West Virginia
Children's Health Insurance Program

Annual Report 2010

West Virginia
Children's Health Insurance Program

2010 Annual Report

Earl Ray Tomblin, Governor

Earl Ray Tomblin, Governor
State of West Virginia

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

Sharon L. Carte, Executive Director
West Virginia Children's Health Insurance Program

Prepared by:
Stacey L. Shamblin, MHA
Financial Officer
West Virginia Children's Health Insurance Program

Our Mission

To provide quality health insurance to eligible children
and strive for a health care system in which all
West Virginia children have access to health care coverage.

Our Vision

All West Virginia's children have access to health care coverage.

Table of Contents

Page

Introductory Section

Letter of Transmittal 2
Principal Officials, Board Members, and Staff 6
Organizational Chart 7

Financial Section

Management's Discussion and Analysis 10
Basic Financial Statements:
Balance Sheet 16
Statement of Revenues, Expenses, and Changes in Fund Balances 17
Notes to Financial Statements 18
Budget to Actual Statement 21
Required Supplementary Information:
Independent Actuary Report 26
Program Outreach and Health Awareness 39

Statistical Section

Enrollment Data

Tables 1 - 10 ..... 46 - 53

Expenditures Data

Tables 11 - 13 ..... 54 - 55

Set of Pediatric Core Measures

Pediatric Core Measures Explanation 56
HEIDS and HEDIS-Type Measures Tables 14 - 30 ..... 57 - 66

Selected Utilization Data as Health Status Indicators

Health Status Indicators Explanation 67
Health Status Indiactors Tables 31 - 37 ..... 68 - 71

Top Ten Physician Services and Prescription Drugs

Tables 38 - 41 ..... 72 - 77

Introductory Section

Did you know? .....

A child's healthy development must include opportunities to play and explore nature, run around, climb, imagine, problem solve and create.

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December 21, 2010

Earl Ray Tomblin, Governor
State of West Virginia

Honorable Members of the
West Virginia Legislature

Board of Directors
West Virginia Children's Health Insurance Program

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

Sharon L. Carte, Executive Director
West Virginia Children's Health Insurance Program

Ladies and Gentlemen:

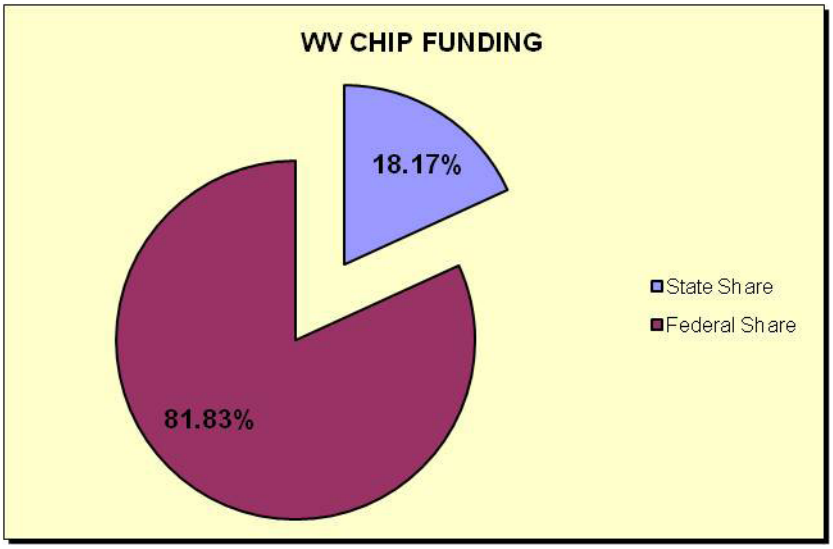
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2010. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented and the completeness and fairness of the presentation, including all disclosures. We believe the data, as presented, are accurate in all material respects and presented in a manner that fairly reports the financial position and results of operations of WVCHIP. All disclosures necessary to enable the reader to gain an understanding of WVCHIP's financial activities have been included. It should be noted that these financial reports are unaudited and for management purposes only.

This Annual Report is presented in three sections: introductory, financial and statistical. The introductory section contains this transmittal letter, a list of the principal officers of WVCHIP, and WVCHIP's organizational chart. The financial section includes the basic financial statements and footnotes as well as certain supplementary information as required by State Code. Also included in the financial section is management's discussion and analysis (MD&A) which provides the reader a narrative introduction, overview and further analysis of the financial information presented. The statistical section includes selected financial and statistical data.

The West Virginia Legislature passed House Bill 4299 on April 19, 1998, to create WVCHIP. Since its inception, it has undergone several changes that include the transfer of the Program from the WV Department of Health and Human Resources to the WV Department of Administration, Children's Health Insurance Agency with the passage of Senate Bill 565 in 2000. WVCHIP is governed by a Board of Directors of up to eleven members, through approval of an annual financial plan and modifications to benefits. Day-to-day operations of WVCHIP are managed by the Executive Director who is responsible for the implementation of policies and procedures established by the Board of Directors. The WV Children's Health Insurance Agency is responsible for the administration of the WVCHIP.

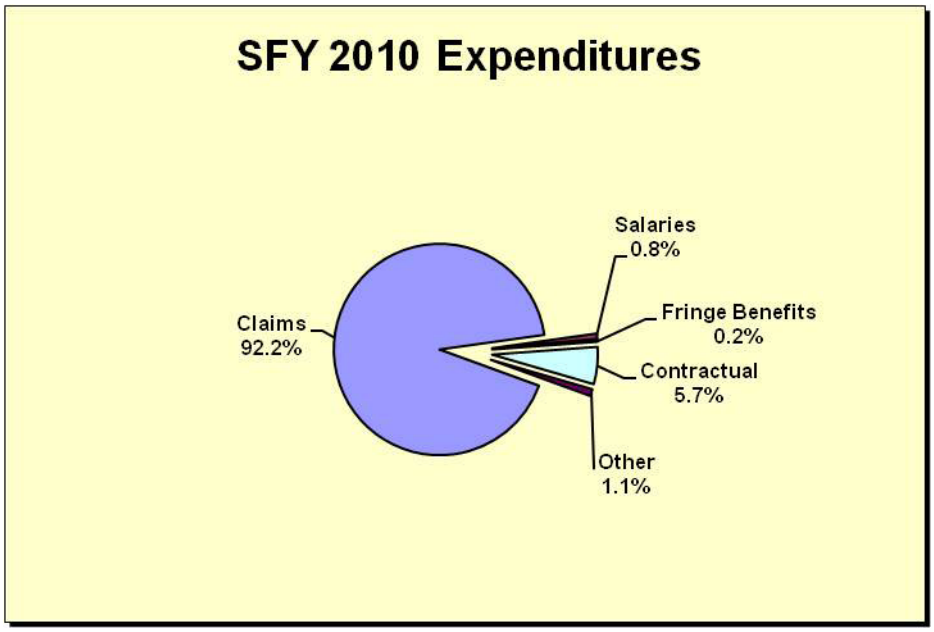
FINANCIAL PERFORMANCE AND OUTLOOK

WVCHIP is funded by both federal and state monies. Each year the program receives an allotment of federal money that may be used to fund program expenditures at a set percentage. Currently, federal allotments are available for a period of two years. State money is provided through general appropriations that are approved by both the Governor and the State Legislature. State money that is not used in the current year is carried-over to the next year. The match rates at June 30, 2010 were 81.83% federal share and 18.17% state share.



WV State Code requires that estimated program claims and administrative costs, including incurred but not reported claims, not exceed 90 percent of the total funding available to the program, and provides for an actuarial opinion to ensure that this requirement will be met. The Actuarial Report dated June 30, 2010 confirms this requirement will be met through SFY 2017, assuming that state appropriations remain at the current level as SFY 2011, $10,425,628, and considering projected enrollment and program costs trends.

Based on estimated funding, enrollment, and costs, the June 30, 2010 Actuarial report projected federal funding shortfalls of $12.2 million and $34.5 million in state fiscal years (SFY) 2016 and 2017 respectively. No federal funding shortfalls are projected for SFYs 2011 through 2015. All projections assume federal allotments will remain at the same level as the 2010 allotment.



REAUTHORIZATION

The Children's Health Insurance Program was reauthorized on February 4, 2009, extending the program through 2013. Under the new bill, states received increased annual allotments based on a revised formula that considers each state's actual projected spending and demographics, as well as national trends. Also, provisions that extend program eligibility and streamlined enrollment processes are part of the bill.

HEALTH CARE REFORM

Congress passed the Affordable Care Act (ACA) which was signed into law on March 23, 2010. Healthcare reform will impact WVCHIP significantly. While the bill extends CHIP reauthorization through 2015, it also increases the federal share for the program from 2016 through 2019. WVCHIP will be virtually 100% federally funded during this time. One major impact of healthcare reform is the increase in the income eligibility limit for the state Medicaid program. Effective January 1, 2014, the upper income limit for Medicaid will increase to 133% FPL. This increase means many children that are now income eligible for WVCHIP will move to Medicaid. The estimate is that WVCHIP will lose around 12,000 kids on this date. Other impacts of the ACA are still being determined.

INITIATIVES

This year WVCHIP actively began laying the groundwork for some very significant program changes – most of which will not be implemented until SFY 2011. The reauthorization of the CHIP program requires that WVCHIP change its methodology used to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). FQHCs and RHCs have been reimbursed under a fee-for-service methodology. WVCHIP is required to change to a prospective payment (PPS) methodology and adjust claims for this methodology back to October 1, 2009 once the new rates are determined. Also, the

program continued its monitoring and analysis of eligibility and enrollment information transfers among its various partners. This work will culminate with changes to the WVCHIP Premium group that allow families to enroll in the program back to the month of application and also provide them with an option to make payments online. WVCHIP partnered with Oregon and Alaska CHIP programs for a five year multi-state grant that focuses on increasing the quality of healthcare provided to children. Also, as called for in Statute, WVCHIP actively participates with other state agencies to prepare the state for healthcare reform, mainly through meetings coordinated by the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP).

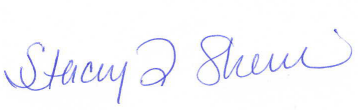
OTHER

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorized Federal grants to states for the provision of child health assistance to uninsured, low-income children. The Centers for Medicare and Medicaid Services (CMS) monitors the operation of WVCHIP. Financial statements are presented for the state fiscal year ended June 30, 2010. The federal fiscal year ends September 30 and further documentation is submitted to CMS based on that period. Certain statistical information such as HEDIS® quality measures, by nature, is presented on a calendar year basis as required.

ACKNOWLEDGMENTS

Special thanks are extended to former Governor Joe Manchin III for his support, as well as to members of the Legislature for their continued support. WVCHIP looks forward to working with Governor Earl Ray Tomblin as he takes on a new leadership role for the State of West Virginia. Gratitude is expressed to the members of WVCHIP's Board of Directors for their leadership and direction. Our most sincere appreciation is extended to Secretary Robert W. Ferguson, Jr., whose leadership and support has helped the Agency embrace new challenges this year. Finally, this report would not have been possible without the dedication and effort of WVCHIP's Executive Director, Sharon L. Carte. Respectfully, we submit this Annual Report for the West Virginia Children's Health Insurance Program for the year ended June 30, 2010.

Sincerely,



Stacey L. Shamblin, MHA
Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

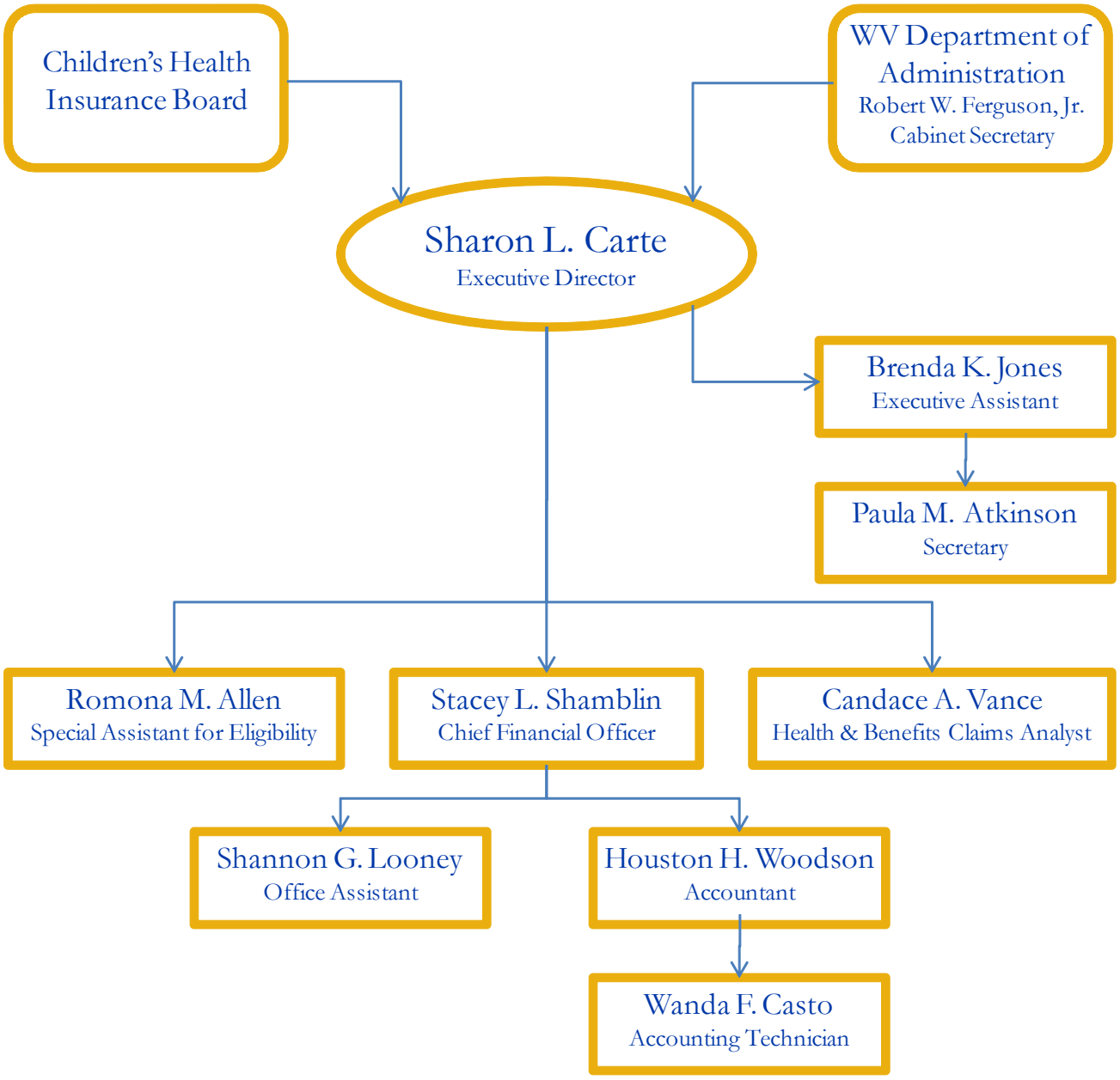
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Michael J. Lewis, Department of Health & Human Resources, Cabinet Secretary
The Honorable Roman Prezioso, West Virginia Senate, Ex-Officio
The Honorable Don Perdue, West Virginia House of Delegates, Ex-Officio
Lynn T. Gunnoe, Citizen Member
Margie Hale, Citizen Member
Travis Hill, Citizen Member
Larry Hudson, Citizen Member
VACANT, Citizen Member
VACANT, Citizen Member

Staff

Sharon L. Carte, Executive Director
Romona M. Allen, Special Assistant for Eligibility
Paula M. Atkinson, Secretary
Wanda F. Casto, Accounting Technician
Brenda K. Jones, Executive Assistant
Shannon G. Looney, Office Assistant
Stacey L. Shamblin, Financial Officer
Candace A. Vance, Health and Benefits Claims Analyst
Houston H. Woodson, Accountant

Staff Organizational Chart



Financial Section

Did you know? .....

Following the 5, 2, 1, 0 Rule helps promote fitness amd prevent children from becoming overweight. This means, 5 or more fruits and vegetables, no more than 2 hours of TV, computer, or video games, at least 1 hour of physical activity, and 0 sugar sweetened beverages each day!

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2010

Management of the West Virginia Children's Health Insurance Program (WVCHIP) provides this Management Discussion and Analysis for readers of WVCHIP's financial statements. This narrative overview of the financial statements of WVCHIP is for the year ended June 30, 2010. We encourage readers to consider this information in conjunction with the additional information that is furnished in the footnotes which are found following the financial statements. Please note that these financial statements are unaudited and for management purposes only.

HISTORY AND BACKGROUND

WVCHIP's primary purpose is to provide health insurance coverage to uninsured children in families whose income disqualifies them from coverage available through the Medicaid Program, but is less than or equal to 250% of the current Federal Poverty Level (FPL). When Congress amended the Social Security Act in 1997 to create Title XXI "State Children's Health Insurance Program" (SCHIP), federal funding was allocated to the states for such programs over a ten year period. The West Virginia Legislature established the legal framework for this State's program in legislation enacted in April 1998. The program was reauthorized through 2013 on February 4, 2009. On March 3, 2010, the program was once again reauthorized through 2015 with the passage of the Affordable Care Act (ACA). This legislation also increases the share of the program's federal funding from 2016 through 2019. The program will be virtually 100% federally funded during this time.

Historically, Congress annually appropriated funds on a national level, and states received their share of this total funding based on a complex allotment formula that considered the state's population of uninsured, low-income children. This annual allotment formula changed in 2009 under reauthorization to consider each state's actual projected expenditures, demographics, and national cost trends. States use this annual Federal allotment to cover expenditures at a federal-matching percentage that is determined by the Centers for Medicare & Medicaid Services (CMS), the program's federal regulatory agency, and posted in the Federal Register.

To use Federal monies allotted for the SCHIP program, each state is required to file a state plan with CMS that outlines the individuals responsible for program administration, where the program is housed within State government, the program's enrollment policies, how it proposes to use the federal monies, as well as other policies and processes used by the state to administer the program. Once the state plan is approved, the state may use its federal allotment, at the federal matching percentage, to finance program expenditures according to the plan.

Since inception in 1998, WVCHIP has undergone several changes of its State Plan to reach its current form. These changes included:

- Phase I: In July 1998, the program began as a Medicaid expansion by covering children from ages 1 to 5 in households with incomes from 131% FPL to 150% FPL.

- Phase II: On April 1, 2000, coverage for children from ages 6 through 18 in households from 100% to 150% FPL was added. WVCHIP also adopted PEIA's Preferred Benefit Plan to serve as the benchmark equivalent coverage program.
- In June 2000, WVCHIP notified the federal government that it was withdrawing the Medicaid expansion program and combining it with Phase II to create a separate state program.
- Phase III: In October 2000, WVCHIP expanded coverage for all children through age 18 in families with incomes between 151% and 200% FPL.
- In June 2002, WVCHIP modified its co-payment requirements for pharmacy benefits to eliminate co-pays for generic drugs and expand co-pay requirements for brand name drugs. It also adopted an annual benefit limit of $200,000 and a lifetime benefit limit of $1,000,000.
- In January 2006, WVCHIP modified its pharmacy benefits by implementing a Preferred Drug List which encouraged utilization of generic drugs and increased the amount of drug rebates received from drug manufacturers.
- In January 2007, WVCHIP expanded its upper income limit for program eligibility to 220%FPL. This expanded program from 200-220%FPL is called WVCHIP Premium. Families enrolled in this group are required to make monthly premium payments based on the number of children enrolled in the family. Children in this group receive full medical and drug benefits, limited dental, and no vision coverage.
- In January 2008, WVCHIP modified its state plan to allow the program to secure federal match to pay for comprehensive well-child exams for uninsured children entering Kindergarten using administrative funds.
- In January 2009, WVCHIP further expanded its upper income limit for program eligibility to 250% FPL. Children covered under this expanded group are enrolled in WVCHIP Premium.
- In July 2009, WVCHIP removed restrictions on dental and vision benefits for members in WVCHIP Premium. Members in this group now receive full dental benefits, but with copayments for some services. They also receive full vision benefits.

OVERVIEW OF THE FINANCIAL STATEMENTS

WVCHIP's financial statements have been prepared on a modified accrual basis of accounting in conformity with generally accepted accounting principles (GAAP) as prescribed or permitted by the Governmental Accounting Standards Board. As a governmental fund, WVCHIP is required to present two basic statements in this section as follows:

Balance Sheet: This statement reflects WVCHIP's assets, liabilities and fund balance. Assets equal liabilities plus fund balances. The major line item asset consists primarily of investments and funds due from the federal government to cover WVCHIP's major liability, incurred claims.

Statement of Revenues, Expenditures and Changes in Fund Balances: This statement reflects WVCHIP's operating revenues and expenditures throughout the year. The major source of revenue is federal grant awards while the major expenditure areas include medical, dental, and prescription drug claims costs.

In addition to these two basic statements and the accompanying notes; required supplementary information is presented in the Management Discussion and Analysis section and the Budget-to-Actual Statement presented for the year. The Budget-to-Actual Statement compares the program's actual expenditures to amounts budgeted for the state fiscal year and is located after the notes to the financial statements.

FINANCIAL HIGHLIGHTS

The following financial statements summarize the financial position and the results of operations for the years ended June 30, 2010 and 2009. (See pages 15 and 16.)

- Total assets increased approximately $2,075,424, or 14% in comparison to the previous year-end amount. This increase is primarily a result of higher ending cash balances that are now shown separately as investments, and reflects the Program's increased carry-over funding for the next year. There was also an increase in funds due from the federal government that is mostly the result of a year-end receivable for expenses paid in the last week in the month of June that was not transferred until early July. An increase of 416% in accrued interest receivable is the result of the Agency switching its investments from the state's money-market fund to its short-term bond pool, increasing returns on investments.
- Total liabilities decreased by approximately $442,395 from last year. The majority of the decrease is attributable to a decrease in deferred revenues.
- Total fund equity increased approximately $2,517,819, or 25%, in comparison to the previous year end amount.
- Total revenues reflect only a very minimal increase when compared to the prior year. While the state appropriation decreased, federal revenues increased, as well as premium and investment revenues.
- Medical, dental and prescription drug expenditures comprise approximately 92% of WVCHIP's total costs. These expenditures remained relatively flat compared to the prior year with only a slight 1% increase.
- Administrative costs accounted for 8% of overall expenditures. These expenditures increased approximately $476,737, representing an increase of 14%. Increases in administrative expenditures also include increases in amounts the program spent on outreach and health promotion. The program sponsored the State Championship for Dance Dance Revolution in the spring of 2010, and also increased amounts spent on advertising the Premium program. Administrative increases are also the result of the new Third-Party Administrator contract that took effect in July 2009 (which includes services such as disease management and a reporting tool that were not included in the prior contract) and amounts spent on upgrading our processes for eligibility and enrollment data transfers between WVCHIP and its partners.

FINANCIAL ANALYSIS

Costs

A 1% trend in medical, dental, and prescription drug claims is slightly less than the 3% increases in spending experienced by plans nationally. After adjusting for a slight increase in enrollment, WVCHIP expenditures remained relatively the same as last year. Three factors affect total claims expenditures; enrollment, utilization of services, and fees paid to providers for services they render to WVCHIP members. Each of these factors contributed to the following increases in WVCHIP's claims costs:

- Enrollment: +1.9%
- Service Utilization: +2.0%
- Price/Fee Increases -2.9%

Note: These percentages are composites and not further broken down by service line item.

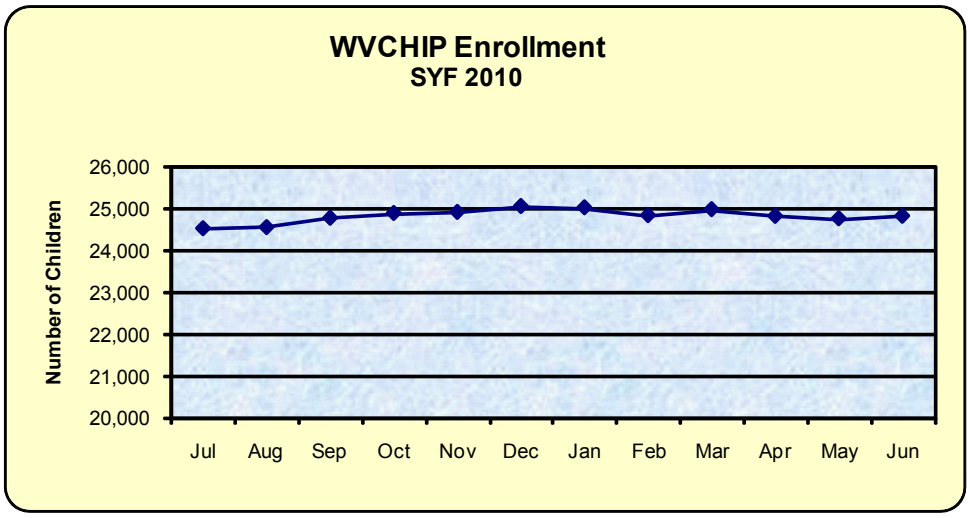
Enrollment

Monthly enrollment increased steadily over the year, with an overall increase in enrollment of 1.9% compared to last year.

WVCHIP has three enrollment groups, categorized by the differing levels of family financial participation (i.e. copayments and/or monthly premiums) based on family income levels as compared to the Federal Poverty Level (FPL). The following chart identifies these three groups, as well as enrollment changes in each:

GROUP	FPL	AVG MONTHLY ENROLLMENT	PERCENT INCREASE
CHIP Gold (Phases I&II)	100% - 150%	15,261	+1.9%
CHIP Blue (Phase III)	151% - 200%	8,678	-3.4%
WVCHIP Premium	201% - 250%	893	+124.4%

WVCHIP Premium is the newest enrollment group and includes children in families with incomes above 200%FPL up to and including 250%FPL. Initially, 12 children were enrolled in this group when it was "rolled-out" in February 2007. By June 2010, enrollment increased to 1,058 members. Enrollment in this group continues to grow and by the end of November 2010, 1,160 children were enrolled. Enrollment has grown 9.6% since June 2010.



Utilization

It is easy to assume that a health plan would incur higher costs with increased enrollment: more members = payments for more services = increased costs. This is not a correct assumption of WVCHIP's experience during SFY 2010, however. Increased payments due to service utilization changes are caused by factors more dynamic than simply the number of members covered by the plan. Not only do changes in plan membership cause the plan to pay for more or less services, but other factors including provider practices and service guidelines; services mandated or recommended by either law or professional organizations; the benefit package and utilization management strategies adopted by the plan; as well as many more factors. A combination of these many factors contributed an increase of 2.0% in claims expenditures for the year.

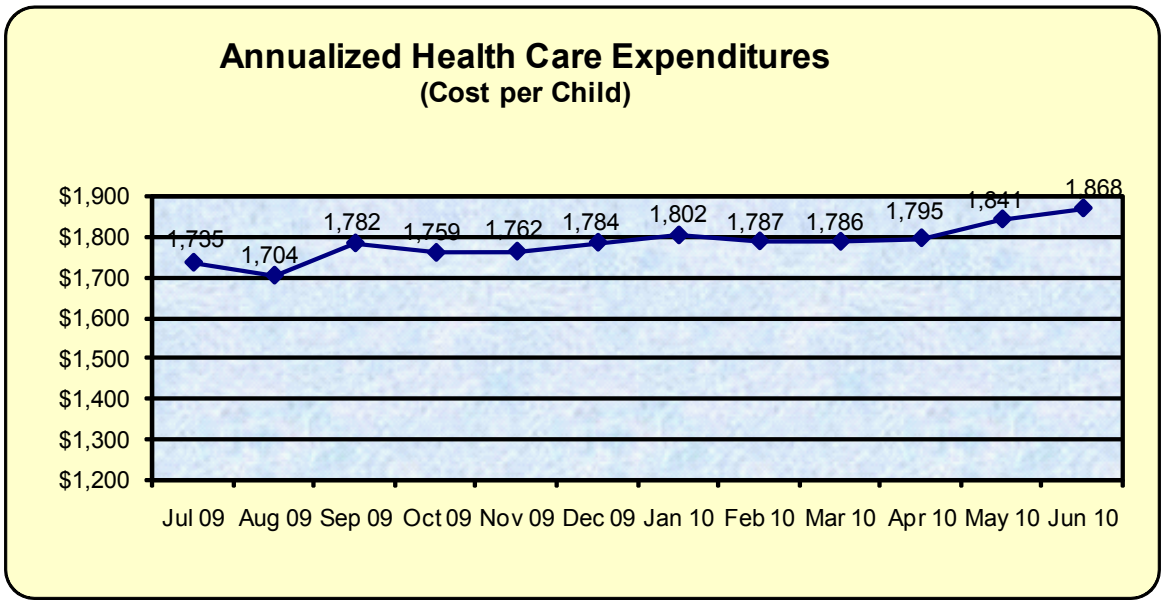
"Pent-up" demand refers to the amount of services utilized by new plan members. Children new to the program may require more medical, dental, or prescription drug services within the first three-months of enrollment due to the fact they may have not been able to access these services prior to enrollment in the plan. This "pent-up" demand is illustrated in Table 13 on page 55.

Prices/Fees

The amount WVCHIP pays providers for particular services is also determined by a number of factors; fee schedules adopted by the plan or rates negotiated with providers, whether the service is provided in West Virginia or outside the state; and service availability, among others. A combination of all these factors contributed to price inflation. During State Fiscal Year 2010, prices decreased around 2.9%. The decrease in prices appears not to be a result of fee schedule decreases, but a result of a shift of services from out-of-state providers to those providers in-state. In July 2009, along with the implementation of the new TPA contract, WVCHIP made an effort through utilization review and prior approval policies to direct members using out-of-state providers to in-state providers. WVCHIP made these changes for a couple of reasons; 1) In-state providers are by statute required to accept WVCHIP fee schedule amounts as payment in full (and may not balance bill members for the difference); 2) these protections are not offered to WVCHIP and its members for services provided out-of-state. Also, the new TPA contract provided WVCHIP a better, less expensive option for its out-of-state network. These changes resulted in a small shift to in-state providers. In SFY 2009, approximately 6% of claims were paid to out-of-state providers, representing around 18% of total dollars. In SFY 2010, the percentage of claims paid to out-of-state providers decreased to around 5% and the percentage of dollars decreased to around 13%. The average cost per claim for in-state services actually increased during this time by 2.3%, while the average cost per claim for out-of-state services actually declined 6.1%.

Average Cost Per Child

WVCHIP's average cost per child for State Fiscal Year 2010 was $1,868. This amount represents the average cost per child based on a "rolling enrollment" calculation and is not adjusted for the total unduplicated enrollment in the program for the year. This average increased 7.9% over the prior year and resulted from all factors discussed above. The fluctuation in the average cost per child during the year is illustrated in the following table on page 15.



Administrative Costs

Administrative costs increased 14% over the prior year. All categories of administrative costs increased with the exception of Current Expenses, which decreased 31%. The largest increase was in Outreach & Health Promotion, 125%, and was mainly due to an ad campaign advertising the Premium program and WVCHIP's sponsorship of the 2010 State Dance Dance Revolution Championship. Eligibility and Enrollment expenditures increased 27% compared to the prior year and reflects WVCHIP's continuing efforts to improve the electronic transfer of its eleligibility and enrollment data between it and its partners.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2010 and 2009
(Accrual Basis)

	June 30, 2010	June 30, 2009	Variance	
Assets:				
Cash	$ 184,859	$ 102,926	$ 81,933	80%
Investments	12,145,487	10,849,481	1,296,006	12%
Due From Federal Government	3,686,029	2,996,053	689,976	23%
Due From Other Funds	668,625	675,131	(6,506)	-1%
Accrued Interest Receivable	18,060	3,500	14,560	416%
Fixed Assets, at Historical Cost	69,738	70,282	(544)	-1%
Total Assets	$16,772,797	$14,697,373	$2,075,424	14%
Liabilities:				
Due To Other Funds	$ 355,529	$ 256,634	$ 98,895	39%
Deferred Revenue	465,645	916,683	(451,038)	-49%
Unpaid Insurance Claims Liability	3,324,298	3,414,550	(90,252)	-3%
Total Liabilities	$ 4,145,472	$ 4,587,867	$(442,395)	-10%
Fund Equity	$12,627,325	$10,109,506	$2,517,819	25%
Total Liabilities and Fund Equity	$16,772,797	$14,697,373	$2,075,424	14%

Unaudited - For Management Purposes Only - Unaudited

West Virginia Children's Health Insurance Program
Comparative Statement of Revenues, Expenditures and Changes in Fund Balances
For the Twelve Months Ended June 30, 2010 and June 30, 2009
(Modified Accrual Basis)

	June 30, 2010	June 30, 2009	Variance	
Revenues:				
Federal Grants	$38,493,281	$38,289,446	$203,835	1%
State Appropriations	10,599,637	10,971,688	(372,051)	-3%
Premium Revenues	344,894	150,892	194,002	129%
Investment Income:				
Investment Earnings	143,476	106,999	36,477	34%
Unrealized Gain On Investments*	129,375	0	129,375	100%
Total Investment Income	272,851	106,999	165,852	155%
Total Revenues	$49,710,663	$49,519,025	$ 191,638	0%
Expenditures:				
Claims:				
Outpatient Services	$12,140,132	$12,039,069	$101,063	1%
Physicians and Surgical	9,652,122	9,692,383	(40,261)	0%
Prescribed Drugs	8,766,472	8,353,732	412,740	5%
Dental	5,114,170	4,921,403	192,767	4%
Inpatient Hospital Services	3,427,734	3,880,590	(452,856)	-12%
Outpatient Mental Health	1,315,472	1,304,259	11,213	1%
Durable & Disposable Equipment	1,205,763	1,200,580	5,183	0%
Inpatient Mental Hospital	779,170	740,324	38,846	5%
Vision	710,974	591,725	119,249	20%
Therapy	489,443	463,922	25,521	6%
Medical Transportation	311,294	341,704	(30,410)	-9%
Other Services	109,820	146,680	(36,860)	-25%
Less Collections**	(606,211)	(709,494)	103,283	-15%
Total Claims	43,416,355	42,966,877	449,478	1%
General and Admin Expenses:				
Salaries and Benefits	493,312	490,749	2,563	1%
Program Administration	2,461,031	2,178,074	282,957	13%
Eligibility	406,420	318,877	87,543	27%
Outreach & Health Promotion	288,303	128,013	160,290	125%
Current	127,423	184,039	(56,616)	-31%
Total Administrative	3,776,489	3,299,752	476,737	14%
Total Expenditures	**47,192,844**	**46,266,629**	**926,215**	**2%**
Excess of Revenues Over (Under) Expenditures	2,517,819	3,252,396	(734,577)	-23%
Fund Equity, Beginning	10,109,506	6,857,110	3,252,396	47%
Fund Equity, Ending	$12,627,325	$10,109,506	$2,517,819	25%

* Short Term Bond Fund Investment began in November 2009
** Collections are primarily drug rebates and subrogation

Unaudited - For Management Purposes Only - Unaudited

West Virginia Children's Health Insurance Program
Notes to Financial Statements
For the Twelve Months Ended June 30, 2010

Note 1

Summary of Significant Accounting Policies

Basis of Presentation

The accompanying general purpose financial statements of the West Virginia Children's Health Insurance Program (WVCHIP) conform to generally accepted accounting principles (GAAP) for governments. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for governmental accounting and financial reporting.

Financial Reporting Entity

The West Virginia Children's Health Insurance Program (WVCHIP) expands access to health services for eligible children. Major revenue sources are federal awards and state appropriations. WVCHIP uses third party administrators to process claims, pay providers, and review utilization of health services. An eleven-member board develops plans for health insurance specific to the needs of children and annual financial plans which promote fiscal stability.

Basis of Accounting

WVCHIP follows the modified accrual basis of accounting. Revenues are recognized when they become both measurable and available. Significant revenues subject to accrual are federal awards. Expenditures are recognized when a related liability is incurred.

Assets and Liabilities

Cash and Investments

Cash and Investments principally consist of amounts on deposit in the State Treasurer's Office (STO). Investments are pooled funds managed by the West Virginia Board of Treasury Investments (BTI). WVCHIP makes interest earning deposits in the WV Money Market Pool as excess cash is available. Deposit and withdrawal transactions can be completed with overnight notice. WVCHIP also has funds invested in the WV Short Term Bond Pool that is structured as a mutual fund and is limited to monthly withdrawals and deposits by Participants. Interest income from these investments is prorated to WVCHIP at rates specified by BTI based on the balance of WVCHIP's deposits maintained in relation to the total deposits of all state agencies participating in the pools. The carrying value of the deposits reflected in the financial statements approximates fair value.

Deferred Revenue

Receipts to reimburse for program expenditures to be incurred in the future periods are classified as deferred revenue.

Unpaid Insurance Claims Liability

The liability for unpaid claims is based on an estimate of claims incurred but not yet reported as of the balance sheet date. Offsetting amounts receivable for the federal and state share of these expenditures have been recorded.

Note 2

Cash and Investments

At June 30, 2010, information concerning the amount of deposits with the State Treasurer's Office is as follows:

	Carrying Amount	Bank Balance	Collateralized Amount
Cash			
Deposits with Treasurer	$ 184,859	———	———
Investments			
	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$ 3,016,112	$10,849,481	Cash Liquidity
	$ 9,129,375	$9,129,375	Short Term Bond Pool
Total	$12,145,487		

Note 3

Due to other funds:

Public Employees Insurance Agency Piggyback Contracts	$ 295,253
DHHR & WVOT (Eligibility)	46,990
Other	13,286
Total due to other funds	$ 355,529

Note 4

Unpaid Insurance Claims Liability

Claims payable, beginning of year	$ 3,517,785
Incurred claims expense	43,416,355
Payments:	
Claim payments for current year	36,165,560
Claim payments for prior year	7,444,282
Claims payable, year to date	$ 3,324,298

Note 5

Contingencies

WVCHIP receives significant financial assistance from the U.S. Government in the form of grants and other federal financial assistance. Entitlement to those resources is generally contingent upon compliance with the terms and conditions of the grant agreements and applicable federal regulations, including the expenditure of the resources for allowable purposes. Federal financial assistance awards are subject to financial and compliance audits under either the federal Single Audit Act or by grantor agencies of the federal government or their designees. Any obligations that may arise from cost disallowance or sanctions as a result of those audits are not expected to be material to the financial statements of WVCHIP.

West Virginia Children's Health Insurance Program
Budget to Actual Statement
State Fiscal Year 2010
For theTwelve Months Ended June 30, 2010

	Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Jun-10	May-10	Apr-10
Projected Cost	$48,693,584	$48,693,584	$44,565,400	$4,128,184	8%	$4,057,799	$3,508,569	$3,839,782	$4,469,935
Premiums	305,826	305,826	344,894	($39,068)	13%	25,486	38,015	27,277	29,977
Subrogation & Rebates	623,650	623,650	603,888	19,762	-3%	51,971	139,568	85,864	696
Net Benefit Cost	47,764,108	$47,764,108	$43,616,617	$4,147,491	9%	3,980,342	3,330,985	3,726,641	4,439,262
Salaries & Benefits	$581,411	$581,411	$493,311	$88,100	15%	$48,451	$40,111	$40,111	$40,882
Program Administration	2,665,833	2,665,833	2,321,379	344,454	13%	222,153	93,571	49,718	-134,371
Eligibility	295,243	295,243	411,444	(116,201)	-39%	24,604	0	79,953	15,824
Outreach	300,000	300,000	292,676	7,324	2%	25,000	3,497	35,565	35,830
Current Expense	352,772	352,772	158,783	193,989	55%	29,398	4,915	12,123	11,114
Total Admin Cost	$4,195,259	$4,195,259	$3,677,593	$517,666	12%	$349,605	$142,094	$217,470	-$30,721
Total Program Cost	$51,959,367	$51,959,367	$47,294,210	$4,665,157	9%	$4,329,947	$3,473,079	$3,944,111	$4,408,541
Federal Share 81.83%	42,489,772	$42,489,772	$38,675,336	3,814,436	9%	3,540,814	2,842,020	3,227,466	3,607,509
State Share 18.17%	9,469,595	$9,469,595	$8,618,874	850,721	9%	789,133	631,058	716,645	801,032
Total Program Cost *	$51,959,367	$51,959,367	$47,294,210	$4,665,157	9%	$4,329,947	$3,473,079	$3,944,111	$4,408,541

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2009 Report.

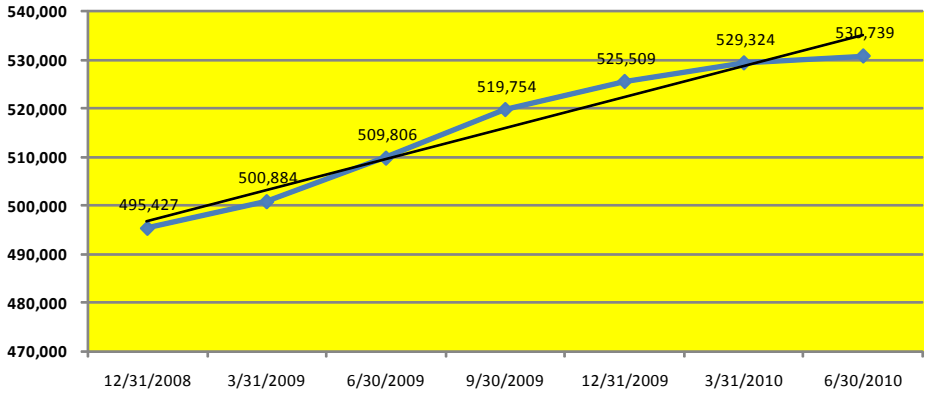
Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES.

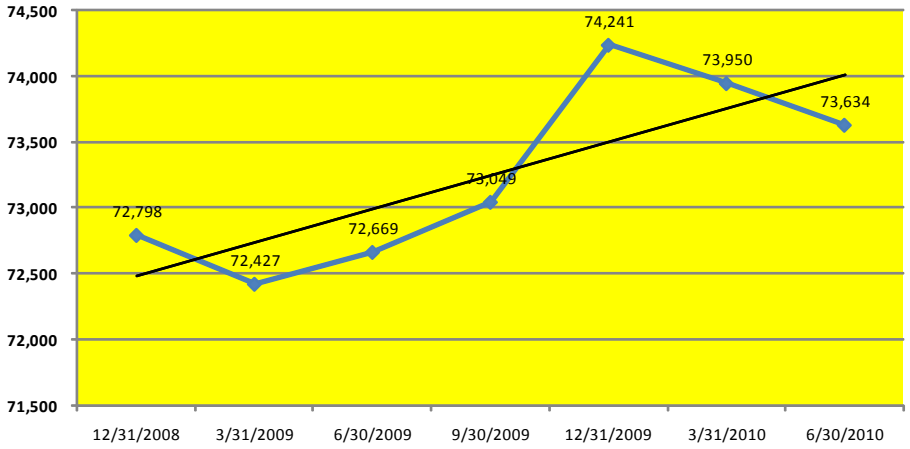
The Downward Economy Impacts Enrollment, But Children Retain Coverage

The graphs below depict the months of coverage for children enrolled in WVCHIP and Medicaid quarterly. The increase in enrollment discussed earlier in this report is based on a member month calculation, or the number of months of coverage. While WVCHIP served fewer children this year, the number of months of coverage provided increased 1.9%, and the average length of coverage during SFY 2010 increased to 7.9, up from 7.6 in SFY 2009. This increase in the length of coverage indicates that children who are on the program are staying on longer and not experiencing a gap in coverage at redetermination.

Medicaid Member Months By Quarter



WVCHIP Member Months By Quarter



Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

The CHIP Reauthorization Act (CHIPRA), passed in February 2009, requires all CHIP programs to pay FQHCs and RHCs under a PPS starting October 1, 2009. Historically, WVCHIP paid FQHCs and RHCs on a fee-for-service basis. Under PPS, WVCHIP will reimburse FQHCs and RHCs a per-visit rate that covers each center's reasonable cost, just as Medicaid programs are required to do. WVCHIP opted to determine each center's rate, or reasonable costs per visit, specific to children and the WVCHIP benefit. WVCHIP decided against using the Medicare calculated rates because the mix of services utilized under the two programs is different. WVCHIP convened an advisory group consisting of representatives of primary care centers to plan the project in the spring of 2010 and released an RFQ to determine these rates in July 2010. The rates will be adjusted annually for medical inflation. There are no cost settlements under the new PPS. WVCHIP expects reimbursements to centers to increase, but has yet to determine the impact of this change. Once rates are determined, WVCHIP is required to pay centers under the new methodology retroactive to October 1, 2009.

Review and Modification of Electronic Enrollment Processes

In the spring of 2009 a group of WVCHIP partners started work on reviewing processes used to transfer enrollment data from the point of origination to the end user, either the third-party administrator or the pharmacy benefit manager. Representatives from the West Virginia Department of Health and Human Resources, RAPIDS, Wells Fargo, TPA, and the state's Office of Technology, responsible for the maintenance and upkeep of WVCHIP's enrollment database, as well as WVCHIP employees participate in this group. The goal of this group is to identify and correct process errors and establish more efficient processes, to lower error rates due to data transfers, and improve customer service, as well as protect WVCHIP funding and private member information. Work on this project continued through all of SFY 2010. One result of this project is a new enrollment database that is more secure, allows WVCHIP employees to directly make necessary changes, and is located on the state's mainframe. The group also worked on establishing or strengthening existing reconciling processes among all WVCHIP enrollment systems to identify and correct errors in enrollment data. Also in SFY 2010, this group began work to provide WVCHIP Premium members with the option of making monthly premium payments on-line. To provide this option to WVCHIP Premium members, it was necessary to change information transfer processes from RAPIDS and its TPAs. Also, the group established a methodology to allow Premium members to determine their start dates, when applicable, to lessen the likelihood that some children would have a gap in coverage simply because they were switching to WVCHIP Premium from one of the other WVCHIP enrollment groups or Medicaid. It was also necessary to update our website. In December 2010, WVCHIP Premium members now have the option to pay online. Monitoring by this group is ongoing but it will meet less often once all current objectives are complete.

Health Care Reform

WVCHIP is partnering with other state Agencies to plan and implement healthcare reform. It regularly participates in meetings coordinated by the Governor's Office on Health Enhancement and Lifestyle Planning (GOHELP), the State Agency responsible for coordinating work among other state agencies. WVCHIP also partnered with Oregon and Alaska CHIP to form the Tri-State Health Improvement Consortium (T-CHIC) and won a Quality Demonstration grant funded by the Children's Health Insurance Reauthorization Act (CHIPRA). Work under this five-year grant focuses on improvement of children's health care quality by demonstrating the unique and combined impact of patient-centered care delivery models and health information technology (HIT) on the quality of children's healthcare as measured by a variety of indicators being assessed simultaneously for their validity and utility in driving quality improvement. The goal of the project is to identify a set of dynamic and robust child health quality measures and the identification of the features of patient-centered care models – including their incorporation of HIT and electronic information exchange – that produce the greatest improvements in quality across a range of provider types, delivery systems, and geographic settings. The project should also create momentum and infrastructure for long-term quality improvement in each state. WVCHIP is partnering with the West Virginia Health Improvement Institute (WVHII) to conduct work on this grant.

CONTACTING WVCHIP's MANAGEMENT

This report is designed to provide our member families, citizens, governing officials and legislators with a general overview of WVCHIP's finances and accountability. If you have questions about this report or need additional information, please contact WVCHIP's Financial Officer at 304-558-2732. General information can also be obtained through our website at www.chip.wv.gov. Electronic application to the program is available on the web at www.wvinroads.org.

Required Supplementary Information

Did you know? .....

Kids should eat a rainbow of colorful fruits and vegetables every day for a healthy, nutricious, and balanced diet.

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2010 Quarterly Report

OVERVIEW

CCRC Actuaries, LLC ("CCRC Actuaries") was engaged by the West Virginia Children's Health Insurance Program ("CHIP Program") to assist the West Virginia CHIP Board in the analysis of actual and projected plan experience in the current State Fiscal Year 2010 ("FY 2010") through Fiscal Year 2017 ("FY 2017"). West Virginia enabling legislation of the CHIP Program requires that an actuary provide a written opinion that all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the fiscal year for which the plan is proposed.

CHIP Program management requested CCRC Actuaries to produce the Baseline Scenario which includes the current WVCHIP Premium expansion to 250% of the Federal Poverty Level ("FPL"). State funding is assumed to be $10,599,637 in FY 2010, and reducing to $10,425,628 in future years. At the Federal level, the Federal funding in FY 2010 for West Virginia was $45,291,868, and we have assumed that this funding remains constant in the future.

In addition, CHIP Program management requested an Expansion Scenario, which assumes a proposed expansion schedule to 300% FPL effective January 2010. Under this scenario, participant premiums are assumed to cover 25% of the policy cost for children in the 250% to 300% FPL group.

Under the submitted West Virginia CHIP Premium expansion plan ("WVCHIP Premium"), the CHIP expansion to 220% began enrollment effective in January 2007. Subsequently, WVCHIP Premium was expanded to 250% FPL effective in January 2009. Premiums are assumed to cover 20% of the policy cost for children in the 200% to 250% FPL eligibility group. The monthly premiums are $35 for families with one child in the program and $71 for families with more than one child in the program. We have assumed the premiums will increase with policy cost increases in the future to maintain the 20% cost share threshold in the 200% to 250% FPL. Premiums will remain at current levels through FY 2011. As of June 2010, there are 1,058 children enrolled in WVCHIP Premium.

The benefit structure for current WVCHIP Premium enrollees has significant cost sharing compared to the benefit structure for children of families under 200% FPL and currently includes the following major components:

- Medical Co-payments: $20 Office Visits
  $25 Inpatient & Outpatient Visits
  $35 Emergency Room Visits
- Prescription Drugs Co-payments: $0 Generic
  $15 Brand
- Full Dental and Vision Benefits with $25 copayments for non-preventative dental services.

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), CHIPRA reauthorizes CHIP for four and a half years through the end of September 2013, and invests $44 billion in new funding for the program for all States on top of the so-called "baseline" of $5 billion per year, bringing the total amount available for CHIP to $69 billion. While this forecast assumes Federal funding levels based on the FY 2010 allotment level, CHIPRA has several mechanisms to adjust Federal expenditures to levels required by the State programs. The Federal funds formula allows for re-basing of the allotment every two years, and there is a contingency fund established separate from the funds allotted to the State of West Virginia that will be used to offset any shortfalls it might experience in Federal funding.

There are several significant changes in the law that are designed to improve the health care that children receive in CHIP and impact the current benefit structure for WVCHIP. Under dental benefits, there are two provisions in the legislation that are designed to improve access to dental care for children.

First, CHIPRA requires States to include dental coverage in their CHIP benefit packages. Now, States must offer a dental benefit that is equivalent to one of the following: the children's coverage that is provided in the Federal Employees Health Benefits Program ("FEHBP"), state employee dependent dental coverage, or dental coverage that is offered through the commercial dental plan in the State with the highest non-Medicaid enrollment. WVCHIP is required to cover Orthodontic, Prosthodontic, and Periodontic services under CHIPRA.

Second, it allows States for the first time to offer dental coverage to children who are enrolled in private or job-based plans that do not include dental coverage. As long as these children are otherwise eligible for CHIP, States can enroll them in CHIP exclusively for dental coverage.

In compliance with CHIPRA's requirements, the benefit for coverages over 200% FPL changed on July 1, 2009. Previously, dental services for this group are limited to preventative services and subject to a maximum of $150 per year. The new dental benefit includes both preventative and restoration services. Services including all restoration, space maintainers, endodontics, prosthodontics, implants, dental surgeries and periodontics are subject to a co-payment of $25 per service and are capped at $100 per year.

Under mental health parity benefit, the new CHIP law also guarantees mental health parity in CHIP. This means that, as with job-based coverage, States must provide the same level of services for mental health benefits in CHIP as they provide for physical health benefits. States that operate CHIP as a Medicaid expansion and hence offer early and periodic screening, diagnosis and treatment ("EPSDT", which essentially guarantees all medically necessary health services for children) are considered to be in compliance with the mental health parity requirement.

In accordance with the mental health parity provision of CHIPRA, West Virginia CHIP place a limit of 26 visits per year on all primary care, specialist, and mental health services. Services above the limit will require prior medical necessity review before the claims are paid. Based on our analysis of current utilization, we have estimated that the program will see no increase in mental health costs effective 7/1/2010.

With reference to "Birth to Three", it is a program administered by West Virginia Department of Health and Human Resources ("WVDHHR") that work with children identified as having developmental delays. WVCHIP has requested that Birth-to-Three costs be included in its financial plan for 2011 and beyond should the WVDHHR request reimbursement for these services. This will increase projected medical cost of additional $300,000 per year effective 7/1/2010.

In regard to the CHIPRA elimination of the waiting period for legal immigrant children and pregnant women benefit, we believe this will be a negligible factor in West Virginia. Due to the low numbers of immigrants living in West Virginia, we are projecting no increase in enrollment and cost to WV CHIP.

It should be noted that this report incorporates some of the provisions of the Patient Protection and Affordable Care Act ("PPACA"), a product of the Health Care Reform ("HCR") Bill. PPACA includes a large number of health-related provisions to take effect over the next several years, particularly, an additional two years extension to CHIPRA reauthorization through September 30, 2015, the expanding Medicaid eligibility starting on January 1, 2014 and an increase in Federal funding participation in FY 2016 through 2019.

Effective January 1, 2014, Medicaid eligibility will expand to individuals and families with income up to 133% FPL. We have assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill. The CHIP Program will serve the remaining children up to 250% FPL. In addition, the HCR Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016.

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2010 will meet the 90% State funding requirement. Based on the Baseline Scenario and the 90% expenditure limitation on State funding of the program, we are not projecting a shortfall in State funding based on funding levels provided by CHIP management through FY 2017.

At the Federal level, the Federal funding in FY 2010 for West Virginia was $45,291,868, and we assume the funding remains constant in the future. Note that we are currently projecting the Federal funding shortfall of approximately $12,194,000 in FY 2016 and $34,525,000 in FY 2017 in the Baseline Scenario under the assumption of Medicaid eligibility of the HCR Bill.

It is noteworthy that under the Baseline scenario, we are not projecting any deficits in the State and Federal financing through 2015 based on current approved funding levels. Under the Expansion to 300% FPL scenario, we are not projecting any deficits in the State and Federal financing through 2015 based on current approved funding levels at the Federal and State level.

It should also be noted that this projection reflects the current information on the availability of Federal funding. We have not assumed any future Federal redistributions for fiscal years 2003 through 2009 in this projection. The Federal share of program expenditure is currently 81.83% for Federal Fiscal Year 2010, 81.27% for Federal Fiscal Year 2011 and it remains unchanged in future years.

Enrollment for the program as of June 2010 has decreased slightly since March 2010. The current program enrollment as of June 2010 consists of 24,824 children total: 15,385 children as part of Phase I and Phase II that consists of children whose families are below 150% of the federal poverty level ("WVCHIP Gold"), 8,381 children as part of Phase III that consists of children whose families are between 150% and 200% of the federal poverty level ("WVCHIP Blue"), and 1,058 children as part of WVCHIP Premium. WVCHIP Blue children are required to make co-payments as part of the benefit structure of the program. Since the March 31, 2010 Quarterly Report with March 2010 enrollment data, overall enrollment has decreased by 155 children. WVCHIP Gold has decreased enrollment by 95 children, WVCHIP Blue has decreased enrollment by 134 children and WVCHIP Premium has increased enrollment by 74 children.

The monitoring and analysis of claim trends is critical to the accurate forecast of future costs of the program. While the program's enrollment has increased in recent months, there has been some moderation of cost trends. Current claim trend experience has been financially favorable over the past several years, and we have maintained the FY 2010 medical claim trend assumption of 8%, and we have increased the FY 2010 dental claim trend assumption to 6.5% from 5%, and we have reduced the FY 2010 prescription drugs claim trend assumption to 6% from 8% as assumed in the March 31, 2010 Quarterly Report, based on trend experience consistent with these assumptions.

Administrative expenses for West Virginia CHIP were originally projected to be $4,221,153 in FY 2010. Net administrative expenses in FY 2010 finished at $3,677,593, representing a 18% increase over FY 2009 administrative expenses of $3,127,615. West Virginia CHIP management team assumes a 5% administrative expense trend in future years.

Drugs rebates were originally projected to be $541,703 in FY 2010, and the year ended with drugs rebates of $522,250. West Virginia CHIP management team assumes a 4% drugs rebates trend in future years.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2010 to be $44,553,761. The updated projection for FY 2011 claims is $49,684,405.

PLAN ENROLLMENT

We have updated our projection based on the enrollment through June 2010. WVCHIP Gold enrollment has been decreasing in recent months. The program had enrollment at the end of FY 2009 of 24,555 children, with 14,727 under WVCHIP Gold, 9,164 under WVCHIP Blue, and 664 under WVCHIP Premium. Current enrollment as of June 2010 is 24,824 children, with 15,385 under WVCHIP Gold, 8,381 under WVCHIP Blue, and 1,058 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment continues to be significantly below projected levels made at the implementation of this component of the Program. For the purposes of this report, we are continuing to utilize the original growth assumptions, combined with actual WVCHIP Premium enrollment through June 2010, and will continue to adjust projected enrollment by actual results.

The following table summarizes the FY 2008 to FY 2010 enrollment information using end of month enrollment information by WVCHIP Gold, WVCHIP Blue, WVCHIP Premium and in total:

Date	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium	Total	Annual % Growth
Jun-03	14,243	7,554		21,797	8.8%
Jun-04	15,015	8,417		23,432	7.5%
Jun-05	15,571	8,944		24,515	4.6%
Jun-06	15,907	8,928		24,835	1.3%
Jun-07	15,658	9,181	100	24,939	0.4%
July-07	15,633	9,073	127	24,833	-0.1%
Aug-07	15,687	9,071	149	24,907	-1.0%
Sep-07	15,712	9,035	166	24,913	-2.4%
Oct-07	15,752	9,102	191	25,045	-1.3%
Nov-07	15,704	9,087	230	25,021	-1.0%
Dec-07	15,617	9,030	246	24,893	-1.5%
Jan-08	15,588	9,045	253	24,886	-1.9%
Feb-08	15,349	8,780	261	24,390	-3.5%
Mar-08	15,316	9,006	264	24,586	-2.3%
Apr-08	15,289	9,061	268	24,618	-1.5%
May-08	15,310	8,963	288	24,561	-1.6%
Jun-08	15,227	8,902	289	24,418	-2.1%
July-08	15,077	8,784	298	24,159	-2.7%
Aug-08	15,134	8,813	309	24,256	-2.6%
Sep-08	15,125	8,827	303	24,255	-2.6%
Oct-08	15,126	8,867	335	24,328	-2.9%
Nov-08	15,096	8,966	348	24,410	-2.4%
Dec-08	15,111	8,925	338	24,374	-2.1%
Jan-09	15,058	8,951	345	24,354	-2.1%
Feb-09	15,020	8,910	374	24,304	-0.4%
Mar-09	14,848	9,160	419	24,427	-0.6%
Apr-09	14,678	9,270	473	24,421	-0.8%
May-09	14,705	9,247	572	24,524	-0.2%
Jun-09	14,727	9,164	664	24,555	0.6%
Jul-09	14,804	9,056	673	24,533	1.5%
Aug-09	14,953	8,875	731	24,559	1.2%
Sep-09	15,137	8,866	775	24,778	2.2%
Oct-09	15,181	8,897	812	24,890	2.3%
Nov-09	15,294	8,772	849	24,915	2.1%
Dec-09	15,349	8,786	918	25,053	2.8%
Jan-10	15,386	8,713	924	25,023	2.7%
Feb-10	15,352	8,561	927	24,840	2.2%
Mar-10	15,480	8,515	984	24,979	2.3%
Apr-10	15,443	8,364	1,016	24,823	1.6%
May-10	15,372	8,351	1,043	24,766	1.0%
Jun-10	15,385	8,381	1,058	24,824	1.1%

The tables below summarize the projected fiscal year June 30th ending enrollment assumptions for Baseline Scenario and Expansion Scenario, by WVCHIP Gold & Blue, and WVCHIP Premium. Effective January 1, 2014, we have assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill.

Baseline Scenario (250% FPL)

Ending Enrollment	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
WVCHIP Gold & Blue	23,766	23,766	23,766	23,766	12,333	12,333	12,333	12,333
WVCHIP Premium	1,058	1,322	1,526	1,670	1,814	1,886	1,886	1,886
Total	24,824	25,088	25,292	25,436	14,147	14,219	14,219	14,219

Expansion Scenario (300% FPL)

Ending Enrollment	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
WVCHIP Gold & Blue	23,766	23,766	23,766	23,766	12,333	12,333	12,333	12,333
WVCHIP Premium	1,058	1,514	1,910	2,246	2,582	2,750	2,750	2,750
Total	24,824	25,280	25,676	26,012	14,915	15,083	15,083	15,083

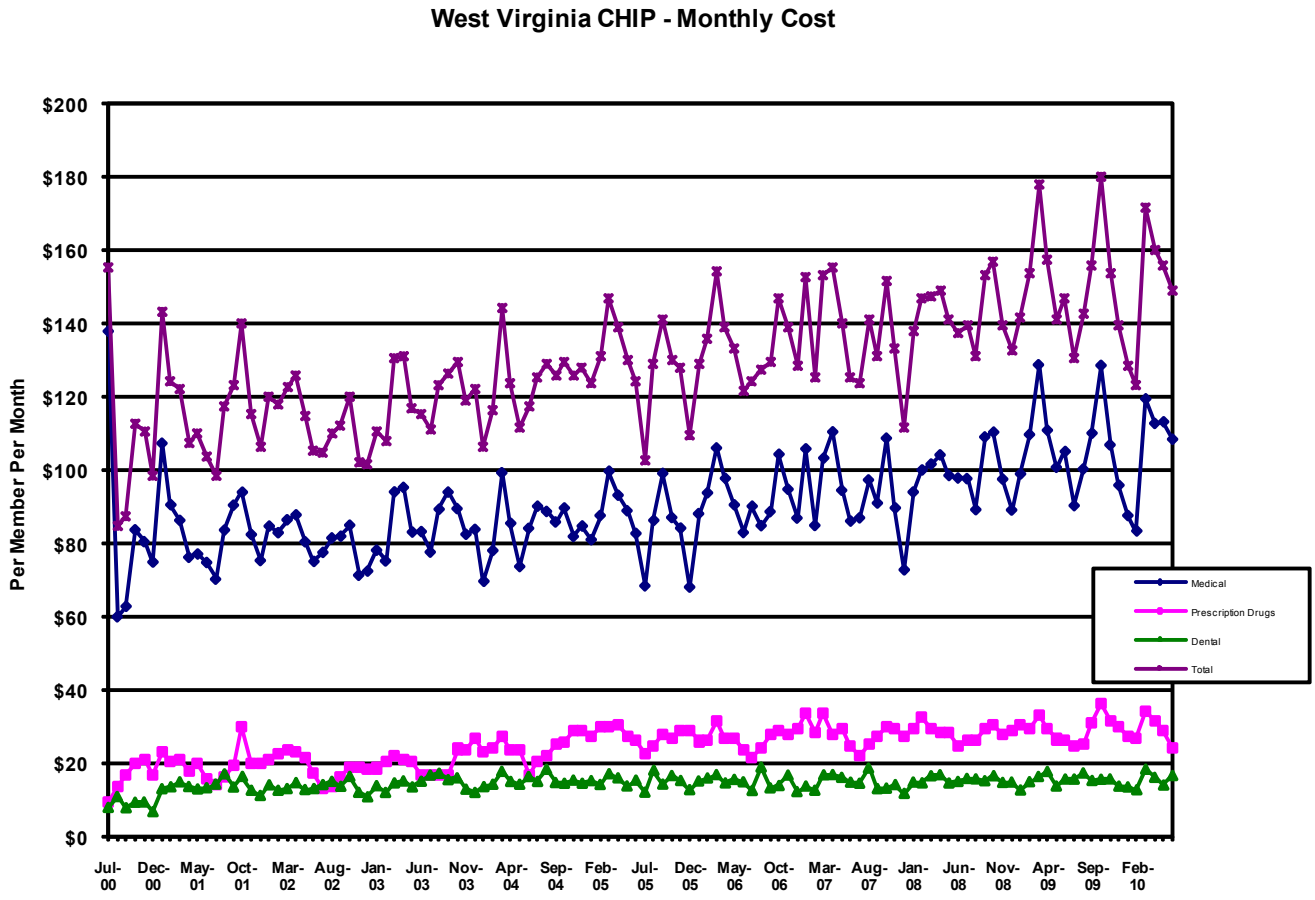
CLAIM COST AND TREND ANALYSIS

We have increased the dental claim trend assumption to 6.5% from 5%, and we have reduced the prescription drugs trend assumption to 6% from 8%, and we have continued to utilize the medical trend assumptions from the March 31, 2010 Quarterly Report. The trend assumptions are 8% for medical claims, 6.5% for dental claims and 6% for prescription drugs claims. Detail historical claim trend analysis for medical, dental and prescription drugs are summarized in the Attachments found at the end of the report.

Overall, the recent experience remains favorable compared to our trend assumptions. It is noteworthy to comment that most recently, medical trend rates have remained below the 8% trend assumption due to lower than expected hospitalizations. As we review trends over different time periods, the six months analysis reflects lower overall trend than the nine months and the twelve months analysis. The table below summarizes WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2010. Overall trend experience has been favorable, with a composite trend of 1.1% over the last twelve months. Note that Prescription Drugs trends are gross of prescription drug rebates received from Express Scripts and Bayer.

Trend Period	Six Months	Nine Months	Twelve Months
Medical	-4.5%	0.5%	0.8%
Dental	0.3%	-0.6%	0.4%
Prescription Drugs	-0.8%	3.4%	2.5%
Composite	-3.3%	1.0%	1.1%

The following graph summarizes incurred claims on a per member per month ("PMPM") basis for the major categories of medical, dental and prescription drugs based on information received through June 2010. The attachment at the end of this report shows the trends for WVCHIP Gold & Blue and an average for the same three categories.



Detailed claim trends for medical, dental and prescription drugs are summarized in the Attachment found at the end of the report. The trends for each of the three categories are relatively flat over the seven years period.

FINANCIAL PROJECTION – STATE FISCAL YEARS 2010-2017

Under the Baseline Scenario, we have assumed FY 2010 State funding of $10,599,637 and future years at $10,425,628. At the Federal level, the Federal funding in FY 2010 for West Virginia was $45,291,868, and we assume the funding remains constant in the future.

The updated incurred claims for FY 2010 is $44,553,761 based on the fiscal year 2010 average enrollment of 24,832 children and the incurred claim per member per month cost data assumption of $149.52, as summarized in the following table.

Category	Current Report FY2010 Baseline Incurred Claims	Current Report FY2010 Baseline Per Member Per Month	3/31/09 Report FY2010 Baseline Per Member Per Month	12/31/08 Report FY2010 Baseline Per Member Per Month
Medical	$30,995,539	$104.02	$107.14	$107.89
Prescription Drugs	8,628,534	28.96	29.31	30.25
Dental	4,929,688	16.54	17.02	17.01
Total	$44,553,761	$149.52	$153.47	$155.15

The Baseline Scenario financial forecast for the Federal and State fiscal years 2010 through 2017 can be found in Appendix A. Based on the assumptions developed under Baseline Scenario, we are not projecting a shortfall in State funding under the 90% funding requirement based on funding levels provided by CHIP management through FY 2017. At the Federal level, we are currently projecting the Federal funding shortfall of approximately $12,194,000 in FY 2016 and $34,525,000 in FY 2017 in the Baseline Scenario under the assumption of Medicaid eligibility of the HCR Bill. It should be noted that the HCR Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016.

Appendix A and B show the Baseline Scenario and the Expansion Scenario with seven-year projection period as requested by CHIP management. The first section of the report is the beginning balances of both Federal and State funding sources. The middle section of the report projects and reports on incurred claim, paid claim and administrative expenses, as well as expected Interest earnings and accrued prescription drugs rebates. This section also projects Federal and State shares of paid expenses, as well as incurred but not received ("IBNR") claim liabilities. The last section of the report projects the ending balances of both Federal and State funding sources.

It should be noted that the Federal Government has not provided projections of expected Federal funding in the final years of the projection and these estimates are subject to change.

Appendix C summarizes the original and restated IBNR claim liabilities for the CHIP Program in Fiscal Year 2008 to 2010. IBNR projections have been recently lower to reflect current claim experience as illustrated.

STATEMENT OF ACTUARIAL OPINION

I, Dave Bond, Managing Partner of CCRC Actuaries, LLC, hereby certify that I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the actuarial qualification standards to render Statements of Actuarial Opinion for Children Health Insurance Program and other self-insured entities. I have been retained by CHIP to render a Statement of Actuarial Opinion regarding the methods and underlying assumptions developed and used in this analysis.

This Statement of Actuarial Opinion was prepared in a manner consistent with the Code of Professional Conduct and Qualification Standards of the American Academy of Actuaries, and the Standards of Practice of the Actuarial Standards Board. Concerning the projection of health care expenses, I am of the opinion that the data and assumptions used are appropriate.

In my opinion, all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the future fiscal years 2010 through 2017 based on current enrollment under the Baseline Scenario.

It should be noted that this opinion is based on State funding levels as illustrated in Appendix A and FY 2010 through FY 2017 have not been appropriated by the West Virginia Legislature.

Dave Bond
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Managing Partner
CCRC Actuaries, LLC
Reisterstown, Maryland
July 23, 2010

Brad Paulis
Reviewing Partner
CCRC Actuaries, LLC
Reisterstown, Maryland
July 23, 2010

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2010 Quarterly Report

(Baseline Scenario)

Available Funding - Beginning of the Year	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Federal 2009	$28,480,578	$0	$0	$0	$0	$0	$0	$0
Federal 2010	45,291,868	35,040,363	0	0	0	0	0	0
Federal 2011	0	45,291,868	37,524,721	0	0	0	0	0
Federal 2012	0	0	45,291,868	36,569,875	0	0	0	0
Federal 2013	0	0	0	45,291,868	31,968,228	0	0	0
Federal 2014	0	0	0	0	45,291,868	24,280,279	0	0
Federal 2015	0	0	0	0	0	45,291,868	13,320,365	0
Federal 2016	0	0	0	0	0	0	45,291,868	0
Federal 2017	0	0	0	0	0	0	0	45,291,868
State Funding 2009	$10,535,285	$2,004,988	$0	$0	$0	$0	$0	$0
State Funding 2010	10,599,637	10,599,637	2,940,478	0	0	0	0	0
State Funding 2011	0	10,425,628	10,425,628	2,822,425	0	0	0	0
State Funding 2012	0	0	10,425,628	10,425,628	1,863,339	0	0	0
State Funding 2013	0	0	0	10,425,628	10,425,628	188,343	0	0
State Funding 2014	0	0	0	0	10,425,628	10,425,628	0	0
State Funding 2015	0	0	0	0	0	10,425,628	8,176,827	4,694,063
State Funding 2016	0	0	0	0	0	0	10,425,628	10,425,628
State Funding 2017	0	0	0	0	0	0	0	10,425,628
Phase II & Phase III Program Costs	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Medical Expenses	$29,866,480	$32,638,513	$35,249,595	$38,069,562	$41,115,127	$44,404,337	$47,956,684	$51,793,219
Prescription Drug Expenses	8,314,226	8,833,208	9,363,200	9,924,992	10,520,492	11,151,721	11,820,825	12,530,074
Dental Expenses	4,750,117	5,790,861	6,167,267	6,568,139	6,995,068	7,449,748	7,933,981	8,449,690
Administrative Expenses	3,507,594	3,656,294	3,839,109	4,031,064	3,214,534	2,306,274	2,421,588	2,542,667
WVCHIP Premium Program Costs								
Medical Expenses	$1,129,059	$1,672,458	$2,176,981	$2,605,338	$3,066,373	$3,544,713	$3,858,982	$4,167,700
Prescription Drugs Expenses	314,307	452,630	578,262	679,229	784,620	890,220	951,199	1,008,271
Dental Expenses	179,571	296,734	380,884	449,499	521,693	594,699	638,432	679,930
Administrative Expenses	169,999	240,199	303,974	353,681	404,704	454,841	481,412	505,482
Premiums (WVCHIP Premium)	$344,894	$455,139	$589,380	$701,753	$821,770	$945,232	$1,023,972	$1,100,449
Program Revenues - Interest	$101,830	$110,962	$114,631	$114,062	$109,441	$101,371	$89,628	$72,848
Program Revenues - Drug Rebates	522,250	543,140	564,866	587,461	610,959	635,397	660,813	687,246
Net Incurred Program Costs Excluding Interest	$47,364,210	$52,582,619	$56,905,025	$61,392,291	$65,189,883	$69,215,925	$74,378,318	$79,889,339
Net Paid Program Costs	47,294,210	52,177,619	56,576,025	61,039,291	64,809,883	68,806,925	73,938,318	79,416,339
Federal Share	$38,732,083	$42,807,510	$46,246,714	$49,893,515	$52,979,818	$56,251,782	$70,805,924	$79,816,491
State Share of Expenses - Net of Interest	8,530,297	9,664,147	10,543,680	11,384,714	12,100,624	12,862,772	3,482,765	0
Beginning IBNR	$3,940,000	$4,010,000	$4,415,000	$4,744,000	$5,097,000	$5,477,000	$5,886,000	$6,326,000
Ending IBNR	4,010,000	4,415,000	4,744,000	5,097,000	5,477,000	5,886,000	6,326,000	6,799,000

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2009 Quarterly Report

(Baseline Scenario)

Funding Sources - End of the Year	2010	2011	2012	2013	2014	2015	2016	2017
Federal 2009	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2010	35,040,363	0	0	0	0	0	0	0
Federal 2011	0	37,524,721	0	0	0	0	0	0
Federal 2012	0	0	36,569,875	0	0	0	0	0
Federal 2013	0	0	0	31,968,228	0	0	0	0
Federal 2014	0	0	0	0	24,280,279	0	0	0
Federal 2015	0	0	0	0	0	13,320,365	0	0
Federal 2016	0	0	0	0	0	0	0	0
Federal 2017	0	0	0	0	0	0	0	0
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$12,193,692***	***$34,524,623***
State Funding 2009	$2,004,988	$0	$0	$0	$0	$0	$0	$0
State Funding 2010	10,599,637	2,940,478	0	0	0	0	0	0
State Funding 2011	0	10,425,628	2,822,425	0	0	0	0	0
State Funding 2012	0	0	10,425,628	1,863,339	0	0	0	0
State Funding 2013	0	0	0	10,425,628	188,343	0	0	0
State Funding 2014	0	0	0	0	10,425,628	0	0	0
State Funding 2015	0	0	0	0	0	8,176,827	4,694,063	4,694,063
State Funding 2016	0	0	0	0	0	0	10,425,628	10,425,628
State Funding 2017	0	0	0	0	0	0	0	10,425,628
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall - 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

415 Main Street
Reisterstown, MD 21136

Phone: 410-833-4220
Fax: 410-833-4229

Email: info@ccrcactuaries.com

December 20, 2010

Ms. Sharon Carte
Director
West Virginia Children's Health Insurance Program
1018 Kanawha Blvd. E., Suite 209
Charleston, WV 25301

Subject: West Virginia Children's Health Insurance Program – Review of Experience

Dear Sharon:

CCRC Actuaries, LLC was engaged by the management of West Virginia Children's Health Insurance Program ("CHIP Program") to assist the West Virginia CHIP Board in the analysis of actual and projected plan experience and review the claim experience through October 2010. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2011 based on the updated information. CHIP Program's financial projections continue to improve primarily due to lower enrollment and lower claim trends.

It is noteworthy that we are not projecting a shortfall in State funding based on funding levels provided by CHIP management through FY 2017 based on the assumption that future funding remains constant. After the September 30, 2010 Quarterly Report was issued in October 2010, several changes have occurred in the program:

- Enrollment for the CHIP Program has gradually declined from 24,824 in June 2010 to 24,482 as of October 2010;
- October 2010 claim experience showed the projected incurred FY 2011 expenditures to be $46,292,805, a decrease of $1,751,117 from $ 48,043,922 in the September 30, 2010 Quarterly Report.
- The categories of FY 2011 medical, dental and prescription drug expenses in the current claim experience through October 2010 showed favorable experience over the September 30, 2010 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2011 is now projected to be $156.56, down from the projected $162.03 PMPM cost in the September 30, 2010 Quarterly Report. Medical PMPM for Fiscal Year 2011 is now projected to be $108.15, down from the projected $113.03 PMPM cost in the September 30, 2010 Quarterly Report. Dental PMPM for Fiscal Year 2011 is now projected to be $17.49, slightly down from the projected $18.01 PMPM cost in the September 30, 2010 Quarterly Report. Prescription Drugs PMPM for Fiscal Year 2011 is now projected to be $30.92, slightly down from the projected $30.99 PMPM cost in the September 30, 2010 Quarterly Report.

The management of the CHIP Program provided the medical, dental and prescription drugs claim lag data, along with the program enrollment. I had reviewed the recent projections based on the gradually increasing enrollment and utilized our trend assumptions with the claim lag data. Actuarial methods, considerations and analyses relied on in forming my opinion conforms to the appropriate standard of practice as promulgated by the Actuarial Standards Board.

Please review this information and if you have any questions or comments about this letter, please feel free to call me at (410) 833-4220.

Sincerely,

Dave Bond, F.S.A., M.A.A.A.
Managing Partner

Program Outreach and Health Awareness

A Continuing Community Partnership

WVCHIP continues to work with many types of community partners and entities as identified in its State Plan, however, as enrollment has stabilized, efforts to promote public awareness of the program have shifted from an enrollment focus to one of promoting child health awareness and prevention messaging on topics such as childhood health screening, child development, immunizations, and the importance of a medical home.

A Targeted Approach

Based on health insurance survey data from the U.S. Census Bureau's "2009 Annual Social and Economic Supplement," WVCHIP continues to prioritize outreach efforts to the top fifth of our counties *(shown on page 43)* in the State with either higher estimated numbers or percentages of uninsured children. Some potential impact of these efforts at the county level can be seen in the Statistical Section in Tables 9 and 10 *(shown on Page 52 and 53)*.

Public Information via the Helpline, Website, and WVinRoads

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Helpline, which averages over 1,700 calls a month and mails out about 400 applications a month. Information is also available through the agency's website at www.chip.wv.gov where program guidelines and applications can be downloaded and printed. The WVCHIP website provides a wealth of information to the public about the agency, its governance, applying and enrolling, benefits, major annual reports, program statistics, and other program and health related information.

An online electronic application process that allows people to apply from the convenience of home and print out their own applications is available by the WVDHHR Rapids Project at www.wvinroads.org. Many *INROADS* users who have evaluated the online application process have commented on its ease of use, costs avoided from travel to pick up applications, and time savings from having to wait in line at local offices.

WV Healthy Kids and Families Coalition-A Community and Faith-Based Emphasis

WVCHIP supports those community partners interested in children's health through a three-tiered approach to outreach: tier one is promoting general awareness through information and materials; tier two is referring to partners or the Helpline who can provide an application; and tier three is application assistance where a local community partner can provide access to electronic application answer questions actively guide an applicant through the process.

For all of the above approaches to outreach, WVCHIP turns to the WV Healthy Kids and Families Coalition (WVHKF), a group of community and faith-based organizations. The WV Council of Churches serves as the fiscal agent for this group which also includes local community health centers, school nurses, child care agencies, and faith based community programs among others. Their efforts include a monthly e-bulletin that goes out to all members interested in children's health issues as well as organizing West Virginia's annual "Growing Healthy Kids" conference. This conference has included nationally recognized speakers for key topics such as oral health, prenatal care, as well as workshops for preventive health and mental health.

Many participating coalition members keep CHIP applications at their work sites and help refer applicants to either the CHIP Helpline or local DHHR offices for assistance. Last year as many as 100 statewide partners ordered health informational materials from WVCHIP's website to promote children's health coverage at local events sponsored in their communities.

This year, WVCHIP continued working with a group of faith-based partners throughout the state to actively assist in the electronic application process available through the wvInroads Community Partner system. Since West Virginians are inclined to turn to those they know and trust in their local communities, this can help the public learn more about the value of electronic applications and make it more widely available to those without online access in the home.

Health Collaborative Efforts

Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP prioritizes prevention efforts to support our State's Healthy People 2010 objectives for children.

The following projects and collaborative efforts were implemented in fiscal year 2010:

- ★ Continued participation in efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, and West Virginia Asthma Coalition.

- ★ WVCHIP continued to promote full periodic and comprehensive well-child visits recommended by pediatricians in a "HealthCheck" Campaign. WVCHIP sponsored health messages focusing on vision, dental, development, and hearing screenings that appeared in Child Care Provider Quarterly Magazine. WVCHIP supports the "HealthCheck" form as a standard form or model for provider use in all well-child exam visits.

- ★ WVCHIP participated on the Oral Health Advisory Board to help develop the State's first Oral Health Plan which was reported to the Legislature in 2010.

- ★ Recognizing some children's health coverage was jeopardized when parents lost employer coverage due to workforce reductions, WVCHIP put more time and resources into supporting dislocated workers this year. Staff members or outreach partners were on hand as part of the Governor's Rapid Response teams to provide CHIP information at 10 sessions throughout the State to several hundred dislocated workers.

- ★ WVCHIP information flyers and pocket slide guidelines on the "ABC's of Baby Care" were provided in Day One Program packets to be distributed to all new mothers at participating West Virginia hospitals.

- ★ WVCHIP worked in close collaboration with West Virginia Alliance for Sustainable Families, the lead agency, who along with community partners working with West Virginia Council of Churches, were awarded a federal grant in 2010 to promote children's coverage through outreach. They have sponsored a number of public events along with press releases to encourage kids to sign up for CHIP in order to be able to get their sports physicals. They also have enabled parents to enroll their children in CHIP at the BB&T bank-mobile bus that goes through West Virginia towns after January to help provide assistance in tax filing.

Health Collaborative Efforts (continued)

★ For the fifth consecutive year, WVCHIP served on the steering committee and as a sponsor of the "Growing Healthy Children Conference." Held annually in Charleston, the conference covers an array of topics on current child health concerns from oral health, mental health, to school-based health. This year's conference was a departure, however, with an entire day and a half summitt exclusively devoted to presentations on the Affordable Care Act and health care reform. The C.W. Benedum Foundation and the American Academy of Pediatricians, WV Chapter are also sponsors.

Camp NEW You and DanceDance Revolution State Tournament:

Camp NEW You

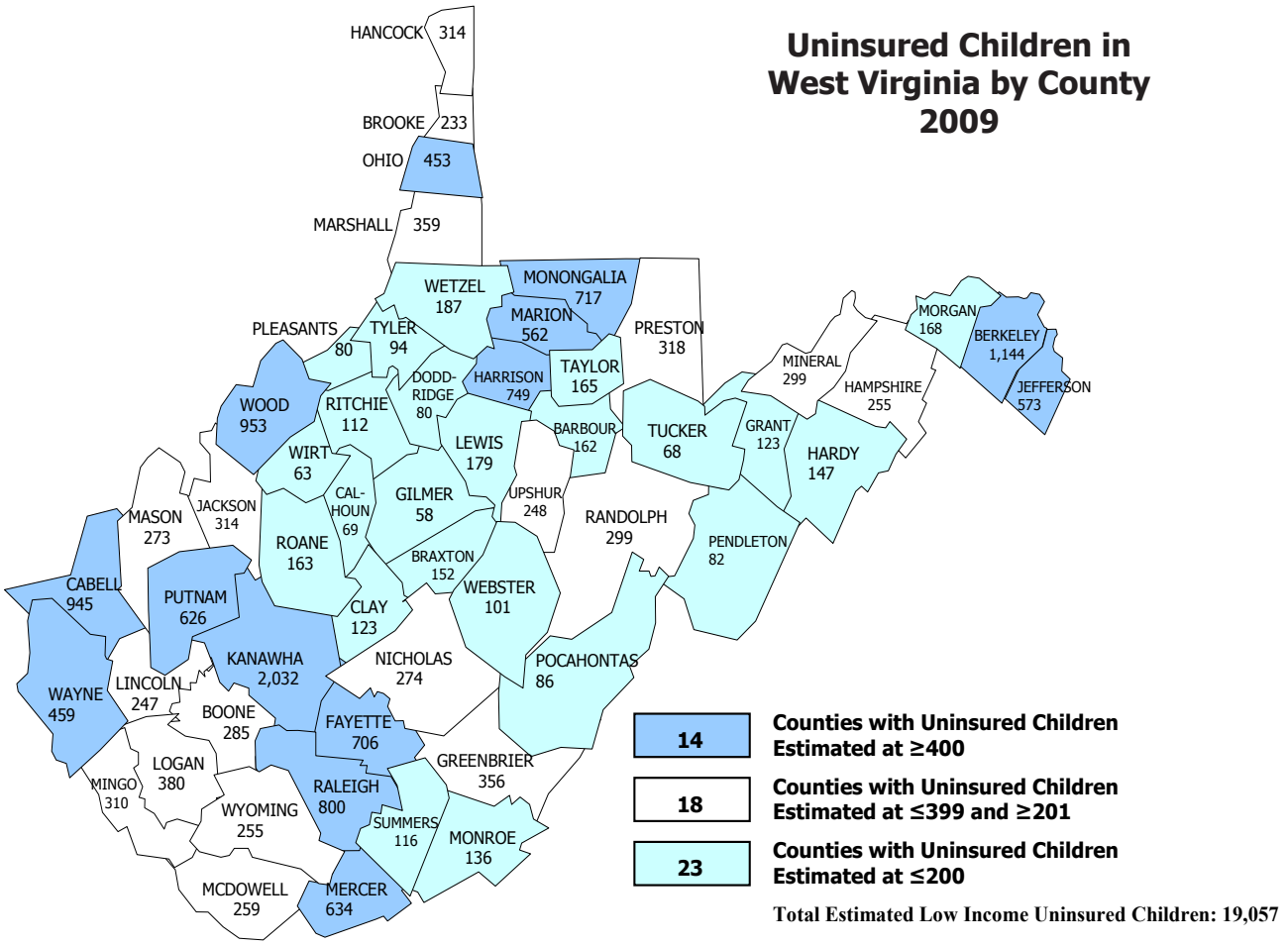
Camp NEW You was designed as an outgrowth of the nationally recognized Cardiac (Coronary Artery Disease Detection in Appalachian Counties) Project run by West Virginia University. It seeks to provide an intervention for overweight youth ages 11 to 14 through a one year program. The program starts with a three week intensive camp experience that includes medical assessments, education and practice of good nutrition, physical activities plan, weight reduction, etc. with the support of trained nutritionists, physical activity experts, and behavioral health experts.

After completion of the three week camp experience, each participant is assigned a "personal lifestyle coach" who has worked with them at the camp and continues to support healthy lifestyle changes and goals work throughout the remaining eleven months of the program. Although WVCHIP cannot provide coverage for this intervention as a regular benefit, it supports limited participation of interested WVCHIP members up to an average of five scholarships each year from its administrative funds.

DanceDance Revolution State Tournament

WVCHIP was a major sponsor of a statewide tournament in middle schools and high schools that provided information about the CHIP program as part of signing up for participation in the tournament. The tournament culminated in June 2010 with the State Championship held at the Capitol in which the top three competitors were awarded monetary prizes by former Governor Joe Manchin III.

Targeted Outreach For Uninsured Children



Note 1: The most recent estimate for all uninsured children statewide from the U.S. Census Current Population Survey is from 6.3% to 5%. Even a five percent extrapolation at the county level may vary significantly from county to county depending on the availability of employee sponsored insurance. However, it remains our best gross estimate of the remaining uninsured children.

Note 2: It has been estimated that 7 of 10 uninsured children qualify or may have qualified for CHIP or Medicaid in the past, WVCHIP uses the lower estimated limit of 5% as a target number for outreach due to the way census sampling is likely to overstate this rate.

Statistical Section

Did you know? .....

Exercise isn't just good for the body, but it is also good for the brain! Research shows physically fit children do better in school.

All statistics are for the fiscal year ended June 30, 2010, unless noted otherwise.

Table 1: Enrollment

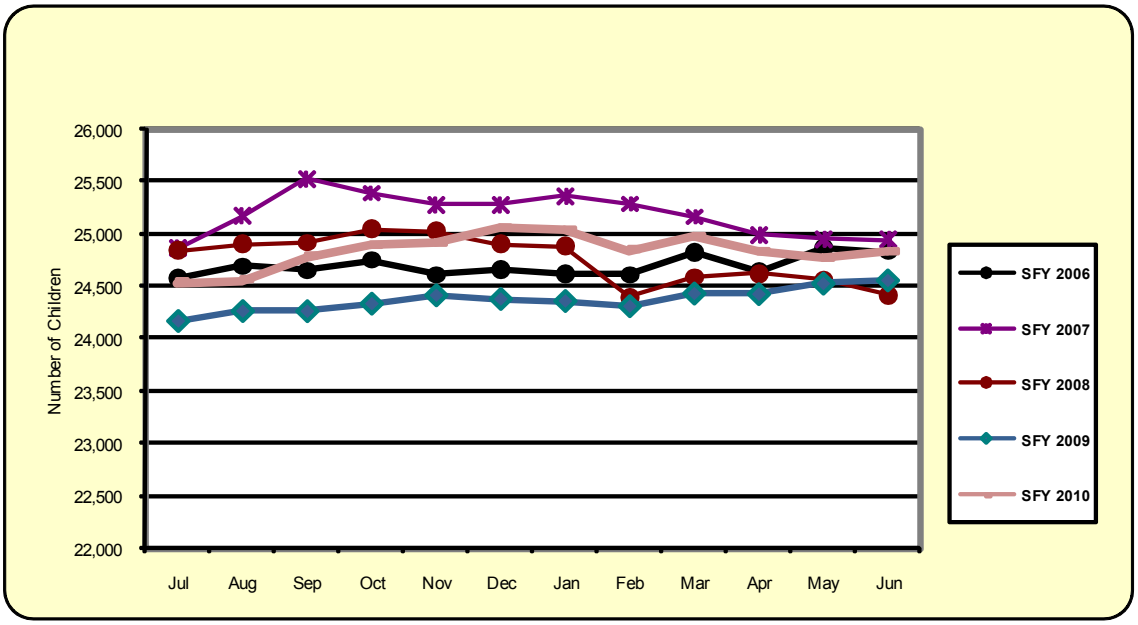
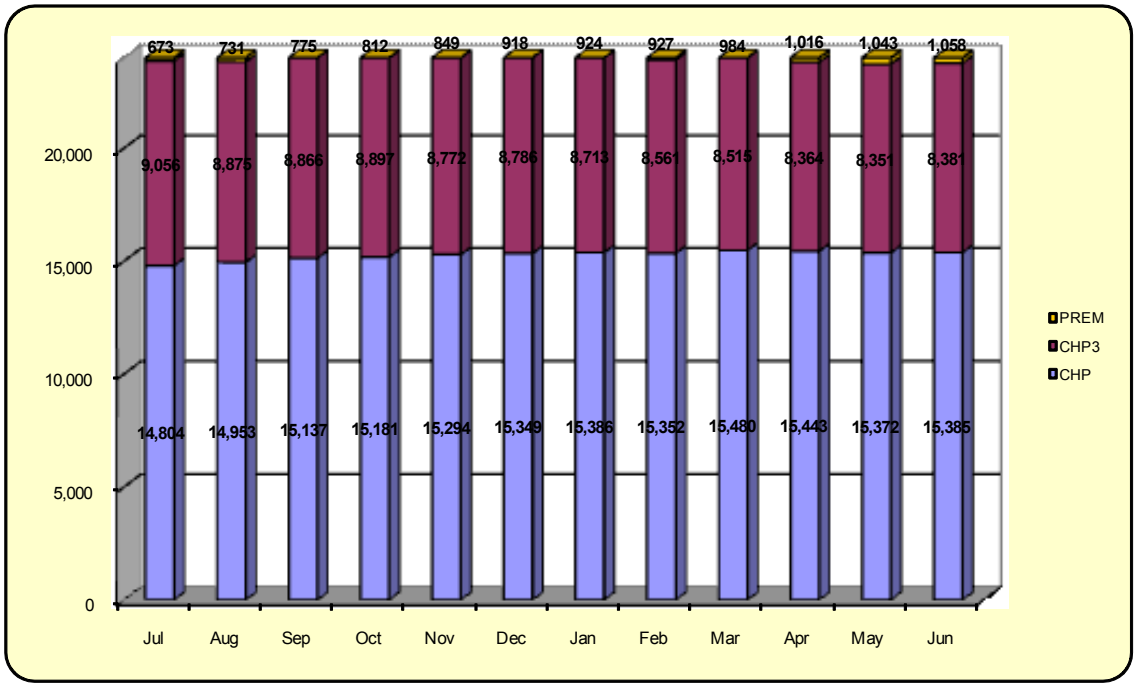
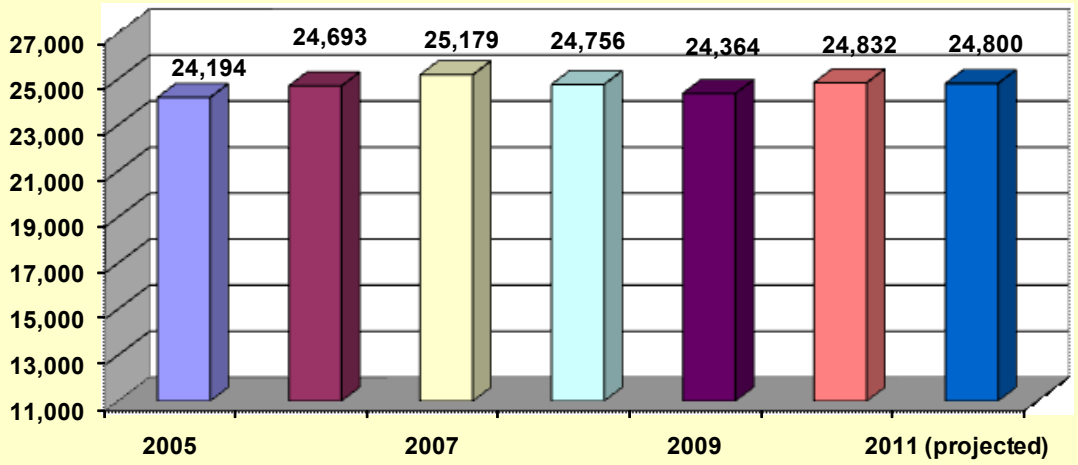


Table 2: Enrollment Detail



Note: CHIP Blue (Phase III) Effective October 2000 PREMIUM effective January 1, 2007

Table 3: Average Enrollment
SFY 2004 - 2010



Unduplicated Count of Children Served in WVCHIP Each Year on June 30

Year	Number	% Change
2001	30,006	
2002	33,569	+11.9%
2003	33,709	+0.4%
2004	35,495	+5.3%
2005	36,978	+4.2%
2006	38,064	+2.9%
2007	38,471	+1.1%
2008	37,707	-0.7%
2009	37,874	+0.4%
2010	37,758	-0.3%

Total unduplicated number of children ever enrolled as of June 30, 2010 in WVCHIP since inception:
126,885

Table 4: Enrollment By Gender

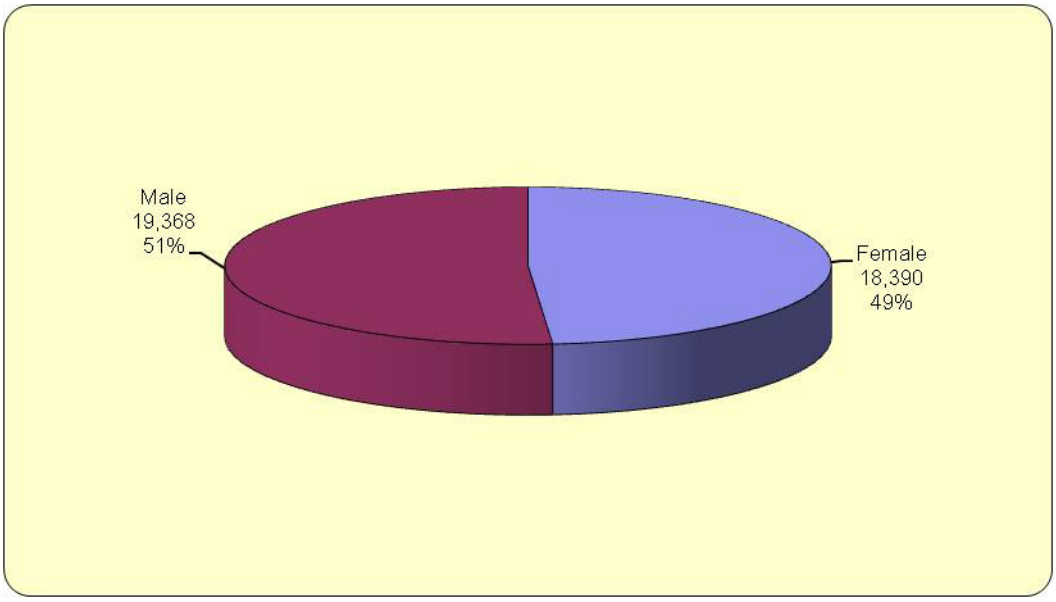


Table 5: Enrollment By Age

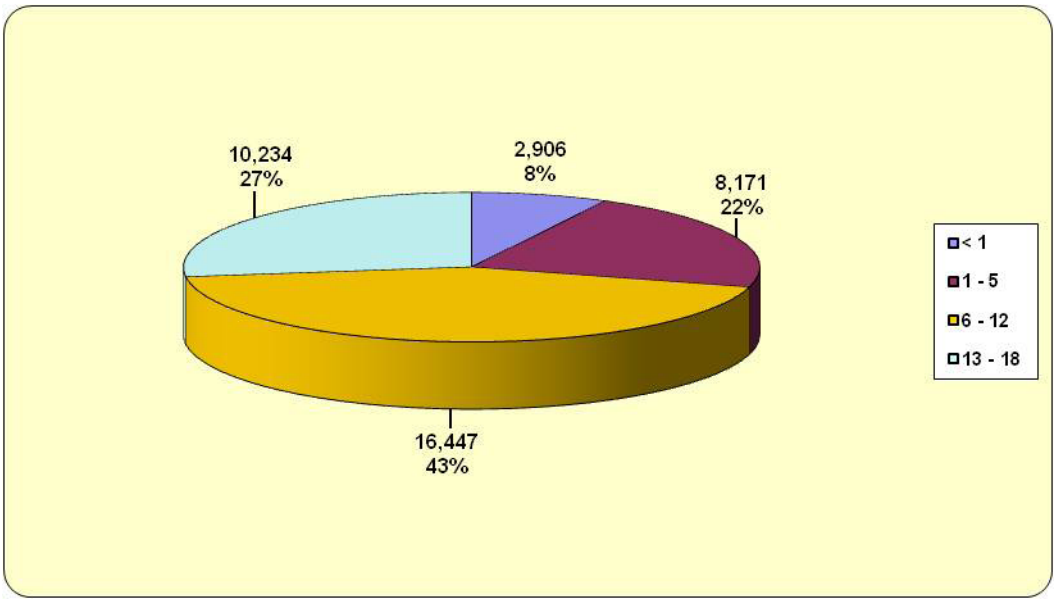
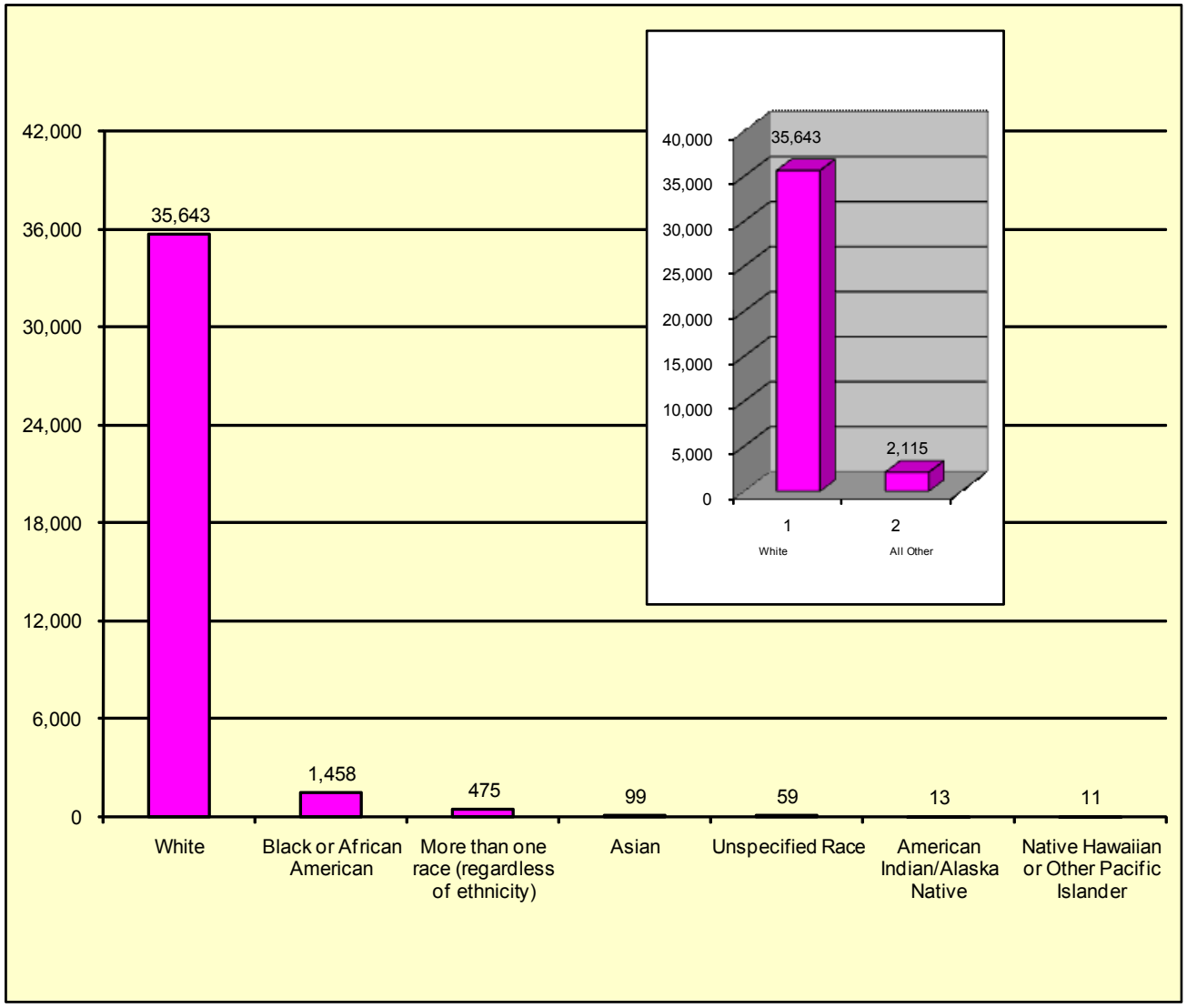
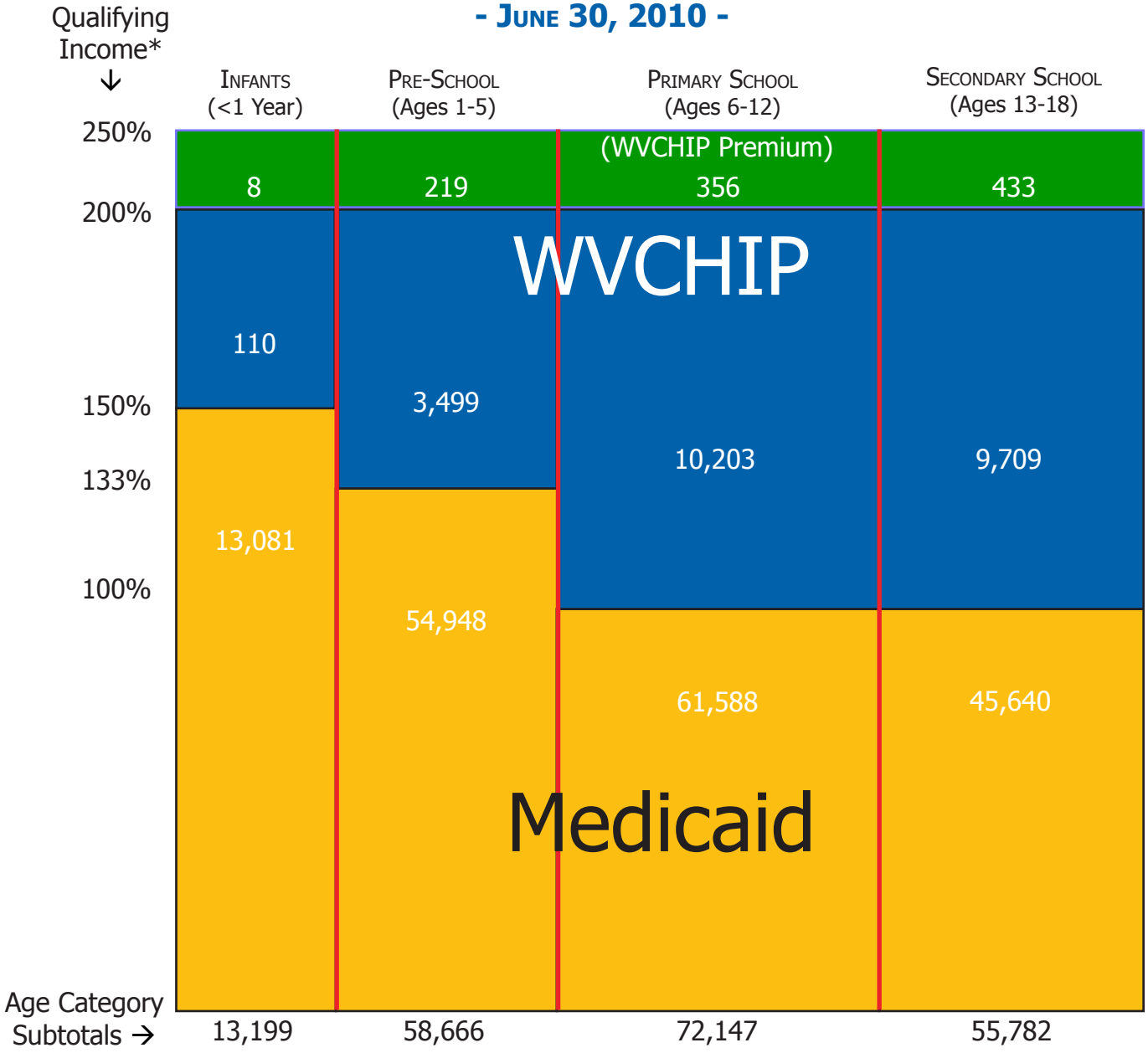


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	35,643	94.4%	362,360	94.5%
Black or African American	1,458	3.9%	13,725	3.6%
More than one race (regardless of ethnicity)	475	1.3%	3,719	1.0%
Asian	99	0.3%	2,530	0.7%
Unspecified Race	59	0.2%	0	0.0%
American Indian/Alaska Native	13	0.0%	882	0.2%
Native Hawaiian or Other Pacific Islander	11	0.0%	77	0.0%
Total	**37,758**	**100.0%**	**383,292**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2010 -



*Household incomes through 250% of the Federal Poverty Level (FPL)

Total WVCHIP Enrollment **24,537** **Total WV Medicaid Enrollment** **175,257**

Total # of Children Covered by WVCHIP and Medicaid - 199,794

TABLE 8: ANNUAL RE-ENROLLMENT AND NON-RESPONSES UPON RENEWAL
JULY 2009 THROUGH JUNE 2010

County	# of Renewal Forms Mailed Monthly To CHIP Households	# of Closure Notices Mailed For Non-Returned Forms	# of Households Re-Opened as CHIP	% of Households Re-Opened After Closure	# of Households Closed with No Response	% of Households Closed
Calhoun	109	39	15	38.5%	19	17.4%
Wirt	97	33	12	36.4%	17	17.5%
Pocahontas	121	29	6	20.7%	22	18.2%
Monongalia	168	54	17	31.5%	31	18.5%
Wetzel	170	71	16	22.5%	32	18.8%
Doddridge	120	42	14	33.3%	23	19.2%
Lewis	259	80	23	28.8%	51	19.7%
Wyoming	326	99	23	23.2%	67	20.6%
Summers	178	51	5	9.8%	38	21.3%
Tucker	131	44	14	31.8%	28	21.4%
Wood	1,013	372	102	27.4%	219	21.6%
Roane	212	66	19	28.8%	46	21.7%
Ohio	479	154	29	18.8%	105	21.9%
Webster	132	51	12	23.5%	29	22.0%
Gilmer	81	38	16	42.1%	18	22.2%
Marion	616	226	55	24.3%	137	22.2%
Mingo	660	238	62	26.1%	147	22.3%
Raleigh	1,104	368	69	18.8%	247	22.4%
Mason	225	80	25	31.3%	51	22.7%
Marshall	321	120	22	18.3%	73	22.7%
Jackson	333	110	23	20.9%	76	22.8%
Monroe	224	85	19	22.4%	52	23.2%
Hardy	139	61	17	27.9%	33	23.7%
Randolph	380	148	35	23.6%	92	24.2%
Mineral	318	120	29	24.2%	77	24.2%
Mercer	242	86	14	16.3%	59	24.4%
Clay	155	71	20	28.2%	38	24.5%
Brooke	273	97	20	20.6%	68	24.9%
Putnam	605	224	48	21.4%	152	25.1%
Nicholas	340	134	37	27.6%	86	25.3%
Greenbrier	503	184	38	20.7%	128	25.4%
Wayne	496	208	53	25.5%	127	25.6%
Hampshire	257	114	29	25.4%	66	25.7%
Hancock	314	129	27	20.9%	83	26.4%
Upshur	363	139	29	20.9%	99	27.3%
Lincoln	369	149	26	17.4%	102	27.6%
Ritchie	123	74	28	37.8%	34	27.6%
Braxton	176	71	14	19.7%	49	27.8%
Harrison	812	322	61	18.9%	228	28.1%
Pleasants	89	46	18	39.1%	25	28.1%
McDowell	982	407	78	19.2%	278	28.3%
Taylor	186	79	19	24.1%	53	28.5%
Morgan	305	119	16	13.4%	87	28.5%
Preston	426	165	34	20.6%	123	28.9%
Boone	269	110	19	17.3%	78	29.0%
Logan	469	205	43	21.0%	138	29.4%
Pendleton	98	39	4	10.3%	29	29.6%
Fayette	804	360	72	20.0%	240	29.9%
Barbour	242	112	23	20.5%	73	30.2%
Cabell	842	384	70	18.2%	259	30.8%
Jefferson	354	157	36	22.9%	109	30.8%
Kanawha	1,972	863	127	14.7%	636	32.3%
Grant	141	70	15	21.4%	48	34.0%
Berkeley	1,156	546	94	17.2%	404	34.9%
Tyler	110	48	8	16.7%	39	35.5%
Totals	**21,389**	**8,491**	**1,799**	**21.2%**	**5,668**	**26.5%**
12-Mo. Ave.		***708***	***150***	***21.2%***	***472***	***26.5%***

MEDIAN

Table 9: Enrollment Changes By County
As % Difference from July 2009 through June 2010

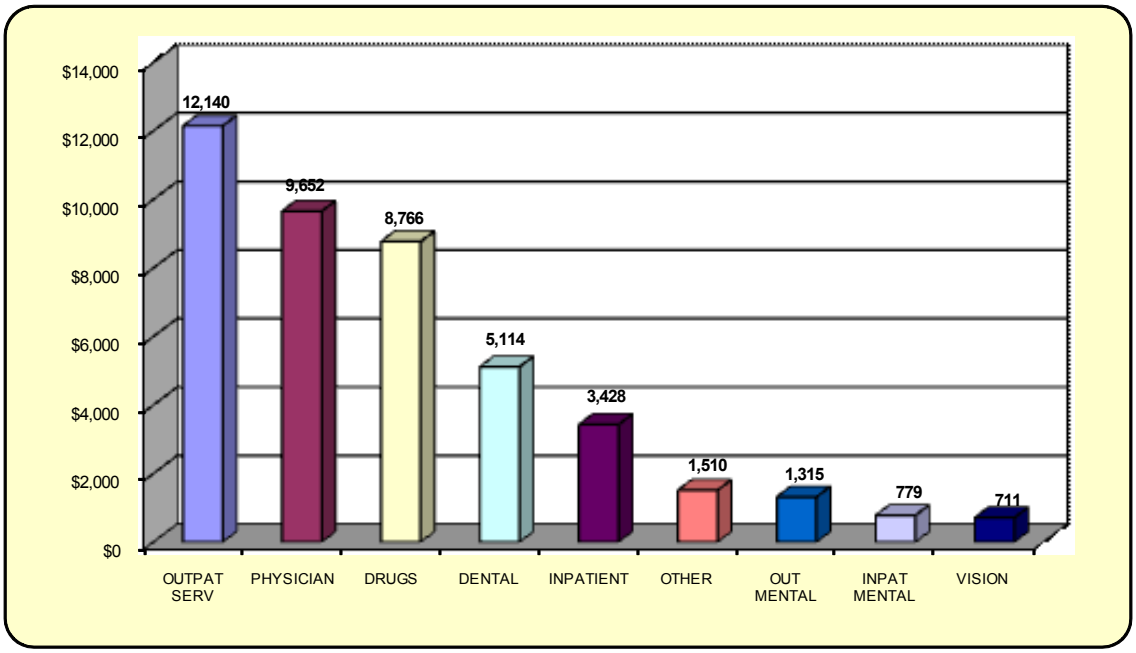
County	Total Enrollees July 2009	Total Enrollees June 2010	Difference	% Change
Monroe	194	231	37	16%
Braxton	197	228	31	14%
Roane	263	302	39	13%
Greenbrier	559	622	63	10%
Grant	153	168	15	9%
Wayne	552	601	49	8%
Hardy	153	166	13	8%
Mason	279	302	23	8%
Hampshire	281	301	20	7%
Cabell	995	1,064	69	6%
Jefferson	414	438	24	5%
Mineral	283	299	16	5%
Mercer	1,108	1,168	60	5%
Jackson	383	403	20	5%
Logan	565	588	23	4%
Harrison	910	940	30	3%
Kanawha	2,217	2,280	63	3%
Lewis	295	303	8	3%
Berkeley	1,265	1,298	33	3%
Morgan	246	252	6	2%
Tyler	128	131	3	2%
Raleigh	1,264	1,290	26	2%
Wyoming	412	419	7	2%
Marshall	362	367	5	1%
Monongalia	736	746	10	1%
Pendleton	104	105	1	1%
Doddridge	131	132	1	1%
Wood	1,139	1,145	6	1%
Boone	308	308	0	0%
Wirt	109	109	0	0%
Preston	474	473	-1	0%
Hancock	361	360	-1	0%
Nicholas	413	411	-2	0%
Marion	722	717	-5	-1%
Pleasants	98	97	-1	-1%
Pocahontas	145	143	-2	-1%
Lincoln	398	390	-8	-2%
Fayette	884	863	-21	-2%
Randolph	436	421	-15	-4%
Mingo	394	378	-16	-4%
Putnam	721	688	-33	-5%
Taylor	232	221	-11	-5%
Ritchie	141	134	-7	-5%
Summers	218	207	-11	-5%
Calhoun	128	121	-7	-6%
Brooke	313	293	-20	-7%
Ohio	551	514	-37	-7%
Upshur	427	389	-38	-10%
Clay	199	181	-18	-10%
McDowell	359	322	-37	-11%
Tucker	144	129	-15	-12%
Gilmer	93	83	-10	-12%
Barbour	294	260	-34	-13%
Wetzel	214	184	-30	-16%
Webster	169	139	-30	-22%
Totals	**24,533**	**24,824**	**291**	**1%**
12-Mo. Ave.		***24,364***	***24***	***0%***

MEDIAN

Table 10: Enrollment Changes By County
As % of Children Never Before Enrolled from July 2009 through June 2010

County	Total Enrollees July 2009	Total Enrollees June 2010	New Enrollees Never in Program	New Enrollees As % of Jun-10	
Hardy	153	166	81	49%	
Grant	153	168	78	46%	
Jefferson	414	438	189	43%	
Marshall	362	367	154	42%	
Tyler	128	131	54	41%	
Mason	279	302	122	40%	
Morgan	246	252	100	40%	
Boone	308	308	122	40%	
Pleasants	98	97	37	38%	
Cabell	995	1,064	405	38%	
Wayne	552	601	227	38%	
Kanawha	2,217	2,280	861	38%	
Berkeley	1,265	1,298	483	37%	
Putnam	721	688	256	37%	
Mineral	283	299	111	37%	
Wetzel	214	184	67	36%	
Logan	565	588	211	36%	
Wood	1,139	1,145	409	36%	
Braxton	197	228	80	35%	
Pocahontas	145	143	50	35%	
Hampshire	281	301	105	35%	
Jackson	383	403	140	35%	
Hancock	361	360	123	34%	
Brooke	313	293	96	33%	
Ohio	551	514	167	32%	
Mercer	1,108	1,168	379	32%	
Harrison	910	940	305	32%	
Lewis	295	303	98	32%	**MEDIAN**
Monroe	194	231	74	32%	
Mingo	394	378	121	32%	
Monongalia	736	746	238	32%	
Nicholas	413	411	131	32%	
Roane	263	302	96	32%	
Greenbrier	559	622	196	32%	
Doddridge	131	132	41	31%	
Marion	722	717	222	31%	
Taylor	232	221	68	31%	
Raleigh	1,264	1,290	391	30%	
Webster	169	139	42	30%	
Fayette	884	863	254	29%	
Ritchie	141	134	39	29%	
Lincoln	398	390	113	29%	
Gilmer	93	83	23	28%	
McDowell	359	322	89	28%	
Calhoun	128	121	33	27%	
Wyoming	412	419	112	27%	
Preston	474	473	125	26%	
Upshur	427	389	101	26%	
Pendleton	104	105	27	26%	
Randolph	436	421	108	26%	
Wirt	109	109	27	25%	
Summers	218	207	50	24%	
Clay	199	181	42	23%	
Barbour	294	260	55	21%	
Tucker	144	129	24	19%	
Totals	**24,380**	**24,658**	**8,271**	**34%**	
12-Mo. Ave.		***24,679***	***689***	***3%***	

Table 11: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

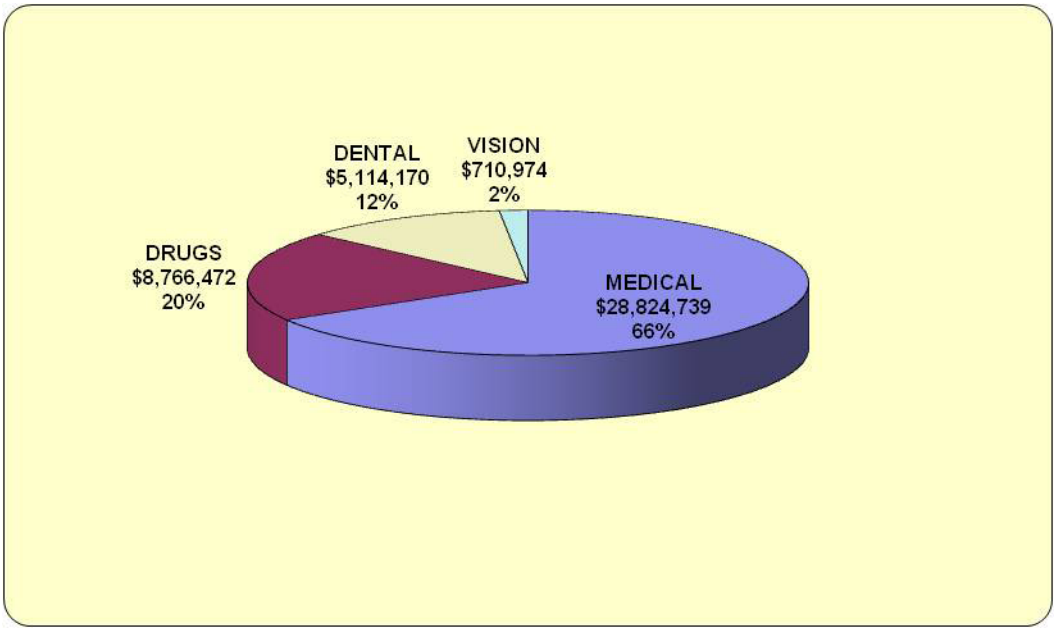


Table 12: Total Program Expenditures

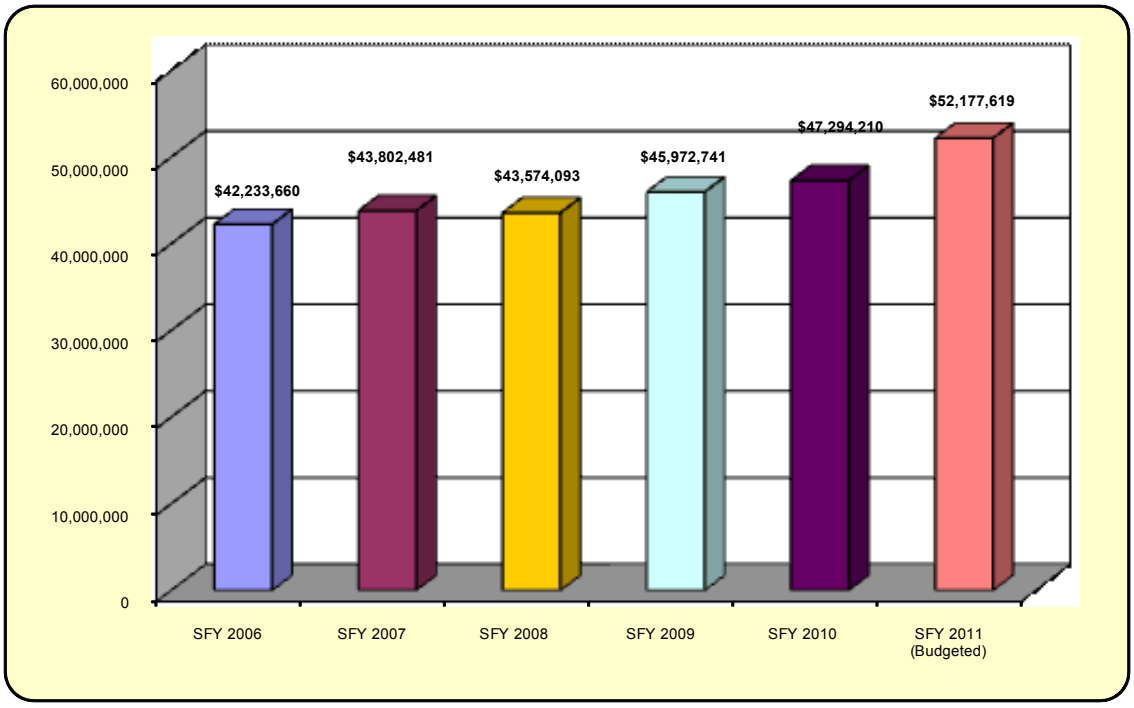
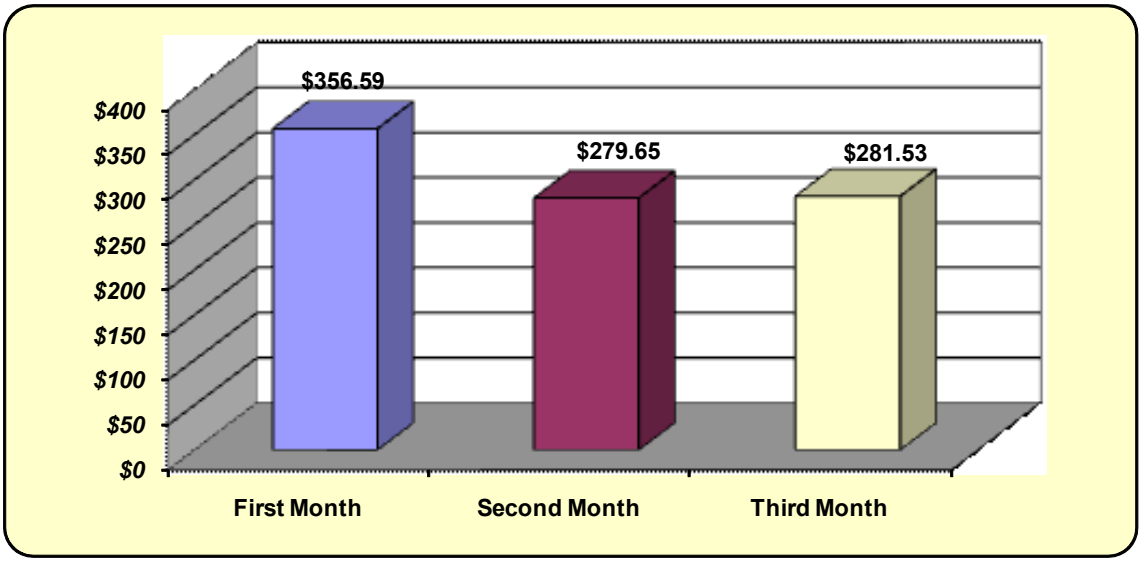


Table 13: Average Claimant Costs in First Three Months
Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2010

In early 2010 the Secretary of the U.S. Department of Health and Human Services identified 24 pediatric core measures on which state CHIP and Medicaid programs could begin voluntary reporting. Since WVCHIP currently has no contracts with managed care plans who might already be reporting some of these measures, it must extract this information to the extent possible from claims data. Most of the data is extracted according to specifications developed for the Health Plan Effectiveness Data and Information Set (HEDIS®). Some core measures were developed by other states and for which they are the steward and were included into the core set by national panels of experts. One such example is the Emergency Department Utilization measure developed by the State of Maine. In this year's report, WVCHIP has expanded to report on 12 of this national measure set, an increase from a set of 8 measures reported on in previous years. There are four measures which relate to perinatal health for which we hope to receive data gathered by the WV Department of Health and Human Resources in the coming year to expand further our set of reported measures. In this first year, few states are likely to report on the entire core set of pediatric measures. This set of measures is expected to be studied and evaluated and will become mandatory reporting for all states' CHIP and Medicaid child health programs in 2013.

HEDIS® is a set of standardized health performance measures that identifies only those individuals with a continuous 12 month enrollment period before the treatment or visit data can be included in calculating the measure. This helps to assure that the population measured is comparable from one health plan to another. HEDIS® specifications are annually reviewed and their sponsorship, support, and maintenance is under the aegis of the National Committee of Quality Assurance. HEDIS®-type data are usually those that meet the continuous 12 month enrollment definition for the denominator and which meet part of additional HEDIS® specifications in the numerator of the measure.

Pediatric Core Measures

Table 14: Preventive Dental Visits (HEDIS-type)

This measure estimates the total unduplicated number of children continuously enrolled for the calendar year 2009 who received dental treatment services.

Age Group	Number of Continuously Enrolled Children	Number Having Preventive Dental Visit	% Year 09
2 to 3 Years	445	232	52.13%
4 to 6 Years	770	586	76.10%
7 to 10 Years	2,342	1,844	78.74%
11 to 14 Years	2,790	2,080	74.55%
15 to 18 Years	2,257	1,565	69.34%
Total	**8,604**	**6,307**	**73.30%**

Table 15: Annual Dental Visits (HEDIS-type)

This measure estimates the number of children, ages 2 through 18 years old, continuously enrolled for the calendar year 2009, who had at least one dental visit during the year.

Age Group	Number of Continuously Enrolled Children	Number Having Dental Checkup Visit	% Year 09	% Prior Year 08	% Prior Year 07
2 to 3 Years	445	429	96.40%	96.62%	97.54%
4 to 6 Years	770	762	98.96%	97.86%	97.58%
7 to 10 Years	2,342	2,271	96.97%	97.10%	97.24%
11 to 14 Years	2,790	2,711	97.17%	96.88%	96.23%
15 to 18 Years	2,257	2,158	95.61%	95.29%	94.17%
Total	**8,604**	**8,331**	**96.83%**	**96.60%**	**96.06%**

Pediatric Core Measures

Table 16: Proper Use of Asthma Medications (HEDIS-type)

This measure estimates the number of children, ages 5 through 18 years, continuously enrolled for the calendar year 2009, as well as the complete year prior with persistent asthma who were prescribed appropriate medication.

Age Group	Asthma Patients	Number with Proper Uses of Medication	% Year 09	% Year 08	% Year 07
5 - 9 years	288	258	89.58%	91.29%	92.23%
10-17 years	472	402	85.17%	88.27%	88.10%
18-19 years	33	25	75.76%	85.71%	
Total	793	685	86.38%	89.36%	92.25%

Table 17: Diabetic Care (HEDIS-type)

This measure estimates the number of children continuously enrolled for the calendar year 2009 with Type 1 and Type 2 diabetes who were shown to have had a hemoglobin A1c (HbA1c) test; a serum cholesterol level (LDL-C) screening; an eye exam and a screen for kidney disease.

Age Group	Diabetic Patients	HB1C Test	Rate of HbA1c Test	Eye Examinations	Rate of Eye Exams	LDLC Test	Rate of LDLC Test
4 to 5 Years	1	1	100.00%	1	100.00%	0	0.00%
6 to 11 Years	18	17	94.44%	18	100.00%	3	16.67%
12 to 18 Years	41	35	85.37%	40	97.56%	15	36.59%
Total % Year 09	60	53	88.33%	59	98.33%	18	30.00%
Total % Prior Year 08	73	65	89.04%	71	97.26%	20	27.40%
Total % Prior Year 07	64	56	87.50%	60	93.75%	13	20.31%

Pediatric Core Measures

Table 18: Vision Visits (HEDIS-type)

This measure estimates the number of children continuously enrolled for the calendar year 2009 who received a preventive vision visit.

Age Group	Number of Continuously Enrolled Children	Number Having Vision Checkup Visit	% Year 09	%Prior Year 08	% Prior Year 07
Under 1 Year	-	-	0.00%	50.00%	0.00%
1 to 5 Years	965	152	15.75%	14.86%	14.27%
6 to 11 Years	3,270	1,105	33.79%	33.73%	30.72%
12 to 18 Years	4,409	1,680	38.10%	37.56%	36.07%
Total	**8,644**	**2,937**	**33.98%**	**33.47%**	**31.54%**

Pediatric Core Measures

Table 19: Well Child Visits and Adolescent Visits (HEDIS)

This measure estimates the number of children, ages birth through 6 years old and 12 to 19 years old, continuously enrolled for the calendar year 2009 who have had a well-child visit with a PCP coded as preventive office visits only.

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Year 09	% Prior Year 08	% Prior Year 07
Well Child					
Less Than Or Equal To 15 Months	9	9	100.00%	100.00%	94.12%
Third Year Of Life	217	162	74.65%	64.59%	89.18%
Fourth Year Of Life	255	204	80.00%	75.83%	88.69%
Fifth Year Of Life	225	182	80.89%	76.34%	84.21%
Sixth Year Of Life	290	177	61.03%	62.26%	82.81%
Total	**996**	**734**	**73.69%**	**70.85%**	**86.04%**
Adolescents					
12 To 19 Years of Age	4,409	1,639	37.17%	36.70%	60.32%
Total	**4,409**	**1,639**	**37.17%**	**36.70%**	**60.32%**

Table 20: Access To Primary Care (HEDIS)

This measure estimates the number of children, ages 1 to 19 years old, continuously enrolled for the calendar year 2009 who received office visits/outpatient services for procedures coded to primary care services only.

Age Group	Number of Continuously Enrolled Children	Number Having Primary Care Visit	%Prior Year 09	% Prior Year 08	%Prior Year 07
12 to 24 Months	58	57	98.28%	98.21%	98.48%
25 Months to 6 Years	1,197	1,164	97.24%	95.24%	94.73%
7 to 11 Years	2,980	2,717	91.17%	87.69%	87.92%
12 to 19 Years	4,409	3,893	88.30%	85.25%	83.49%
Total	**8,644**	**7,831**	**90.59%**	**90.06%**	**89.55%**

Pediatric Core Measures

Table 21: Childhood Immunizations (HEDIS)

This measure estimates the percentage of children who turned 2 years old during calendar year 2009 and who were continuously enrolled 12 months prior to the child's second birthday, and who had four diptheria, tetanus and acellular pertussis (DTAP), three polio (IPV), one measles mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B, one chicken pox (VZV), and four pneumococcal conjugate vaccines by their second birthday.

Age Group	Immunization Type	Number of Continuously Enrolle	Number Receiving Immunizations	% Year 09
2 years old	**Administration (Combination Two)**			
	DTaP (four immunizations)	17	12	
	Hepatitus B (three immunizations)			
	Hib (two immunizations)			
	IPV (three immunizations)			
	MMR (one immunization)			
	VZV (one immunization)			
	Total for 2009	**17**	12	**70.50%**
2 years old	**Administration (Combination Three)**			
	DTaP (four immunications)	**17**	**11**	
	Hepatitus B (three immunizations)			
	Hib (two immunizations)			
	IPV (three immunizations)			
	MMR (one immunization)			
	VZV (one immunization)			
	Pneumococcal conjugate (four immunizations)			
	Total for 2009	**17**	**11**	**64.71%**

Table 22: Adolescent Immunizations (HEDIS)

This measure estimates the percentage of adolescents who turned 13 years of age during calendar year 2009 and who were continuously enrolled 12 months prior to the adolescent's 13th birthday, and who had one dose of meningococcal vaccine (MCV4) and one tetanus, diptheria toxoid andacellular pertussis vaccine (Tdap) or one tetanus, diptheria toxoid vaccine (Td) by their 13th birthday.

Age Group	Immunization Type	Number of Continuously Enrolled	Number Receiving Immunizations	% Year 09
Adolescents 13 Years old	**Administration**			
	DTaP	**734**	**541**	**73.71%**
	Hepatitus B			
	Hib			
	IPV / OPV			
	MMR			
	Measles			
	VZV			
	Total for 2009	**734**	**541**	**73.71%**

Pediatric Core Measures

Table 23: Number of Wellness Visits for Children in First 15 Months of Life (HEDIS)

This measure estimates the percentage of members who turned 15 months old during the calendar year 2009 who got the recommended six or more well-child visits with a PCP during their first 15 months of life.

2009

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2009
9	0	0	0.00%
9	1	1	11.11%
9	2	0	0.00%
9	3	1	11.11%
9	4	1	11.11%
9	5	4	44.44%
9	6 or more	2	22.22%
Total		**9**	**100.00%**

2008

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2008
17	0	1	5.88%
17	1	2	11.76%
17	2	1	5.88%
17	3	1	5.88%
17	4	2	11.76%
17	5	7	41.19%
17	6 or more	3	17.65%
Total		**17**	**100.00%**

2007

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2007
16	0	0	0.00%
16	1	0	0.00%
16	2	0	0.00%
16	3	0	0.00%
16	4	4	25.00%
16	5	7	43.75%
16	6 or more	5	31.25%
Total		**16**	**100.00%**

Pediatric Core Measures

Table 24: BMI - Nutrition and Counseling (HEDIS)

This measure estimates the percentage of members, ages 2 to 17 years old, continuously enrolled for the calendar year 2009 who had an outpatient visit with a PCP or OB/GYN with evidence of BMI percentile documentation, and who had counseling for nutrition and physical activity during the measurement year.

Age Group	Continuously Enrolled	BMI/Nutrition & Counseling	% with Measure
Age 2	228	0	0.00%
Age 3	217	0	0.00%
Age 4	255	0	0.00%
Age 5	225	0	0.00%
Age 6	290	0	0.00%
Age 7-12	2980	2	0.07%
Age 12 and up	4409	5	0.11%
Total	8604	7	0.08%

Table 25: Follow-Up After Hospitalization for Mental Illness (HEDIS)

This measure estimates the number of children, ages 6 years old and older who were enrolled on the date of discharge and 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge, and within 30 days of discharge.

# 6 years & older Hospitalized with Mental Health Dx	# With follow-up w/i (7) days of Discharge Year 2009	# With follow-up w/i (30) days of Discharge Year 2009
117	32	64

Pediatric Core Measures

Table 26: Follow-Up Care for Children Prescribed ADHD Medication (HEDIS)

This measure estimates the percentage of children, ages 6 to 12 years of age, with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. Two rates are reported below: first, the inital 30 day phase, and second, the continuation maintenance (10 month) phase.

Age Group	#Members Receiving ADHD Medications	# Members on Medicationwith follow-up visits	% Compliance for 2009 Year
6 years	7	7	100.00%
7 years	12	12	100.00%
8 years	27	27	100.00%
9 years	56	56	100.00%
10 years	72	72	100.00%
11 years	94	94	100.00%
12 years	92	92	100.00%
Total	**360**	**360**	**100.00%**

Age Group	# Continuation & Maintenance Members	# Members on Medication with follow-up visits	% Compliance for 2009 Year
6 years	3	3	100.00%
7 years	4	4	100.00%
8 years	15	15	100.00%
9 years	38	38	100.00%
10 years	53	53	100.00%
11 years	72	72	100.00%
12 years	72	72	100.00%
Total	**257**	**257**	**100.00%**

Pediatric Core Measures

Table 27: Preventive Dental Services (EPSDT 416 measure)

This measure estimates the unduplicated number of children who received preventive dental services for the calendar year 2009 as a percentage of the total number unduplicated enrollees in the program.

Unduplicated Number of Children	Number of Children with Preventive Dental Visits	% Year 2009
38,465	16,028	41.67%

Table 28: Dental Treatment Services (EPSDT 416 measure)

This measure estimates the unduplicated number of children continuously enrolled for the calendar year 2009 who received dental treatment services as a percentage of the total number unduplicated enrollees in the program.

Age Group	Number of Continuously Enrolled Children	Number Having Dental Treatment	% Year 09
2 to 3 Years	445	440	98.88%
4 to 6 Years	770	701	91.04%
7 to 10 Years	2,342	2,163	92.36%
11 to 14 Years	2,790	2,534	90.82%
15 to 18 Years	2,257	2,091	92.65%
Total	**8,604**	**7,929**	**92.15%**

Pediatric Core Measure

Table 29: Emergency Department Utilization (State of Maine measure)

This measure estimates the number of visits by member per year of all child and adolescent members enrolled and eligible during the calendar year 2009.

Number of Members	Number of ER Users	Number of ER Encounters	Number of ER Encounters Per Person	Number of ER Encounters Per User
38,465	9,039	14,535	0.3779	1.608

Table 30: Annual Number of Asthma Patients with ED Encounter (State of Alabama measure)

This measure estimates the number of asthma emergency department utilization for all children less than 1 year of age diagnosed with asthma or treatment with at least two short-acting beta adrenergic agents during the measurement year with more than one asthma-related ED visit.

Number of Asthmatics over Age 1	Number with ED Encounter for Asthma	% with Asthma ED Encounter
850	127	14.94%

Selected Utilization Data as Health Status Indicators

WVCHIP currently operates exclusively in a fee-for-service payment structure. The data in Tables 31 - 37 reflect preventive services as extracted from claims payments. The selected preventive services are:

- → Vision
- → Dental
- → Well Child Visits
- → Access to Primary Care
- → Immunizations

Other Non-Preventive Measures:

- → Overall ER Utilization
- → Annual Number of Asthma Patients with ED Encounters

Unlike the HEDIS®-type data in the preceding Tables 14 - 30, the health status indicator data reflects services for all WVCHIP enrollees whether they are enrolled for one month or twelve months in the annual measurement period. Also, it captures more specific data for the entire population, which may not be captured in a HEDIS® measure. (e.g. the HEDIS® child immunization measure is specific to a required combined set of several immunizations over a two year period for two year-olds resulting in a "0" measure, whereas the selected immunization data reflect more detail.)

The advantage of having separate HEDIS®-type measures is to allow comparison among managed health care plans and with other states' CHIP or Medicaid programs.

Table 31:
Health Status Utilization
January 1, 2009 to December 31, 2009

Vision Services

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 09	Per Member Per Year 08	Per Member Per Year 07
0 to 364 Days	110	4	0.04	358.95	3.26		3.15
1 to 2 Years	1542	61	0.04	5,678.57	3.68	3.45	3.20
3 Years	778	58	0.07	5,408.80	6.95	5.35	7.65
4 to 5 Years	1588	258	0.16	22,777.12	14.34	14.81	12.55
6 to 11 Years	9263	2925	0.32	261,049.59	28.18	25.96	23.55
12 to 18 Years	11796	4044	0.34	352,073.28	29.85	27.79	25.64
Overall	**25,077**	**7,350**	**0.29**	**647,346.31**	**25.81**	**23.80**	**21.52**

Table 32:
Health Status Utilization
January 1, 2009 to December 31, 2009

Dental Services

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 09	Per Member Per Year 08	Per Member Per Year 07
0 to 364 Days	110	-	-	-	-	-	-
1 to 2 Years	1542	515	0.33	65,758.35	42.64	36.02	24.24
3 Years	778	807	1.04	100,685.95	129.42	130.07	97.35
4 to 5 Years	1588	2356	1.48	286,753.03	180.57	193.95	147.75
6 to 11 Years	9263	14607	1.58	1,823,897.36	196.90	200.13	145.12
12 to 18 Years	11796	16037	1.36	2,286,942.24	193.87	199.69	134.03
Overall	**25,077**	**34,322**	**1.37**	**4,564,036.93**	**182.00**	**185.82**	**165.08**

Table 33:
Health Status Utilization
January 1, 2009 to December 31, 2009

Well Child Visits

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 09	Per Member Per Year 08	Per Member Per Year 07
0 to 364 Days	110	548	4.98	53,935.78	490.33	357.89	504.50
1 to 2 Years	1542	2534	1.64	266,417.98	172.77	150.24	139.27
3 Years	778	635	0.82	57,033.28	73.31	61.11	60.86
4 to 5 Years	1588	1436	0.90	144,110.16	90.75	88.18	74.39
6 to 11 Years	9263	3725	0.40	380,544.20	41.08	35.04	33.57
12 to 18 Years	11796	3887	0.33	384,973.06	32.64	30.34	30.68
Overall	**25,077**	**12,765**	**0.51**	**1,287,014.46**	**51.32**	**46.24**	**43.33**

Table 34:
Health Status Utilization
January 1, 2009 to December 31, 2009

Access to Primary Care Services

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 09	Per Member Per Year 08	Per Member Per Year 07
0 to 364 Days	110	1171	10.65	89,085.64	809.87	580.84	535.91
1 to 2 Years	1542	10392	6.74	733,385.74	475.61	438.06	393.55
3 Years	778	3786	4.87	242,480.87	311.67	264.72	247.60
4 to 5 Years	1588	8029	5.06	542,778.80	341.80	316.40	273.59
6 to 11 Years	9263	34178	3.69	2,305,974.14	248.94	227.27	210.75
12 to 18 Years	11796	41013	3.48	2,734,251.87	231.79	212.98	194.03
Overall	**25,077**	**98,569**	**3.93**	**6,647,957.06**	**265.10**	**241.99**	**231.14**

Table 35:
Health Status Utilization
January 1, 2009 to December 31, 2009

Immunizations Services

Age Group	Immunization Type	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year
0 to 364 days	DTaP	110	51	0.4636	-	-
	Diptheria & Tetanus		1	0.0091	-	-
	Hepatitus B		123	1.1182	-	-
	Hib		73	0.6636	23.34	0.2122
	IPV/OPV		20	0.1818	-	-
	MMR		1	0.0091	-	-
	VZV		1	0.0091	-	-
	Total	**110**	**270**	**2.4545**	**23.34**	**0.2122**
1 to 2 years	Admin -Influenza Vaccine	1542	14	0.0091	130.00	0.0843
	Admin - Pneumococcal Vaccine		1	0.0006	27.78	0.018
	DTaP		12	0.0078	-	-
	Diptheria & Tetanus		3	0.0019	-	-
	Hepatitus B		53	0.0344	-	-
	Hib		426	0.2763	197.60	0.1281
	IPV/OPV		47	0.0305	-	-
	MMR		386	0.2503	178.92	0.116
	Measles		1	0.0006	-	-
	Mumps		1	0.0006	-	-
	VZV		393	0.2549	148.42	0.0963
	Total	**1542**	**1337**	**0.8671**	**682.72**	**0.4427**
3 years	Admin - Influenza Vaccine	778	6	0.0077	70.00	0.09
	DTaP		1	0.0013	-	-
	Hepatitus B		6	0.0077	-	-
	Hib		19	0.0244	-	-
	IPV/OPV		6	0.0077	-	-
	MMR		8	0.0103	-	-
	VZV		18	0.0231	-	-
	Total	**778**	**64**	**0.0823**	**70.00**	**0.09**
4 to 5 years	Admin - Influenza Vaccine	1588	13	0.0082	138.00	0.0869
	DTaP		14	0.0088	0.01	0.00
	Diptheria & Tetanus		4	0.0025	-	-
	Hepatitus B		8	0.005	-	-
	Hib		15	0.0094	21.78	0.0137
	IPV/OPV		314	0.1977	52.36	0.033
	MMR		616	0.3879	475.34	0.2993
	Measles		1	0.0006	-	-
	VZV		611	0.3848	812.38	0.5116
	Total	**1588**	**1596**	**1.005**	**1499.87**	**0.9445**
6 to 11 years	Admin - Hepatitus B	9263	1	0.0001	12.00	0.0013
	Admin - Influenza Vaccine		69	0.0074	821.31	0.0887
	Admin - Pneumococcal Vaccine		1	0.0001	12.00	0.0013
	DTaP		6	0.0006	-	-
	Diptheria & Tetanus		1	0.0001	-	-
	Hepatitus B		17	0.0018	-	-
	Hib		3	0.0003	-	-
	IPV/OPV		12	0.0013	46.18	0.005
	MMR		20	0.0022	-	-
	Tetanus		6	0.0006	20.21	0.0022
	VZV		505	0.0545	154.84	0.0167
	Total	**9263**	**641**	**0.0692**	**1066.54**	**0.1151**
12 to 18 years	Admin - Hepatitus B	11796	1	0.0001	12.00	0.001
	Admin - Influenza Vaccine		87	0.0074	995.29	0.0844
	Admin - Pneumococcal Vaccine		2	0.0002	11.00	0.0009
	DTaP		8	0.0007	-	-
	Diptheria & Tetanus		2	0.0002	-	-
	Hepatitus B		134	0.0114	-	-
	IPV/OPV		11	0.0009	-	-
	MMR		24	0.002	44.73	0.0038
	Tetanus		31	0.0026	96.9	0.0082
	VZV		318	0.027	179.84	0.0152
	Total	**11796**	**618**	**0.0524**	**1339.76**	**0.1136**
	OVERALL	**25,077**	**4,526**	**0.1805**	**4,682.23**	**0.1867**

Table 36:
Health Status Utilization
January 1, 2009 to December 31, 2009

Overall ER Utilization

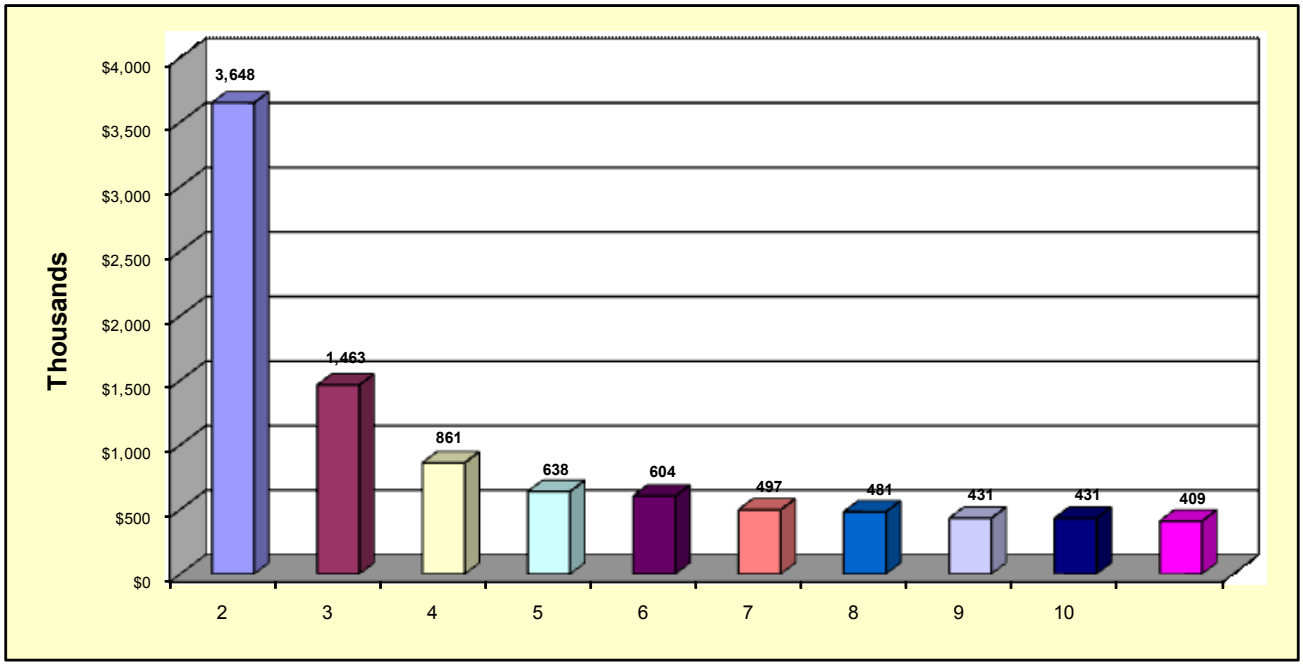
Age Group	Continuously Enrolled	ER Users	ER Encounters	ER Encounters Per Person	ER Encounters Per User	% of Enconter Year 2009
Under Age 2	40	14	15	0.38	1.07	37.50%
Age 2	228	116	184	0.81	1.59	80.70%
Age 3	217	114	162	0.75	1.42	74.65%
Age 4	255	118	164	0.64	1.39	64.43%
Age 5	225	103	121	0.54	1.17	53.78%
Age 6	290	119	168	0.58	1.41	57.93%
Ages 7-12	2980	1010	1438	0.48	1.42	48.26%
Ages 12 and Up	4409	1542	2464	0.56	1.60	55.89%
TOTAL	**8644**	**3136**	**4716**	**0.55**	**1.50**	54.56%

Table 37:
Health Status Utilization
January 1, 2009 to December 31, 2009

Annual Number of Asthma Patients with ED Encounter

Age Group	Continuously Enrolled	Asthma Patients	ED Encounters for Asthma	Asthma ED Encounters per Person	Asthma Encounters Per User
Under Age 2	40	0	0	0.00	0.00
Age 2	228	9	9	0.04	1.00
Age 3	217	3	0	0.00	0.00
Age 4	255	12	5	0.02	0.42
Age 5	225	6	1	0.00	0.17
Age 6	290	4	10	0.03	2.50
Ages 7-12	2980	94	17	0.01	0.18
Ages 12 and Up	4409	97	17	0.00	0.18
Total	**8644**	**225**	**59**	**0.01**	**0.26**

Table 38: Top Ten Physician Services
By Amounts Paid
(in thousands)



Key

		CPT Code*
1	Office Visit - Limited - Est. Patient	(99213)
2	Office Visit - Intermediate - Est. Patient	(99214)
3	Individual Psychotherapy Insight	(90806)
4	ER Exam - Extended - New Patient	(99284)
5	ER Exam - Intermediate - New Patient	(99283)
6	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
7	Office Visit - Intermediate - New Patient	(99203)
8	ER Exam - Comprehensive	(99285)
9	Office Visit - Brief - Est. Patient	(99212)
10	Periodic Comprehensive Wellness Exam Age 5-11 - Est. Patient	(99393)

**As described in Current Procedure Terminology 2009 by the American Medical Association.*

Table 38: Top Ten Physician Services
By Amounts Paid

CPT Code Description

1 Office Visit - Limited - Est. Patient: for an established patient taking about 15 minutes or less of face-to-face time with patient and/or family for problems with low to moderate severity; requires 2 of 3 key components: an expanded problem focused history and examination and medical decision making of low complexity *(CPT 99213*)

2 Office Visit - Intermediate - Est. Patient: for an established patient taking about 25 minutes of face-to-face time with the patient and/or family for problem(s) of moderate to high severity; 2 of 3 required visit components are a detailed history and examination and medical decision making of moderate complexity *(CPT 99214)*

3 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

4 ER Exam - Extended - New Patient: requiring 1) a detailed history; 2) a detailed examination; and 3) medical decision making of moderate coplexity - usually when urgent evaluation is needed for a problem of high severity *(CPT 99284)*

5 ER Exam - Intermediate - New Patient: requiring 1) an expanded problem-focused history; 2) an expanded problem focused examination; and 3) medical decision making of moderate complexity - usually for a problem of moderate severity *(CPT 99283)*

6 Ophthalmological Exam - Comprehensive - Est. Patient: for an established patient at an intermediate level in a face-to-face encounter by the physician for a general evaluation of the complete visual system including history, general medical observation, external and ophthalmological examinations, gross visual fields and basic sensorimotor examination. It need not be performed all in one session *(CPT 92014)*

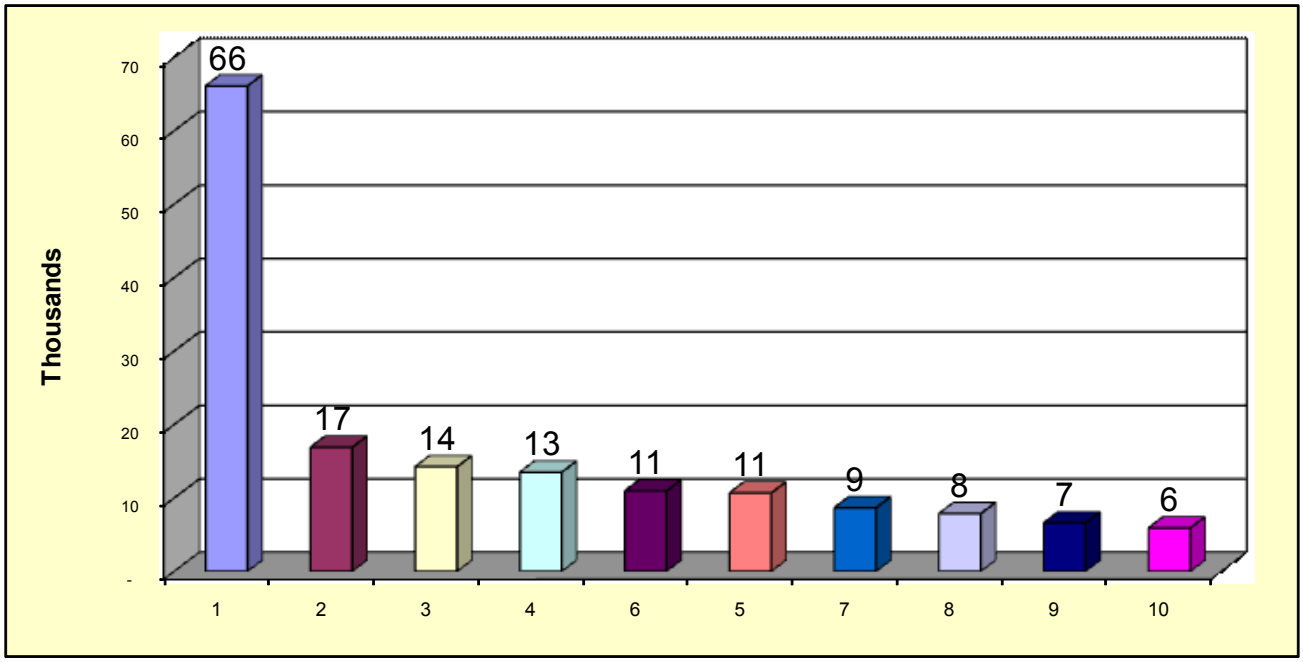
7 Office Visit - Intermediate - New Patient: for a new patient taking about 30 minutes of face-to-face time with the patient and/or family for problems of moderate severity; requires three key components including a detailed history, an exam, and medical decision making of low complexity (*CPT 99203)*

8 ER Exam - Comprehensive: emergency department visit for a new or established patient where the presenting problem(s) are of high severity and pose an immediate or significant threat to life or physiologic function; requires three key components including a comprehensive history, an exam, and a medical decision making of high complexity (*CPT 99285)*

9 Office Visit - Brief - Est. Patient: for an established patient taking about ten minutes or less of face-to-face time with patient and/or family for self limiting or minor problems; 2 of 3 required visit components are a problem focused history and examination and straightforward medical decision making *(CPT 99212)*

10 Periodic Comprehensive Wellness Exam Age 5-11 - Est. Patient: an age and gender specific preventive medical exam that includes appropriate history, exam, any needed counseling/anticipatory guidance/risk factor reduction interventions as well as ordering of appropriate immunizations and laboratory tests for an established patient. These exams are coded to the correct age/stage period and are guided by criteria established by the American Academy of Pediatrics *(CPT 99393)*

Table 39: Top Ten Physician Services
By Number of Transactions
(in thousands)



Key

		CPT Code*
1	Office Visit - Limited - Est. Patient	(99213)
2	Office Visit - Intermediate - Est. Patient	(99214)
3	Office Visit - Brief - Est. Patient	(99212)
4	Immunization Administration	(90471)
5	Blood Count	(85025)
6	Individual Psychotherapy Insight	(90806)
7	Test for Streptococcus	(87880)
8	ER Exam - Intermediate - New Patient	(99283)
9	Immunization Administration - Each Add. Vaccine	(90472)
10	Rx Management	(90862)

**As described in Current Procedure Terminology 2009 by the American Medical Association.*

Table 39: Top Ten Physician Services
By Number of Transactions

CPT Code Description

1 Office Visit - Limited - Est. Patient: for an established patient taking about 15 minutes or less of face-to-face time with patient and/or family for problems with low to moderate severity; requires 2 of 3 key components: an expanded problem focused history and examination and medical decision making of low complexity *(CPT 99213*)

2 Office Visit - Intermediate - Est. Patient: for an established patient taking about 25 minutes of face-to-face time with the patient and/or family for problem(s) of moderate to high severity; 2 of 3 required visit components are a detailed history and examination and medical decision making of moderate complexity *(CPT 99214)*

3 Office Visit - Brief - Est. Patient: for an established patient taking about ten minutes or less of face-to-face time with patient and/or family for self limiting or minor problems; 2 of 3 required visit components are a problem focused history and examination and straightforward medical decision making *(CPT 99212)*

4 Immunization Administration: injection of a vaccine (single or combination toxoid) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90471)*

5 Blood Count: automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count *(CPT 85025)*

6 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

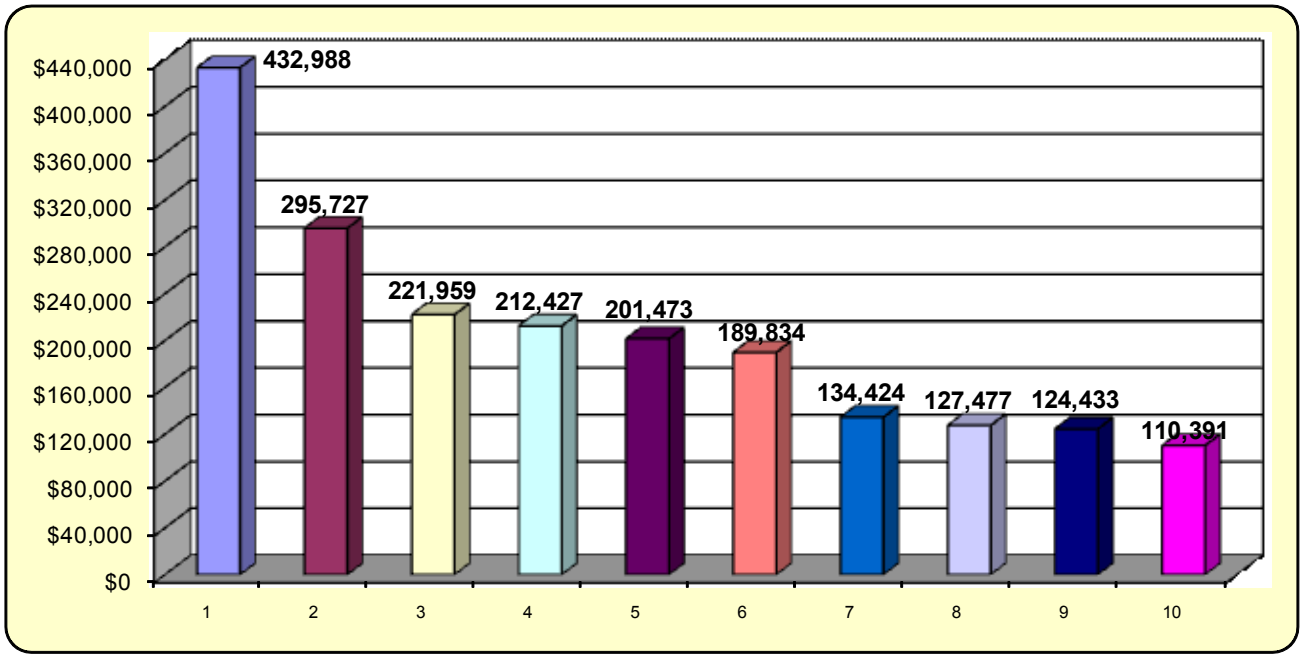
7 Test for Streptococcus: laboratory testing for Streptococcus bacteria group A as identified by colony morphology, growth on selective media *(CPT 87880)*

8 ER Exam - Intermediate - New Patient: requiring 1) an expanded problem-focused history; 2) an expanded problem focused examination; and 3) medical decision making of moderate complexity - usually for a problem of moderate severity *(CPT 99283)*

9 Immunization Administration - Each Add. Vaccine: injection of each additional vaccine (over one) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90472)*

10 Rx Management: pharmacologic management that includes prescription, use, and review of medication with no more than minimal medical psychotherapy *(CPT 90862)*

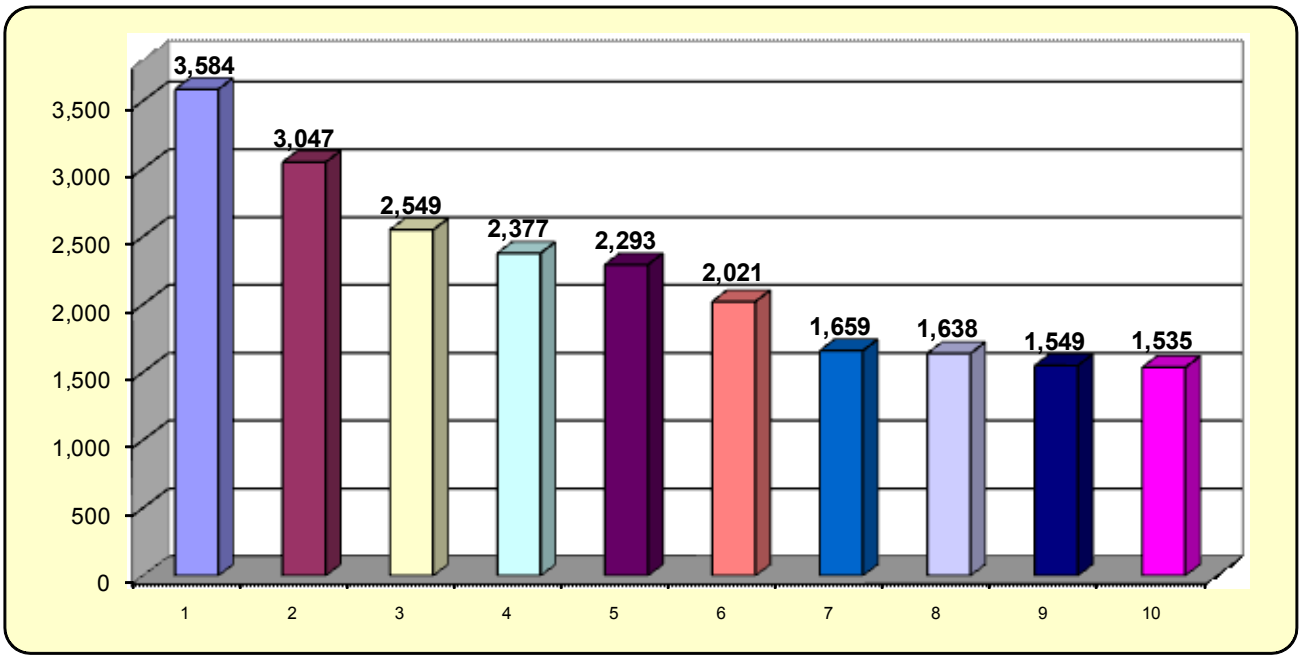
Table 40: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Singulair 5MG	-	Asthma
2	Concerta ER 36MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
3	Humatrope 24MG	-	Growth Hormone
4	Concerta ER 54MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
5	Singulair 10MG	-	Asthma
6	Dextroamp-amphet ER 20MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
7	Dextroamp-amphet ER 30MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
8	Genotropin 12MG	-	Growth Hormone
9	Proair HFA 90 MCG	-	Asthma
10	Novolog 100Unit/ML	-	Diabetes

Table 41: Top Ten Prescription Drugs
By Number of Rx



Key

	Drug Brand Name	Major Use Indication
1	Singulair 5MG	- Asthma
2	Proair HFA 90MCG	- Asthma
3	Fluticasone 50MCG	- Allergies
4	Loratadine 10MG	- Allergies
5	Azithromycin 250MG	- Antibiotic
6	Amoxicillin 400MG/5ML	- Antibiotic
7	Singulair 10MG	- Asthma
8	Concerta ER 36MG	- Attention Deficit Hyperactivity Disorder (ADHD)
9	Azithromycin 250MG	- Antibiotic
10	Amoxicillin 250MG/5ML	- Antibiotic