visit http://tinyurl.com/lfada6v.

◆ **PEOPLE ON THE MOVE:** Blue Shield of California named **Michelle Simpson** senior vice president of enterprise sales and service. Simpson will be responsible for the overall management and performance of the company's employer group business units. She was most recently a vice president for the insurer, responsible for the overall strategy, management and direction of the California Public Employees' Retirement System (CalPERS) business….Magellan Health, Inc. named **Karen Amstutz, M.D.**, chief medical officer, responsible for setting the strategic roadmap and vision for Magellan's clinical strategy and policy. Amstutz most recently was vice president of medical affairs for Evolent Health….Blue Cross and Blue Shield of Kansas City said President and CEO **David Gentile** is retiring. Gentile has been with the Blues plan for the past 23 years and has served as the top executive since December 2010. He is leaving to focus on his back-related health problems. **Danette Wilson** was named interim president and CEO. Wilson previously served as group executive, external operations and chief marketing executive.

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