West Virginia
Children's Health Insurance Program

Annual Report
2008



West Virginia's rate of uninsured, low-income children - the population originally targeted in CHIP legislation over 10 years ago - is now 2.4%!

Source: U.S. Census Current Population Survey
2008 Annual and Economic Supplement

West Virginia
Children's Health Insurance Program

2008 Annual Report



Joe Manchin III, Governor

Joe Manchin III, 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 to strive for a health care system in which all West Virginia children have access to health care coverage.

Our Vision

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

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STATE OF WEST VIRGINIA
JUNE
20
1863
MONTANI SEMPER LIBERI

Introductory Section



Who Are The Remaining Children Not Benefiting?

"Children with health care coverage are more likely to receive timely care for childhood illnesses such as sore throats, ear aches, and asthma; make fewer visits to the emergency room or hospital; and have access to needed medications and better preventive services."

-Fernando Indacochea, MD, Grant County Pediatrician and American Academy of Pediatrics, WV Chapter President



West Virginia Children's Health Insurance Program
1018 Kanawha Boulevard East
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Charleston, WV 25301

304-558-2732 voice / 304-558-2741 fax
Helpline 877-982-2447
www.wvchip.org

December 15, 2008

Honorable Joe Manchin III, 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:

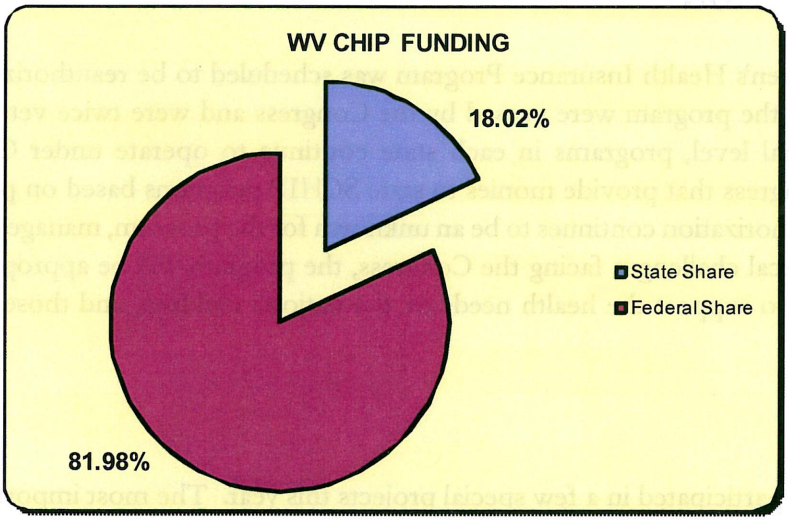
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2008. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented 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.

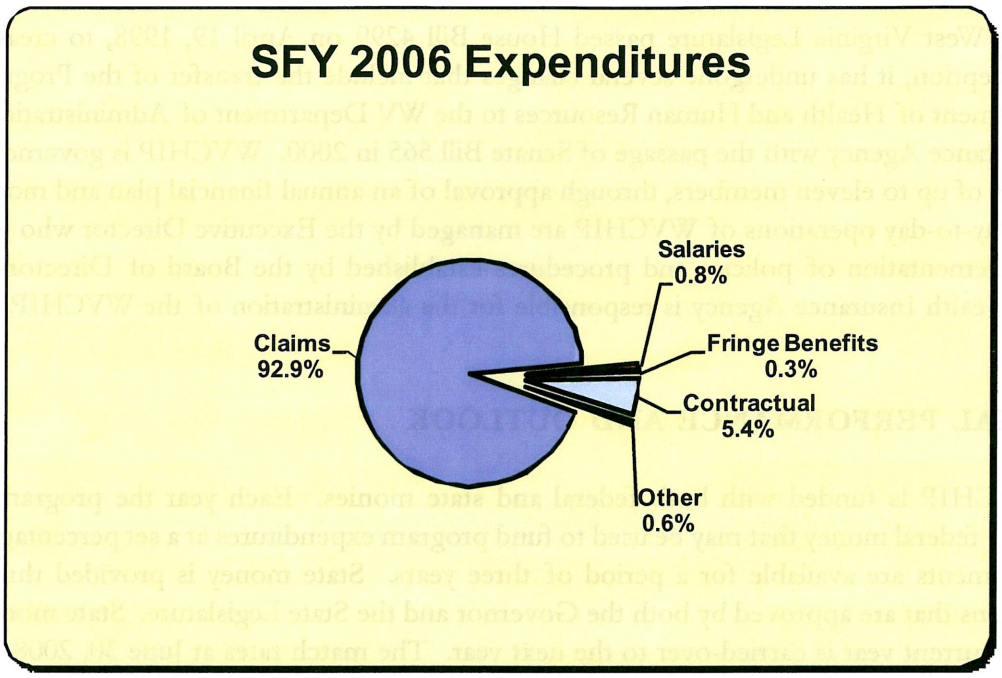
FINANCIAL PERFORMANCE AND OUTLOOK

WVCHIP is funded with 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 three 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, 2008 were 81.98% federal share and 18.02% 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, 2008 confirms this requirement will be met through SFY 2015, assuming that state appropriations remain at the current level as SFY 2009, $10,971,688, and considering projected enrollment and costs.

Based on estimated funding, enrollment, and costs, the June 30, 2008 Actuarial Report projected federal funding shortfalls of $3.6 million, $16.7 million, $19.6 million and $22.8 million in state fiscal years (SFY) 2010, 2011, 2012 and 2013 respectively. No federal funding shortfalls are projected for SFY 2009. All projections assume federal allotments will remain at the same level as the 2008 allotment and that sufficient federal funding will be made available to the program either under Continuing Resolutions of the Congress or until the program is reauthorized at the federal level sometime within the next year.



REAUTHORIZATION

The Children's Health Insurance Program was scheduled to be reauthorized in 2007. While two bills reauthorizing the program were passed by the Congress and were twice vetoed by the President in 2007, on a national level, programs in each state continue to operate under Continuing Resolutions passed by the Congress that provide monies to state SCHIP programs based on prorated 2007 allotment levels. While reauthorization continues to be an unknown for the program, management remains confident that despite the fiscal challenges facing the Congress, the program will be appropriated funding at levels sufficient enough to support the health needs of the nation's children, and those of West Virginia also.

INITIATIVES

WVCHIP participated in a few special projects this year. The most important in terms of agency effort and resources was the Payment Error Rate Measurement project, also referred to as PERM, mandated by the Centers for Medicare and Medicaid Services (CMS), WVCHIP's federal oversight authority. Overall, findings reflect a high rate of payment accuracy by WVCHIP's claims payer. This was the first year for the Kids First initiative that provides comprehensive well child exams to all Kindergarten enrollees that are not insured. WVCHIP took part in the Public Employees Insurance Agency's Request for Proposal (RFP) process for both Third-party Administrator (TPA) and Pharmacy Benefits Manager (PBM) services this past year. The program was most gratified with the results released in the Current Population Survey (CPS) 2008 Annual Social and Economic Supplement, sponsored by the US Census Bureau, that shows a dramatic decline in the rate of uninsured, low income children in West Virginia since inception of the WVCHIP, and places West Virginia as one of a handful of states with an uninsured rate for children in this group at less than 3%. All initiatives are discussed in more detail in the Major Initiatives section of the Management's Discussion and Analysis found on page 10 of this report.

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, 2008. The federal fiscal year ends September 30 and further documentation is submitted to CMS based on that period. Certain statistical information such as HEDIS-type reports, by nature, is presented on a calendar year basis as required.

ACKNOWLEDGMENTS

Special thanks are extended to Governor Joe Manchin III and to members of the Legislature for their continued support. 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, 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, 2008.

Sincerely,

Stacey L. Shamblin, MHA
Financial Officer

Principal Officials

Joe Manchin III, Governor
State of West Virginia

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

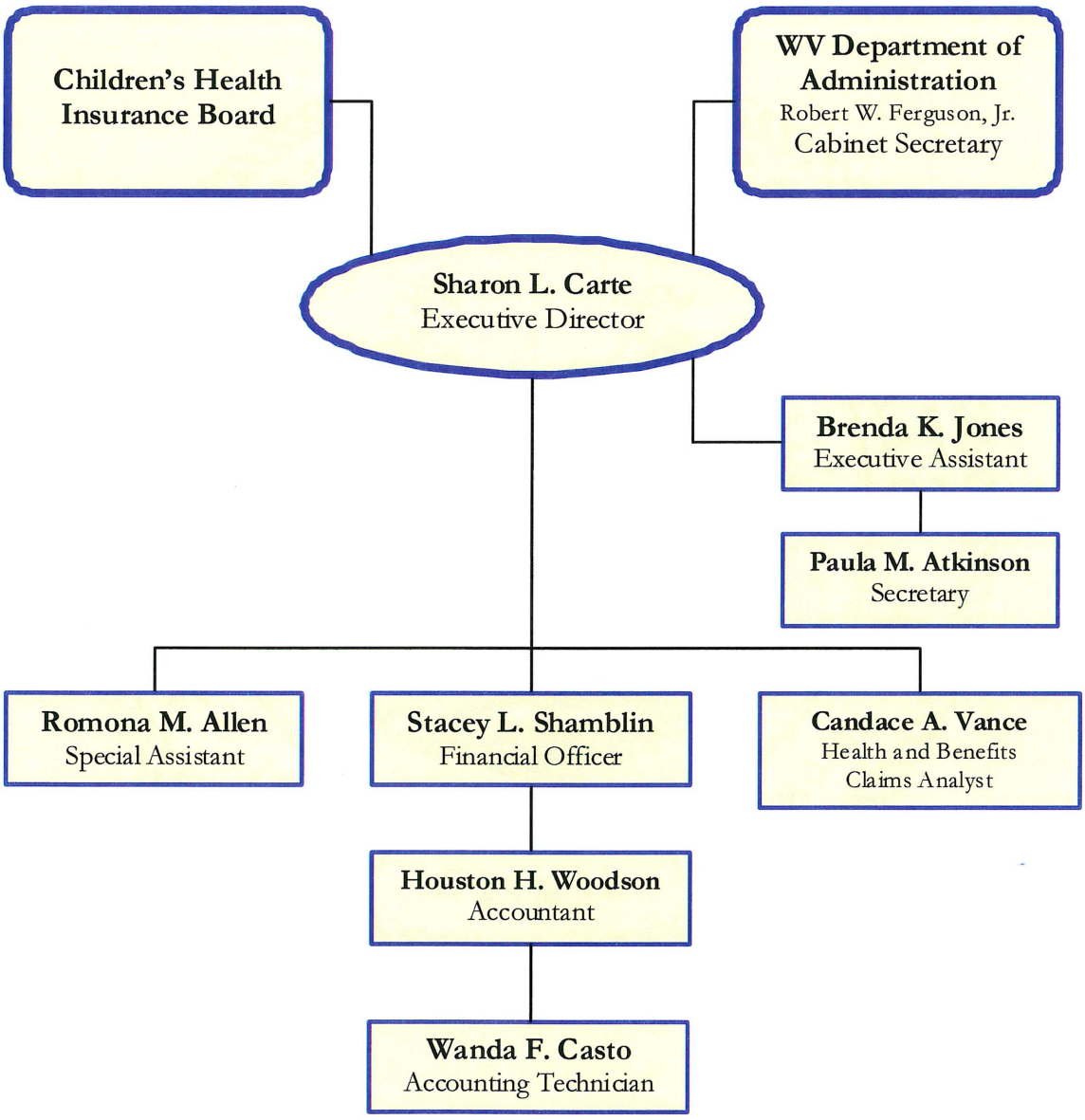
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Martha Yeager Walker, 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
Judith Radcliff, Citizen Member
Debra Sullivan, Citizen Member

Staff

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

Staff Organizational Chart



STATE OF WEST VIRGINIA
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FINANCIAL SECTION



"We have the ability to prevent or control many of the health care problems associated with common childhood conditions that can have a long term detrimental impact on children's development and opportunities in life. This argues for access to well-child care for all children to identify problems early and manage chronic conditions effectively."

Committee on the Consequences of Uninsurance
Institute of Medicine of the National Academies
2002

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2008

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, 2008. 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 220% 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.

Annually, Congress appropriates funds on a national level, and states receive their share of this total funding based on a complex allotment formula that considers the state's population of uninsured, low-income children. 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.

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 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. 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, 2008 and 2007. (See pages 15 and 16.)

- Total assets increased approximately $3,382,924, or 41% in comparison to the previous year-end amount. This increase is primarily a result of higher ending cash balances and reflects the Program's increased carry-over funding for the next year. There were also slight increases in fixed assets and funds due from the federal government based on a higher ending balance of unpaid insurance claims liability compared to last year.

- Total liabilities decreased by approximately $585,388 from last year. The majority of the decrease is attributable to a decrease in deferred revenues.

- Total fund equity increased approximately $3,968,388 in comparison to the previous year-end amount.

- Total operating revenues increased slightly by $143,077.

- Medical, dental, and prescription drug expenditures comprise approximately 93% of WVCHIP's total costs. These expenditures decreased by approximately 3%, or $1,425,363 from the prior year.

- Administrative costs accounted for 7% of overall expenditures. These expenditures increased approximately $57,869, representing an increase of 2%.

FINANCIAL ANALYSIS

Costs

A negative 3% trend in medical, dental, and prescription drug claims is significantly lower than the 3% increases in spending experienced by plans nationally. After adjusting for decreased enrollment, a net increase of less than 1% appears to be more in line with national experience. Three factors affect total claims expenditures; enrollment, utilization of services, and fees paid to providers for services they render to WVCHIP members. The impact each of these factors had on the total decrease in WVCHIP's claims costs are as follows:

- Enrollment: -1.7%
- Service Utilizaton: -3.1%
- Price/Fee Increases +1.4%

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

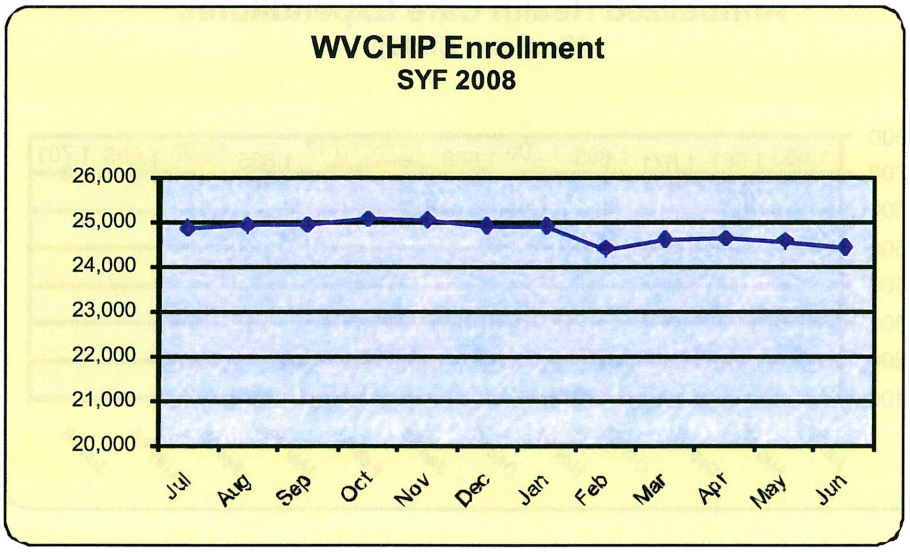
Enrollment

Monthly enrollment decreased steadily over the year, with an overall decrease in enrollment of 1.7% 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 (Phases I&II)	100% - 150%	15,515	-2.8%
CHP3 (Phase III)	151% - 200%	9,013	-2.0%
WVCHIP Premium	201% - 220%	228	+365.3%

WVCHIP Premium is the newest enrollment group and includes children in families with income above 200% FPL up to and including 220% FPL. Initially, 12 children were enrolled in this group when it was "rolled-out" in February 2007. By June 2008, enrollment increased to 289 members. Enrollment in this group continues to grow and by the end of November 2008, 348 children were enrolled.



Utilization

It is easy to understand why a health plan would incur lower costs with decreased enrollment: less members = payments for less services = decreased costs. Decreased payments due to service utilization changes, however, 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 a decline of 3.1% in claims expenditures for the year.

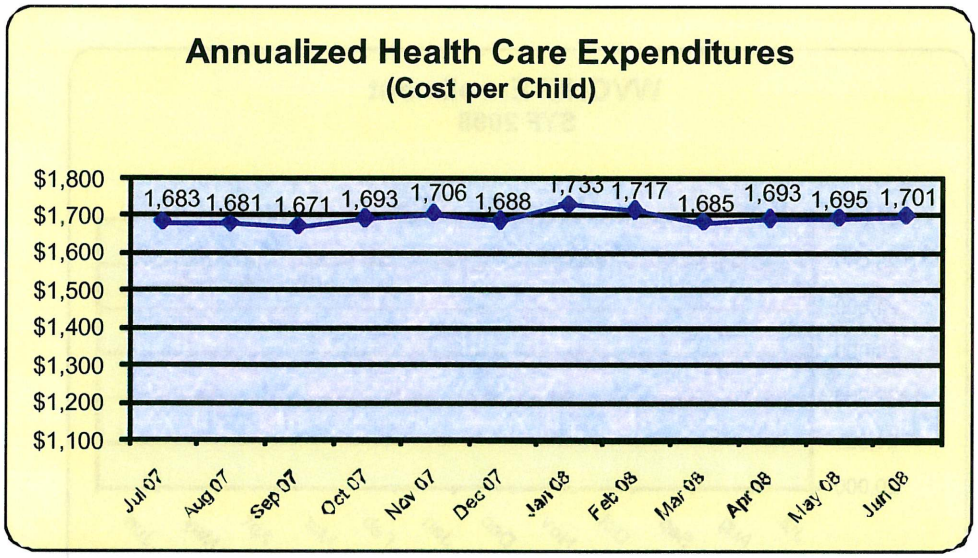
"Pent-up" demand refers to the amount of services utilized by new plan members. Children new to the program may require more medical, dental, or prescription drug services within the first three-months of enrollment due to the fact they may have not been able to access these services prior to enrollment in the plan. This "pent-up" demand is illustrated in Table 13 on page 53.

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 2008, price increases were around 1.4%.

Average Cost Per Child

WVCHIP's average cost per child for State Fiscal Year 2008 was $1,701. 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 1.8% over the prior year and resulted from all factors discussed above. The fluctuation in the average cost per child is illustrated in the following table.



Administrative Costs

In addition to employee salaries, the plan pays a number of other costs to administer the plan. One of the largest areas of administrative costs are payments made to outside contractors for claims payments and benefits management services. The two largest contractors are Wells Fargo, Third-Party Administrators and Express Scripts, Incorporated. Wells Fargo processes medical and dental claims for the plan, as well as utilization management services. Express Scripts is the plan's Pharmacy Benefits Manager. Also, administrative payments are made to the West Virginia Department of Health and Human Resources for eligibility determinations, West Virginia University's Rational Drug Therapy Program that reviews prior authorization requests for drugs, and the program's HelpLine established to assist families with questions and problems, among other payments necessary for to administer the program. Administrative costs increased slightly by 2% over the prior year.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2008 and 2007
(Accrual Basis)

	June 30, 2008	June 30, 2007	Variance	
Assets:				
Cash and Cash Equivalents	$ 8,254,028	$4,977,366	$3,276,662	66%
Due From Federal Government	2,770,112	2,650,397	119,715	5%
Due From Other Funds	608,897	622,910	(14,013)	-2%
Accrued Interest Receivable	14,753	20,640	(5,887)	-29%
Fixed Assets, at Historical Cost	71,379	64,933	6,446	10%
Total Assets	$11,719,170	$8,336,246	$3,382,924	41%
Liabilities:				
Due To Other Funds	$ 102,684	$ 149,947	$ (47,263)	-32%
Deferred Revenue	1,483,051	2,174,141	(691,090)	-32%
Unpaid Insurance Claims Liability	3,276,325	3,123,360	152,965	5%
Total Liabilities	$ 4,862,060	$5,447,448	$(585,388)	-11%
Fund Equity	$ 6,857,110	$2,888,798	$3,968,312	137%
Total Liabilities and Fund Equity	$11,719,170	$8,336,246	$3,382,924	41%

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, 2008 and June 30, 2007
(Modified Accrual Basis)

	June 30, 2008	June 30, 2007	Variance	
Revenues:				
Federal Grants	$35,752,885	$35,758,528	$ (5,643)	0%
State Appropriations	10,968,995	10,966,703	2,292	0%
Premium Revenues	88,681	11,433	77,248	676%
Investment Earnings	237,746	168,566	69,180	41%
Total Operating Revenues	$47,048,307	$46,905,230	$ 143,077	0%
Operating Expenditures:				
Claims:				
Outpatient Services	$10,904,046	$10,446,632	$ 457,414	4%
Physician and Surgical	9,313,246	9,403,916	(90,670)	-1%
Prescribed Drugs	8,091,038	8,521,422	(430,384)	-5%
Dental	4,912,268	4,987,934	(75,666)	-2%
Inpatient Hospital	3,778,757	4,491,611	(712,854)	-16%
Outpatient Mental Health	1,253,366	1,545,992	(292,626)	-19%
Vision	1,192,031	1,250,098	(58,067)	-5%
Inpatient Mental Hospital	568,000	883,943	(315,943)	-36%
Durable & Disposable Equipment	529,657	484,416	45,241	9%
Therapy	376,665	348,681	27,984	8%
Medical Transportation	234,090	359,938	(125,848)	-35%
Other Services	91,774	131,155	(39,381)	-30%
Less Collections*	(601,431)	(786,868)	185,437	-24%
Total Claims	40,643,507	42,068,870	(1,425,363)	-3%
General and Admin Expenses:				
Salaries and Benefits	471,346	462,360	8,986	2%
Program Administration	2,045,437	1,925,168	120,269	6%
Eligibility	303,426	304,118	(692)	0%
Outreach & Health Promotion	80,419	174,161	(93,742)	-54%
Current	132,180	109,132	23,048	21%
Total Administrative	3,032,808	2,974,939	57,869	2%
Total Expenditures	43,676,315	45,043,809	(1,367,494)	-3%
Excess of Revenues Over (Under) Expenditures	3,371,992	1,861,421	1,510,571	81%
Fund Equity, Beginning	3,485,118	1,027,377	2,457,741	239%
Fund Equity, Ending	$ 6,857,110	$ 2,888,798	$ 3,968,312	137%

* 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, 2008

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 Cash Equivalents

Cash equivalents principally consist of amounts on deposit in the State Treasurer's Office (STO) that are pooled funds managed by the West Virginia Board of Treasury Investments (BTI). In addition, WVCHIP makes interest-earning deposits in certain investment pools maintained by BTI that are available to WVCHIP with overnight notice. 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 pool. 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.

Insurance Claims Payable

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, 2008, information concerning the amount of deposits with financial institutions, including deposits, of the State Treasurer's Office is as follows:

	Carrying Amount	Bank Balance	Collateralized Amount
Cash			
Deposits with Treasurer	$ 101,412	———	———
Investments			
	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$8,152,616	$8,152,616	Cash Liquidity
Total	$8,254,028		

Reconciliation of cash and cash equivalents and investments as reported in the financial statements to the amounts disclosed in the footnote:

Deposits	
Cash and Cash equivalents as reported	$8,254,028
Less: investments disclosed as cash equivalents	8,152,616
Carrying amount of deposits as disclosed in this footnote	$ 101,412
Investments	
Investments as Reported	---------
Add: investments disclosed as cash equivalents	$8,152,616
Carrying value of investments as disclosed in this footnote	$8,152,616

Note 3

Due to other funds:

Public Employees Insurance Agency Piggyback Contracts	$ 70,758
DHHR & WVOT (Eligibility)	29,600
Other	2,326
Total due to other funds	$102,684

Note 4

Risk Management
Unpaid Claims Liabilities

Claims payable, beginning of year	$ 3,123,360
Incurred claims expense	40,643,507
Payments:	
Claim payments for current year	33,736,362
Claim payments for prior year	6,754,180
Claims payable, year to date	$ 3,276,325

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 2008
For the Twelve Months Ended June 30, 2008

	Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Jun-08	May-08	Apr-08
Projected Cost	$49,020,492	$49,020,492	$41,184,132	$7,836,360	16%	$4,085,041	$2,988,143	$4,415,470	$3,492,568
Premiums	136,290	136,290	88,681	$47,609	-35%	11,358	$8,830	$9,012	$7,997
Subrogation & Rebates	760,000	760,000	601,431	158,569	-21%	63,333	35,672	22,968	38,413
Net Benefit Cost	47,058,152	$47,058,152	$40,494,020	$6,564,132	14%	3,921,513	2,943,641	4,383,490	3,446,158
Salaries & Benefits	$519,673	$519,673	$471,346	$48,327	9%	$43,306	$37,558	$36,473	$36,199
Program Administration	2,166,796	2,166,796	2,077,514	89,282	4%	180,566	164,014	266,297	177,979
Eligibility	340,055	340,055	312,925	27,130	8%	28,338	110,054	1,235	1,430
Outreach	27,157	27,157	80,419	(53,262)	-196%	2,263	19,479	3,328	3,846
Current Expense	287,741	287,741	137,869	149,872	52%	23,978	15,352	18,132	10,167
Total Admin Cost	$3,341,422	$3,341,422	$3,080,073	$261,349	8%	$278,452	$346,457	$325,465	$229,621
Total Program Cost	$50,399,574	$50,399,574	$43,574,093	$6,825,481	14%	$4,199,965	$3,290,098	$4,708,955	$3,675,779
Federal Share 81.98%	40,823,655	$40,823,655	$35,626,232	5,197,423	13%	3,401,971	2,697,222	3,860,401	3,013,403
State Share 18.02%	9,575,919	$9,575,919	$7,947,861	1,628,058	17%	797,993	592,876	848,554	662,375
Total Program Cost **	$50,399,574	$50,399,574	$43,574,093	$6,825,481	14%	$4,199,965	$3,290,098	$4,708,955	$3,675,779

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2007 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES.

Payment Error Rate Measurement (PERM)

The Improper Payments Information Act of 2002 (IPIA) requires heads of federal agencies to estimate and report to the Congress annually the estimates of improper payments for the programs they oversee and the actions the agencies are taking to reduce erroneous payments. In response to this legislation, the Centers for Medicare and Medicaid Services (CMS) implemented the PERM project. Under PERM, each state's Medicaid and SCHIP are audited once every three years for improper payments due to errors in eligibility determinations, payments for services that weren't medically necessary, and data processing errors.

CMS contracts nationally with three firms: one that helps states pull a statistically valid sample, one that collects state policies and medical documentation requests, and the third conducts the medical necessity and data processing reviews. Eligibility determination reviews are left to the states, but are required to be conducted by agencies independent from those setting policies and completing the actual eligibility determinations.

The process starts by generating a random sample of approximately 500 claims and requesting medical records from providers included in the sample. Nurses review the records against national criteria to determine if documentation supports the payment for a medically necessary service, or if the level of service was correctly billed. Auditors also re-price all sample claims using information about benefits, policies, and fees independent of the claims processing system. The re-priced amount is then compared to the amount originally paid on the claim to determine the amount of any error, either an over or an under payment.

Eligibility determination reviews are conducted independent of the claims sample reviews. The West Virginia Department of Health and Human Resources Office of Inspector General (OIG) completed the eligibility reviews for WVCHIP. To complete the reviews, auditors re-evaluated applications, verified information, and assessed whether the eligibility determinations were either correct or incorrect. The dollar amount of the errors is estimated for the incorrect case determinations. The eligibility error rates, data processing, and medical necessity error rates are then combined to determine the amount of improper payments. Subsequently, Medicaid and SCHIP error rates are combined to determine an error rate for the state. Payments made in error are returned to CMS.

West Virginia was one of the states selected for 2007. The audit was completed in August 2008 and the program is waiting for final error amounts. WVCHIP is then required to submit an action plan to correct the errors to the CMS.

Kids First

Governor Manchin charged an interdepartmental team with working on a goal of assuring that every child starts school healthy and ready to learn. In an initiative called ***Kids First***, the strategy to reach this goal is to assure that every child has had an opportunity for a comprehensive wellness exam by a physician prior to entering Kindergarten. WVCHIP played a key part in this strategy by seeking approval of a State Plan change that would permit the program to reimburse providers rendering wellness exams to uninsured children as a special public health or preventive measure. The plan was approved in January 2008 and the program started in the spring. Please refer to page 38 for more information on Kids First.

Third Party Administrator and Pharmacy Benefits Manager Services

WVCHIP contracts for TPA and PBM services through PEIA. Both contracts were due for re-bid this past year. WVCHIP participated with PEIA in the evaluation process. WVCHIP is pleased to announce that both Wells Fargo Third-Party Administrators and Express Scripts continue to be the program's TPA and PBM. While the PBM contract will work similar to years past, the TPA contract has some exciting changes. Under the new TPA contract, Aetna will provide case management and out-of-state networks. We look forward to our ongoing partnerships with both these companies.

TEN YEARS OF WVCHIP COVERAGE AND A DECREASING RATE OF UNINSURED CHILDREN IN WEST VIRGINIA

U.S. Census 2008 Annual Social and Economic Supplement

In 2008, now that ten years have passed since the inception of a separate Children's Health Insurance Program in West Virginia, and with the recent release of health insurance survey data from the Annual Social and Economic Supplement, the resulting decreased rate of low-income (less than 200%FPL), uninsured children is clear. This year's supplement estimates the uninsured rate for West Virginia to be 2.4%, a drop of 64% compared to the estimated rate prior to inception of WVCHIP. West Virginia had the fourth largest drop in the rate of uninsured, low income children of all the states. It should be noted that the overall decrease is attributed not only to gains in WVCHIP enrollment, but also increased enrollment in Medicaid during this same period. (Source: http://pubdb3.census.gov/1032008/health/h10_000.htm)

When viewed over 10 years, it is important to note that the trend does not always decrease as in 1998-2001 when it increased due to erosion in employer sponsored insurance in response to climbing health care costs, and job market changes that took place in the state's economy at that time.

Families USA recently released a report also based on Census data estimates, that shows a rate of 7.0% uninsured for all West Virginia children, ranking the state with the 11th lowest uninsurance rate for all children.

CONTACTING WVCHIP's MANAGEMENT

This report is designed to provide our enrollees, 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 http://www.wvchip.org. Electronic application to the program is available on the web at www.wvinroads.org.

Required Supplementary Information



"West Virginia's children through age 18 may only be 23% of the population, but they are 100% of West Virginia's future!"

WVCHIP Outreach Brochure

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2008 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 2008 ("FY 2008") through Fiscal Year 2015 ("FY 2015"). 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 CHIP Premium expansion to 220% of the Federal Poverty Level ("FPL") and the continuation of FY 2009 State funding of $10,971,688 that we have assumed the funding remains unchanged in future years. At the Federal level, CHIP reauthorization remains uncertain. The Federal funding in FY 2008 for West Virginia was $25,666,451, and we assume this funding remains constant in the future. In addition, CHIP Program management requested two Alternative Expansion Scenarios: A proposed expansion schedule to 250% FPL and a proposed expansion schedule to 300% FPL, both effective January 2009. Under all scenarios, family premiums are assumed to cover 20% of the policy cost for families in the 200% to 250% FPL group and 25% of the policy cost for families in the 250% to 300% FPL group.

Under the submitted West Virginia CHIP Premium expansion plan ("CHIP Premium"), the CHIP expansion began enrollment effective in January 2007. Under this Baseline Scenario, family premiums are assumed to cover 20% of the policy cost for the 220% FPL. The initial monthly premiums will be $35 for families with one child in the program and $71 for families with more than one child in the program. For the purposes of this Baseline Scenario, we have assumed that the initial premium will be unchanged through June 2008. As of June 2008, there are 289 children enrolled between 200% FPL and 220% FPL.

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

- Medical Copayments: $20 Office Visits
  $25 Inpatient & Outpatient Visits
  $35 Emergency Room Visits
- Prescription Drugs Copayments: $0 Generic
  $15 Brand
- Dental Benefits are limited to $150 Preventative services only
- No Vision services are covered

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2008 met the 90% funding requirement and we have assumed the same State funding in FY 2008 for the projected future years as shown in Appendix A.

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 2015. We have assumed FY 2009 State funding of $10,971,688 remains unchanged in future years. Note that we are currently projecting the Federal funding shortfall of approximately $3,016,000 in FY 2010, $16,023,000 in FY 2011, $18,757,000 in FY 2012, $21,555,000 in FY 2013, $24,509,000 in FY 2014 and $27,653,000 in FY 2015 in the Baseline Scenario. Federal reauthorization of the CHIP Program could significantly change future funding. The CHIP Program nationally is going through a process of reauthorization.

It is noteworthy that under both possible Expansion Scenarios, we are not projecting any deficits in State Funding. Both scenarios are assuming that State Funding will remain at current levels through 2015. Federal deficits are projected to occur in State Fiscal year 2010 under both Expansion Scenarios.

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 2007 in this projection. The Federal share of program expenditure is currently 81.98% for Federal Fiscal Year 2008. The Federal share of program expenditure is assumed to be 81.61% for Federal Fiscal Year 2009, and 81.54% for Federal Fiscal Year 2010 and future years.

Enrollment for the program as of June 2008 has continued to decline consistent with the previous Quarterly Report. In fact, current enrollment is consistent with the enrollment as of April 2005. The current program enrollment as of June 2008 consists of 24,418 children total: 15,227 children as part of Phase I and Phase II that consists of children whose families are below 150% of the federal poverty level, 8,902 children as part of Phase III that consists of children whose families are between 150% and 200% of the federal poverty level, and 289 children as part of CHIP Premium. Phase III children are required to make co-payments as part of the benefit structure of the program. Since the March 31, 2008 Quarterly Report, overall enrollment has decreased by 168 children. While Phase I and Phase II had decreased enrollment of 89 children and Phase III had decreased enrollment of 104 children, CHIP Premium had increased enrollment of 25 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 decreased 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 reduced the FY 2008 medical claim trend assumption to 6%, dental claim trend assumption to 5% and prescription drugs claim trend assumption to 8%.

Administrative expenses, including CHIP Premium, were originally projected to be $3,590,424 in FY 2008. Net administrative expenses in FY 2008 finished at $3,073,329, representing a 4% increase over FY 2007 administrative expenses of $2,965,912. The projection assumes a 5% administrative expense trend in future years.

Drugs rebates were originally projected to be $627,887 in FY 2008 and the year ended with drugs rebates of $518,870. The projection assumes a 4% drugs rebates trend in future years.

Under the State fiscal year basis, we calculate the incurred claim costs under the Baseline Scenario assumptions for FY 2008 is $40,448,314. The updated projection for FY 2009 claims is $42,519,590.

PLAN ENROLLMENT

We have updated our projection based on the enrollment through June 2008. Phase I and Phase II enrollment and Phase III enrollment have been decreasing in recent months. The program had enrollment at the end of FY 2007 of 24,939 children, with 15,658 under Phase II, 9,181 under Phase III, and 100 under CHIP Premium. Current enrollment as of June 2008 is 24,418 children, with 15,227 under Phase I and Phase II, 8,902 under Phase III, and 289 under CHIP Premium.

It is noteworthy that CHIP 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 CHIP Premium enrollment through June 2008, and will continue to evaluate these projections in the future.

The following table summarizes the FY 2006 to FY 2008 enrollment information using end of month enrollment information by Phase II, Phase III, CHIP Premium and in total:

Date	Phase II	Phase III	CHIP Premium	Total	Annual % Growth
July-05	15,612	8,961	----	24,573	4.0%
Aug-05	15,793	8,898	----	24,691	3.6%
Sep-05	15,792	8,857	----	24,649	2.6%
Oct-05	15,831	8,917	----	24,748	3.2%
Nov-05	15,624	8,983	----	24,607	2.1%
Dec-05	15,656	9,000	----	24,656	1.5%
Jan-06	15,509	9,109	----	24,618	1.6%
Feb-06	15,755	8,899	----	24,654	1.4%
Mar-06	15,916	8,905	----	24,821	1.4%
Apr-06	15,813	8,830	----	24,643	1.0%
May-06	15,934	8,933	----	24,867	1.3%
Jun-06	15,907	8,928	----	24,835	1.3%
July-06	15,867	8,993	----	24,860	1.2%
Aug-06	16,006	9,163	----	25,169	1.9%
Sep-06	16,207	9,312	----	25,519	3.5%
Oct-06	16,083	9,300	----	25,383	2.6%
Nov-06	15,986	9,284	----	25,270	2.7%
Dec-06	16,027	9,246	----	25,273	2.5%
Jan-07	16,153	9,205	----	25,358	3.0%
Feb-07	16,075	9,195	12	25,282	2.5%
Mar-07	15,975	9,162	21	25,158	1.4%
Apr-07	15,829	9,120	42	24,991	1.4%
May-07	15,728	9,155	68	24,951	0.3%
Jun-07	15,658	9,181	100	24,939	0.4%
Jul-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%

The tables below summarize the fiscal year June 30th ending enrollment projection assumptions for Baseline Scenario and two Alternative Scenarios, by Phase II & III, and CHIP Premium.

Baseline Scenario (220% FPL)

Ending Enrollment	FY2008	FY2009	FY2010	FY2011	FY2012
Phase II & III	24,129	24,129	24,129	24,129	24,129
CHIP Premium	289	409	529	649	709
Total	24,418	24,538	24,658	24,778	24,838

Alternative Scenario 1 (250% FPL)

Ending Enrollment	FY2008	FY2009	FY2010	FY2011	FY2012
Phase II & III	24,129	24,129	24,129	24,129	24,129
CHIP Premium	289	694	958	1,222	1,426
Total	24,418	24,823	25,087	25,351	25,555

Alternative Scenario 2 (300% FPL)

Ending Enrollment	FY2008	FY2009	FY2010	FY2011	FY2012
Phase II & III	24,129	24,129	24,129	24,129	24,129
CHIP Premium	289	1,149	1,605	2,061	2,457
Total	24,418	25,278	25,734	26,190	26,586

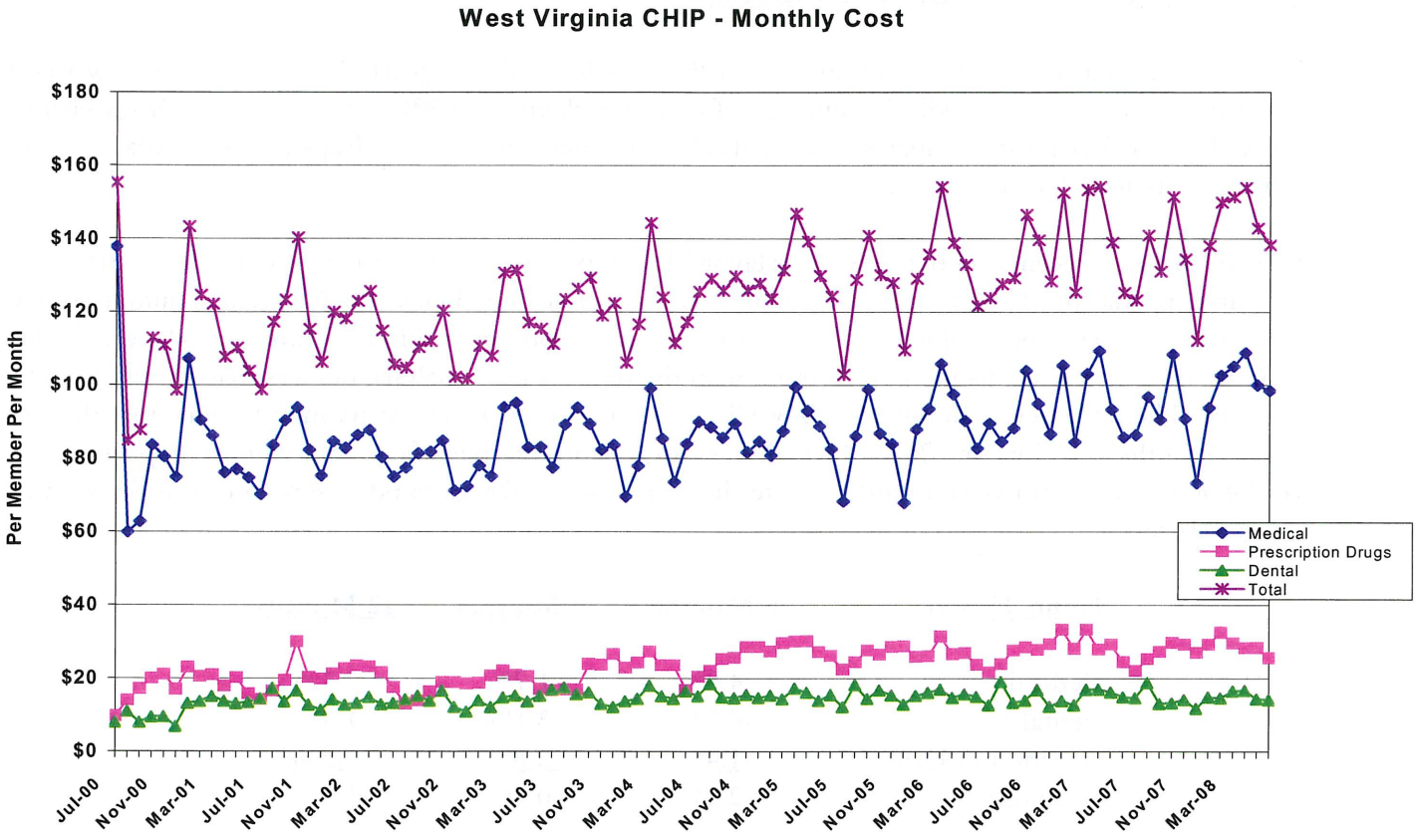
CLAIM COST AND TREND ANALYSIS

We have reduced the trend assumptions from the March 31, 2008 Quarterly Report. The new trend assumptions are 6% for medical claims, 5% for dental claims and 8% 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 most recent experience remains favorable compared to our trend assumptions. It is noteworthy to comment that most recently, medical trend rates have remained below the 6% trend assumption due to lower than expected hospitalizations. As we review trends over different time periods, the twelve months analysis reflects higher overall trend than the nine months analysis, but less than the six months analysis. The table below summarizes WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2008. Overall trend experience has been favorable, with a composite trend of 1.4% over the last twelve months. Note that Prescription Drugs trends are before consideration of drugs rebates.

Trend Period	6 Months	9 Months	12 Months
Medical	4.8%	1.7%	2.3%
Dental	-0.3%	-3.1%	-1.4%
Prescription Drugs	-1.4%	-0.8%	-0.2%
Composite	2.9%	0.7%	1.4%

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 2008. The attachment at the end of this report shows the trends for Phase II and Phase III 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 2008-2015

Under the Baseline Scenario, we have assumed the continuation of FY 2009 State funding of $10,971,688, and the funding remains unchanged in future years. At the Federal level, CHIP reauthorization remains uncertain. The Federal funding in FY 2008 for West Virginia was $25,666,451, and we assume this funding remains constant in the future. This amount is based on a national funding level assumed to be the same as in FY 2007.

The updated incurred claims for FY 2008 is $40,448,314 based on the fiscal year 2008 average enrollment of 24,756 children and the incurred claim per member per month cost data assumption of $136.16, as summarized in the following table. It should be noted that we expect higher inpatient hospital payments in medical claims in Fiscal Year 2009 due to the discontinuance of 33% discount on July 1, 2007, with an additional 2.5% adjustment to the inpatient hospital PPS payments from the PEIA rate updates on July 1, 2008.

Category	Current Report FY2008 Baseline Incurred Claims	Current Report FY2008 Baseline Per Member Per Month	3/31/08 Report FY2008 Baseline Per Member Per Month	12/31/07 Report FY2008 Baseline Per Member Per Month
Medical	$28,430,201	$95.70	$100.17	$102.58
Prescription Drugs	7,845,512	26.41	28.56	29.81
Dental	4,172,601	14.05	15.07	15.57
Total	$40,448,314	$136.16	$143.80	$147.96

The Baseline Scenario financial forecast for the Federal and State fiscal years 2008 through 2015 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 2015; and projecting a Federal funding shortfall of approximately $3,016,000 in FY 2010, $16,023,000 in FY 2011, $18,757,000 in FY 2012, $21,555,000 in FY 2013, $24,509,000 in FY 2014 and $27,653,000 in FY 2015 in the Baseline Scenario.

Appendix A, B and C show the Baseline Scenario and two Alternative Scenarios 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. We have not assumed any future Federal redistributions for fiscal years 2003 through 2007 in this projection.

Appendix D summarizes the original and restated IBNR claim liabilities for the CHIP Program in Fiscal Year 2007 to 2008. 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 2008 through 2015 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 2008 through FY 2015 have not been appropriated by the West Virginia Legislature.

Dave Bond

Dave Bond
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Managing Partner
CCRC Actuaries, LLC
Reisterstown, Maryland
July 22, 2008

Brad Paulis

Brad Paulis
Reviewing Partner
CCRC Actuaries, LLC
Reisterstown, Maryland
July 22, 2008

APPENDIX B *(Alternative Scenario 1 - Expansion to 250% FPL)*

West Virginia Children's Health Insurance Program

June 30, 2008 Quarterly Report

Available Funding - Beginning of the Year	2008	2009	2010	2011	2012	2013	2014	2015
Federal 2006	$3,870,413	$0	$0	$0	$0	$0	$0	$0
Federal 2007	27,516,914	0	0	0	0	0	0	0
Federal 2008	25,666,451	21,511,075	0	0	0	0	0	0
Federal 2009	0	25,666,451	10,288,133	0	0	0	0	0
Federal 2010	0	0	25,666,451	0	0	0	0	0
Federal 2011	0	0	0	25,666,451	0	0	0	0
Federal 2012	0	0	0	0	25,666,451	0	0	0
Federal 2013	0	0	0	0	0	25,666,451	0	0
Federal 2014	0	0	0	0	0	0	25,666,451	0
Federal 2015	0	0	0	0	0	0	0	25,666,451
State Funding 2006	$0	$0	$0	$0	$0	$0	$0	$0
State Funding 2007	3,231,637	0	0	0	0	0	0	0
State Funding 2008	10,968,995	7,930,719	0	0	0	0	0	0
State Funding 2009	0	10,971,688	10,965,225	2,399,269	0	0	0	0
State Funding 2010	0	0	10,971,688	10,971,688	4,206,437	0	0	0
State Funding 2011	0	0	0	10,971,688	10,971,688	5,374,166	0	0
State Funding 2012	0	0	0	0	10,971,688	10,971,688	5,869,441	0
State Funding 2013	0	0	0	0	0	10,971,688	10,971,688	5,640,341
State Funding 2014	0	0	0	0	0	0	10,971,688	10,971,688
State Funding 2015	0	0	0	0	0	0	0	10,971,688
Phase II & Phase III Program Costs	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Medical Expenses	$28,165,117	$29,369,070	$31,131,214	$32,999,087	$34,979,032	$37,077,774	$39,302,440	$41,660,587
Prescription Drug Expenses	7,772,361	8,257,517	8,918,118	9,631,567	10,402,093	11,234,260	12,133,001	13,103,641
Dental Expenses	4,133,695	4,269,731	4,483,218	4,707,379	4,942,748	5,189,885	5,449,379	5,721,848
Administrative Expenses	3,036,687	3,136,622	3,293,453	3,458,125	3,631,032	3,812,583	4,003,212	4,203,373
CHIP Premium Costs								
Medical Expenses	$265,083	$594,272	$1,095,015	$1,526,820	$1,980,775	$2,343,474	$2,721,920	$3,100,577
Prescription Drugs Expenses	73,152	167,088	313,688	445,639	589,045	710,053	840,280	975,235
Dental Expenses	38,905	86,396	157,694	217,804	279,895	328,023	377,401	425,847
Administrative Expenses	36,642	81,370	148,519	205,131	263,611	308,938	355,443	401,070
Premiums (CHIP Premium)	$88,681	$271,566	$492,156	$700,236	$921,690	$1,082,880	$1,265,664	$1,445,136
Program Revenues - Interest	$243,633	$324,299	$376,360	$417,634	$448,639	$468,673	$477,170	$473,240
Program Revenues - Drug Rebates	518,870	539,625	561,210	583,658	607,004	631,284	656,535	682,796
Net Incurred Program Costs Excluding Interest	$42,914,092	$45,150,874	$48,487,551	$51,907,658	$55,539,536	$59,290,826	$63,260,878	$67,464,246
Net Paid Program Costs	43,574,092	44,993,874	48,260,551	51,665,658	55,282,536	59,016,826	62,969,878	67,154,246
Federal Share	$35,072,615	$36,889,393	$39,545,235	$42,325,504	$45,286,937	$48,345,740	$51,582,920	$55,010,347
State Share of Expenses - Net of Interest	7,597,844	7,937,182	8,565,956	9,164,519	9,803,959	10,476,413	11,200,788	11,980,660
Beginning IBNR	$4,110,000	$3,450,000	$3,607,000	$3,834,000	$4,076,000	$4,333,000	$4,607,000	$4,898,000
Ending IBNR	3,450,000	3,607,000	3,834,000	4,076,000	4,333,000	4,607,000	4,898,000	5,208,000

APPENDIX B *(Alternative Scenario 1 - Expansion to 250% FPL)*

West Virginia Children's Health Insurance Program

June 30, 2008 Quarterly Report

Funding Sources - End of the Year	2008	2009	2010	2011	2012	2013	2014	2015
Federal 2006	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2007	0	0	0	0	0	0	0	0
Federal 2008	21,511,075	0	0	0	0	0	0	0
Federal 2009	0	10,288,133	0	0	0	0	0	0
Federal 2010	0	0	0	0	0	0	0	0
Federal 2011	0	0	0	0	0	0	0	0
Federal 2012	0	0	0	0	0	0	0	0
Federal 2013	0	0	0	0	0	0	0	0
Federal 2014	0	0	0	0	0	0	0	0
Federal 2015	0	0	0	0	0	0	0	0
Federal Shortfall	***$0***	***$0***	***$3,590,650***	***$16,659,053***	***$19,620,486***	***$22,679,289***	***$25,916,469***	***$29,343,896***
State Funding 2006	$0	$0	$0	$0	$0	$0	$0	$0
State Funding 2007	0	0	0	0	0	0	0	0
State Funding 2008	7,930,719	0	0	0	0	0	0	0
State Funding 2009	0	10,965,225	2,399,269	0	0	0	0	0
State Funding 2010	0	0	10,971,688	4,206,437	0	0	0	0
State Funding 2011	0	0	0	10,971,688	5,374,166	0	0	0
State Funding 2012	0	0	0	0	10,971,688	5,869,441	0	0
State Funding 2013	0	0	0	0	0	10,971,688	5,640,341	0
State Funding 2014	0	0	0	0	0	0	10,971,688	4,631,369
State Funding 2015	0	0	0	0	0	0	0	10,971,688
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

Email: info@ccrcactuaries.com

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

December 9, 2008

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 November 2008. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2009 based on the updated information.

It is noteworthy that we are not projecting a shortfall in State funding based on funding levels provided by CHIP management. After the September 30, 2008 Quarterly Report was issued in October 2008, several changes have occurred in the program:

- Enrollment for the CHIP Program as of November 2008 had been steady, remaining around 25,000 since November 2007. Overall enrollment for the CHIP Program as of November 2008 was 24,410;

- November 2008 claim experience showed the projected incurred FY 2009 expenditure to be $42,345,266, a slight decrease of $169,512 from $ 42,514,778 in the September 30, 2008 Quarterly Report.

- The categories of FY 2008 medical, dental and prescription drug expenses in the current claim experience through November 2008 showed slight improvement over the September 30, 2008 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2009 is now projected to be $144.74, slightly down from the projected $145.89 PMPM cost in the September 30, 2008 Quarterly Report. Medical PMPM for Fiscal Year 2009 is now projected to be $101.44, slightly down from the projected $102.04 PMPM cost in the September 30, 2008 Quarterly Report. Dental PMPM for Fiscal Year 2009 is now projected to be $15.32, slightly up from the projected $14.95 PMPM cost in the September 30, 2008 Quarterly Report. Prescription Drugs PMPM for Fiscal Year 2009 is now projected to be $27.98, slightly down from the projected $28.90 PMPM cost in the September 30, 2008 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

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 "2008 Annual Social and Economic Supplement," WVCHIP continues to prioritize outreach efforts to the top ten (10) counties (shown on page 41) of the State with either higher numbers or percentages of uninsured children. The potential impact of these efforts at the county level can be seen in the Statistical Section in Tables 9 and 10 (shown on Page 50 and 51).

Public Information via the Call Center, Website, and WVinRoads

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Call Center, which averages over 1,700 calls a month and mails out an about 400 applications a month. Information is also available through the agency's website at www.wvchip.org 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 continues to be made 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, avoided travel costs from having to pick up applications, and time savings from having to wait in line at local offices.

"Brain Under Construction" Zone: A Child Development Education Project

In 2007-2008, WVCHIP began a partnership with the United Way of the River Cities to replicate their *Brain Under Construction Zone* program in the Mid-Ohio Valley Region. This project is based on the the importance of early brain development and the belief that supporting parents' abilities to take advantage of everyday opportunities to stimulate and enhance their children's learning and development is crucial. United Way of River Cities does this through a Cabell County hospital-based program of trained volunteers providing mothers of newborns with a portfolio for the newborn with information on an array of early developmental activities and identifying resources in the local community to assist them. Each portfolio also includes information needed to apply for WVCHIP. The program is spread throughout surrounding counties by including other participating community partners, such as child care centers, who will support various themes of child development in concert throughout their communities with projects having child development themes such as a "reading and rhyming with your child" information display board and related activities available onsite. This year with support from WVCHIP, the Mid-Ohio Valley Region based in Wood County and surrounding neighboring counties formed a steering committee that developed its plan and needed project resources with implementation scheduled to begin at the end of 2008. The *Brain Under Construction Zone* project, allows communities to support family efforts to improve parent and child interactions. This approach can provide an environment that can foster a child's readiness for school and can potentially impact on a child's short and long term developmental outcomes.

The Governor's "Kids First" Initiative - A Special Prevention Project

By the start of 2008, WVCHIP had applied for and received approval from the federal government to begin a special presentation project known as "Kids First." This approval allowed WVCHIP to reimburse providers for the cost of a comprehensive wellness exam for any of the estimated 5% uninsured children about to enter Kindergarten. Since all county school districts offer health screening to those children entering Kindergarten, this project represents an opportunity for multiple purposes such as identifying uninsured children and offering application for coverage as well as potential enrollment in a medical home. Under a Superintendent's Interpretive Ruling, it also allowed a documented comprehensive well-child exam to be accepted in lieu of health screens previously mandated to be performed by county school health officials which could alleviate screening workload for some counties. Perhaps most importantly, the West Virginia Department of Education began a process of gathering vision, hearing, developmental, and body mass index data into an aggregate database. Since implementation of the project occurred in September 2008, no data summary or other summary information is available at this time.

A Faith-Based Emphasis

The faith community plays a vital role in supporting families and nurturing the development of children, by integrating faith, access to care, and health of the whole person. Health ministries, parish nurse programs, congregations, and other faith-based organizations are getting actively involved in tending directly to the health concerns of their members and the large community. Faith organizations that sponsor community-based programs such as child care centers, food pantries, and summer camps are becoming more attentive to the insistent problems children face.

For this reason, WVCHIP is a partner to the faith community's efforts to educate and support families in obtaining health care coverage and promoting healthy lifestyles. WVCHIP does this by making its program and application information available to the members of West Virginia Healthy Kids and Families Coalition as well as providing materials to child health focused events sponsored by their members. The West Virginia Council of Churches acts as fiscal agent for the Coalition and employs its executive director. The Coalition publishes an online news bulletin for members throughout the state, supports CHIP outreach events by its members, and sponsors the annual "Growing Healthy Children" conference.

Health Intervention Collaborative Efforts

In 2004, WVCHIP began working with several State agencies and community health programs as a way to refocus WVCHIP's outreach efforts as a leader in health prevention and promoting a healthy lifestyle. 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 2008:

- ★ Continued participation in efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, West Virginia Asthma Coalition, and the Medical Advisory Council of the Office of Maternal Child and Family Health.

- ★ This past year, WVCHIP continued its partnership with DHHR's Office of Infant, Child and Adolescent Health 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. As part of this partnership, WVCHIP supports the "HealthCheck" form as a standard form or model for provider use in all well-child exam visits.

Health Intervention Collaborative Efforts (continued)

★ WVCHIP partnered with the West Virginia Immunization Network and the State's Immunization Program in continued work on strategies to implement an immunization campaign targeting adolescents to help boost their immunization rates. WVCHIP has sponsored Raleigh County as one of several target counties by providing matching funds to implement its own "Take Your Best Shot" adolescent campaign since it began in October 2007.

★ 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 materials were included in the State's Immunization Program packets to new mothers through the Right from the Start Program for mothers and infants in higher risk health circumstances.

★ For the third consecutive year, WVCHIP served on both the planning committee and as a sponsor of the "Growing Healthy Children Conference." Held annually in Charleston, the conference covers an array of major topics of current child health concerns from oral health, mental health, school-based health and child development presented in open plenary and workshop sessions. The C.W. Benedum Foundation and the American Academy of Pediatricians, WV Chapter are also sponsors.

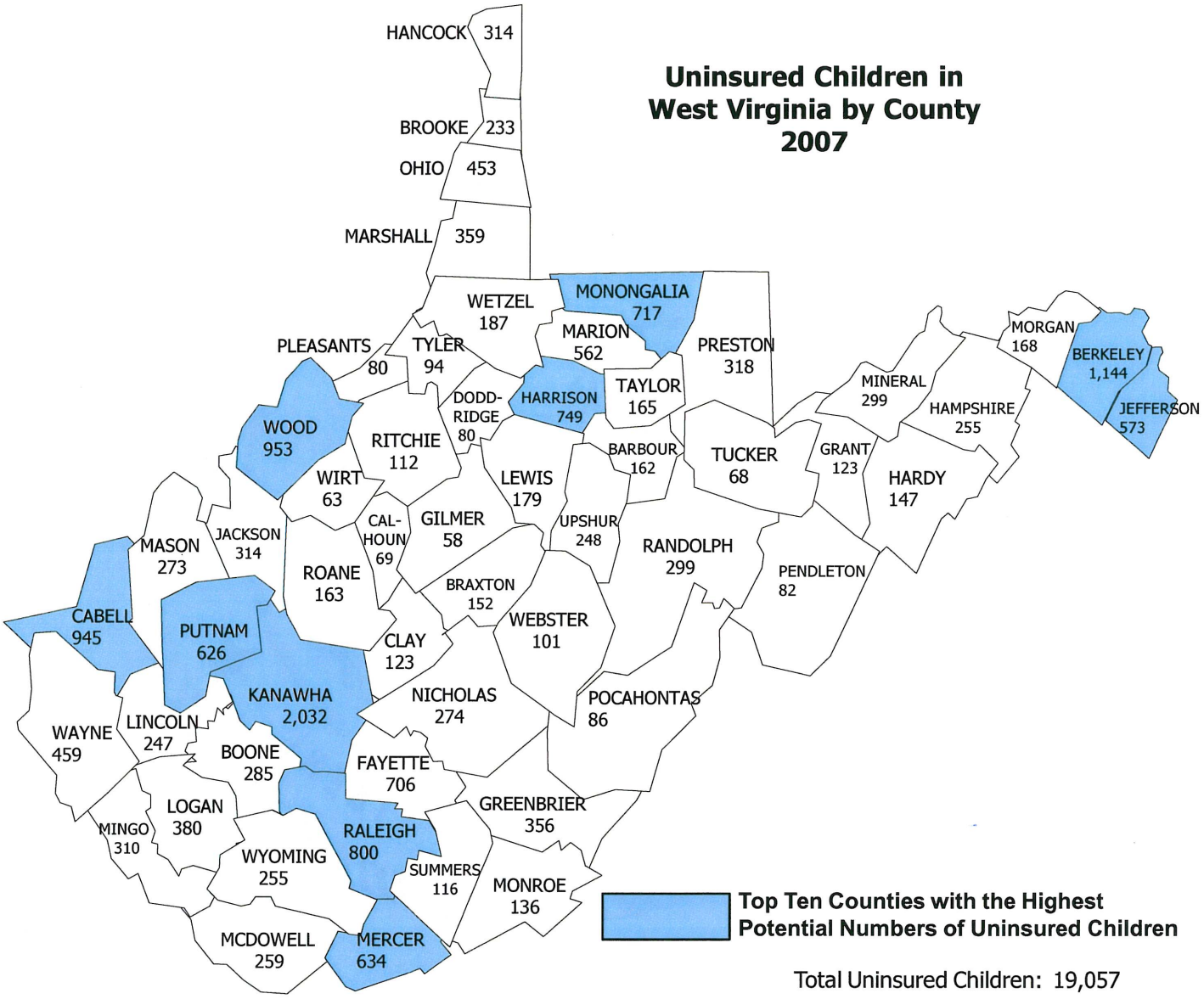
"Camp NEW You" Participation - A Special Intervention for Obesity

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 health lifestyle change 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.

Targeted Outreach For Uninsured Children



The 2008 U.S. Census Current Population Survey now estimates the uninsured rate of all children in WV at 7%. For outreach purposes of targeting those eligible at income levels of 250% FPL or lower, a five percent rate is used. It should be noted however, the five percent extrapolation to the county level could 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.

STATE OF WEST VIRGINIA
MONTANI SEMPER LIBERI

STATISTICAL SECTION



".....all our nation's children, deserve the attention, the encouragement, and the intervention of health professionals from many disciplines to ensure that they develop the healthy bodies, minds, emotions, and attitudes to prepare them to be competent and contributing adults."

-Morris Green, MD
Bright Futures Guidelines, 1994
American Academy of Pediatrics

All statistics are for the fiscal year ended June 30, 2008, unless noted otherwise.

Table 1: Enrollment

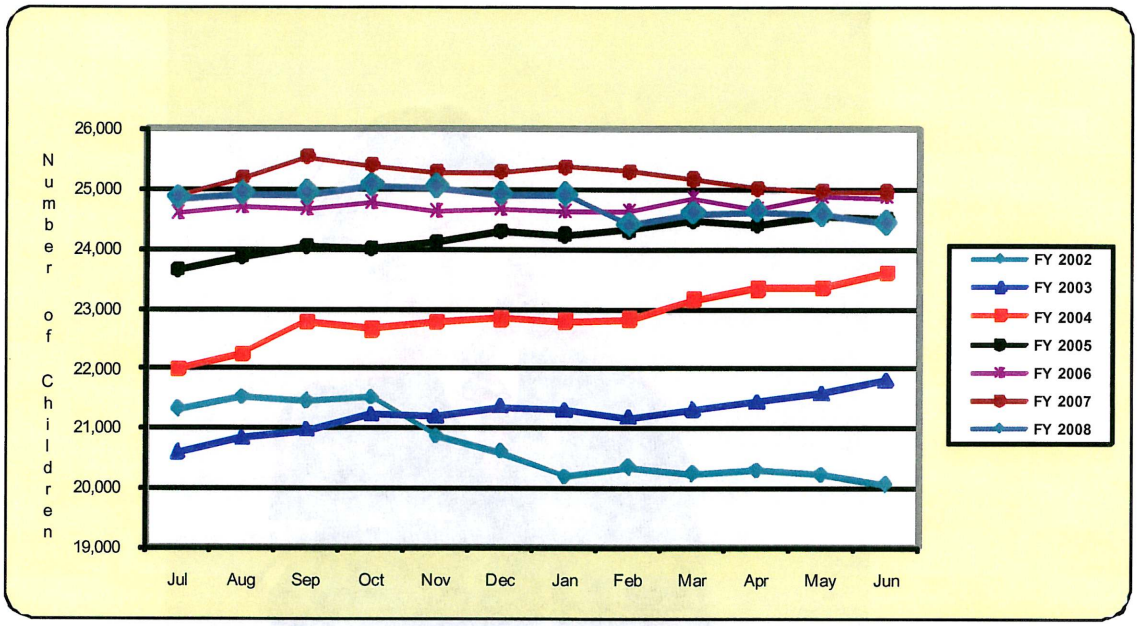
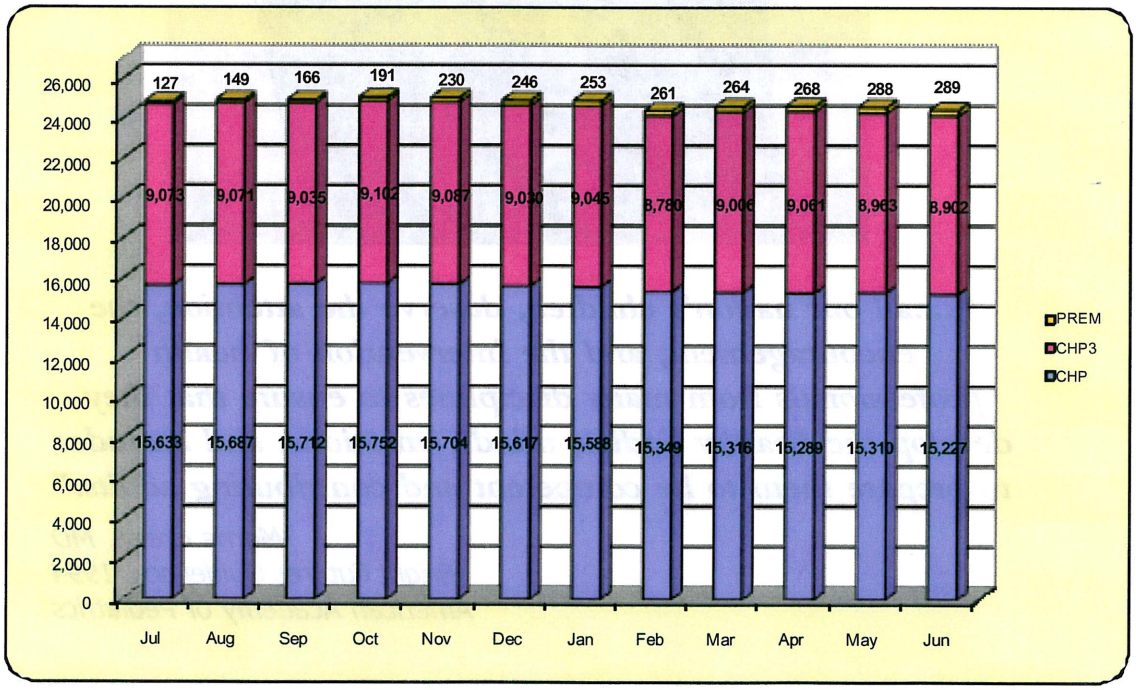
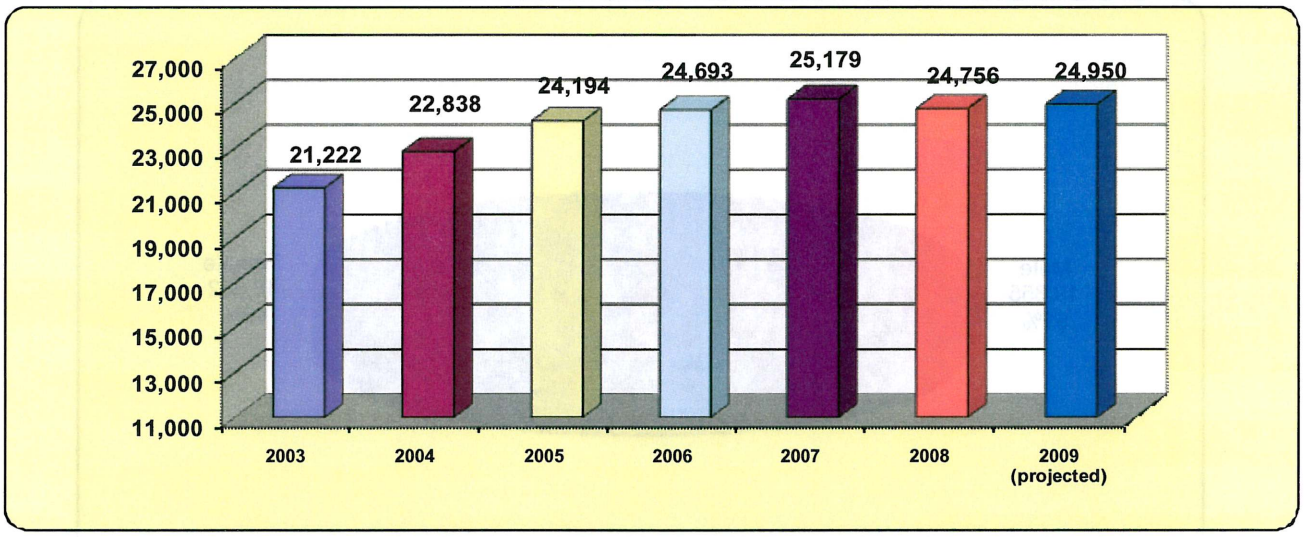


Table 2: Enrollment Detail



Note: Phase III Effective October 2000 PREMIUM effective January 1, 2007

TABLE 3: AVERAGE ENROLLMENT
SFY 2001 - 2007



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	38,190	-0.7%

Total unduplicated number of children ever enrolled as of June 30, 2008 in WVCHIP since inception:
109,036

Table 4: Enrollment By Gender

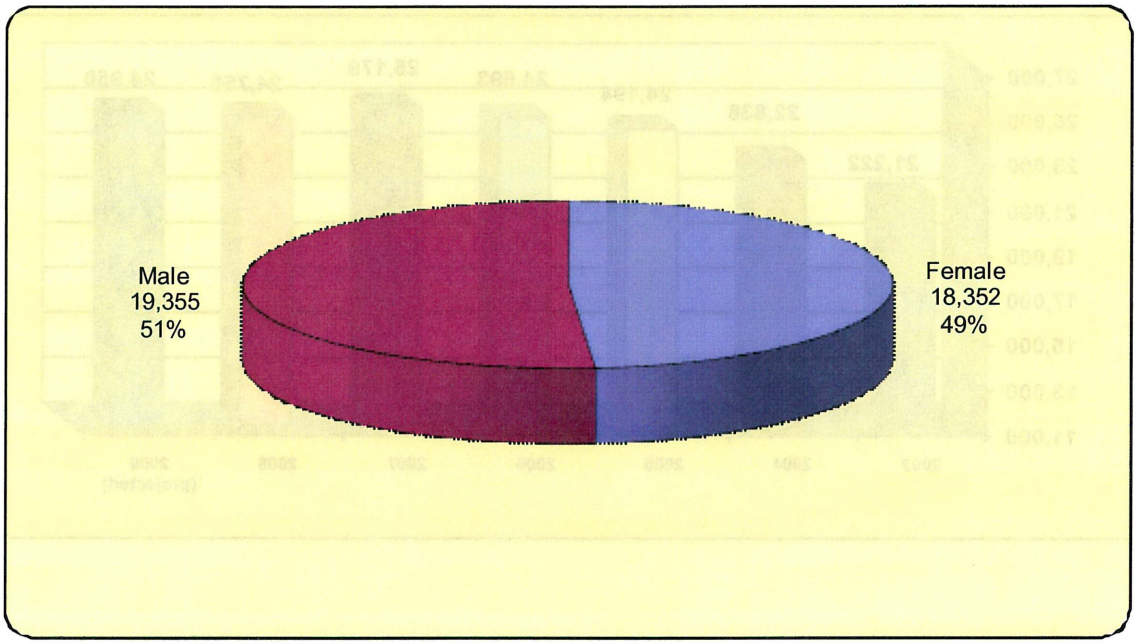


Table 5: Enrollment By Age

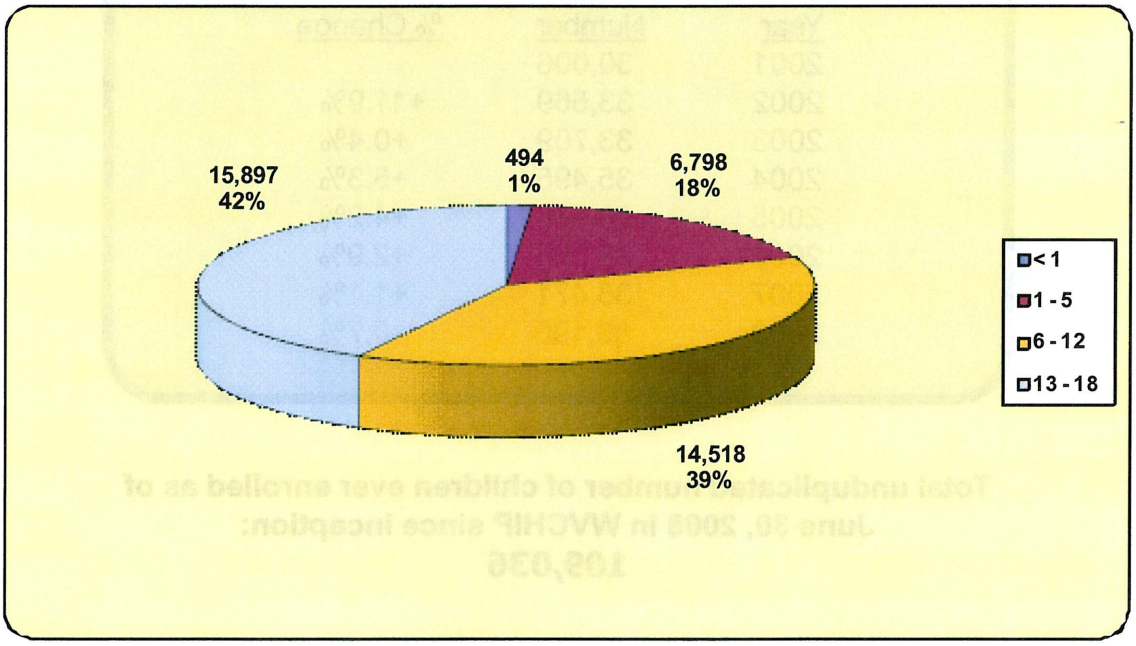
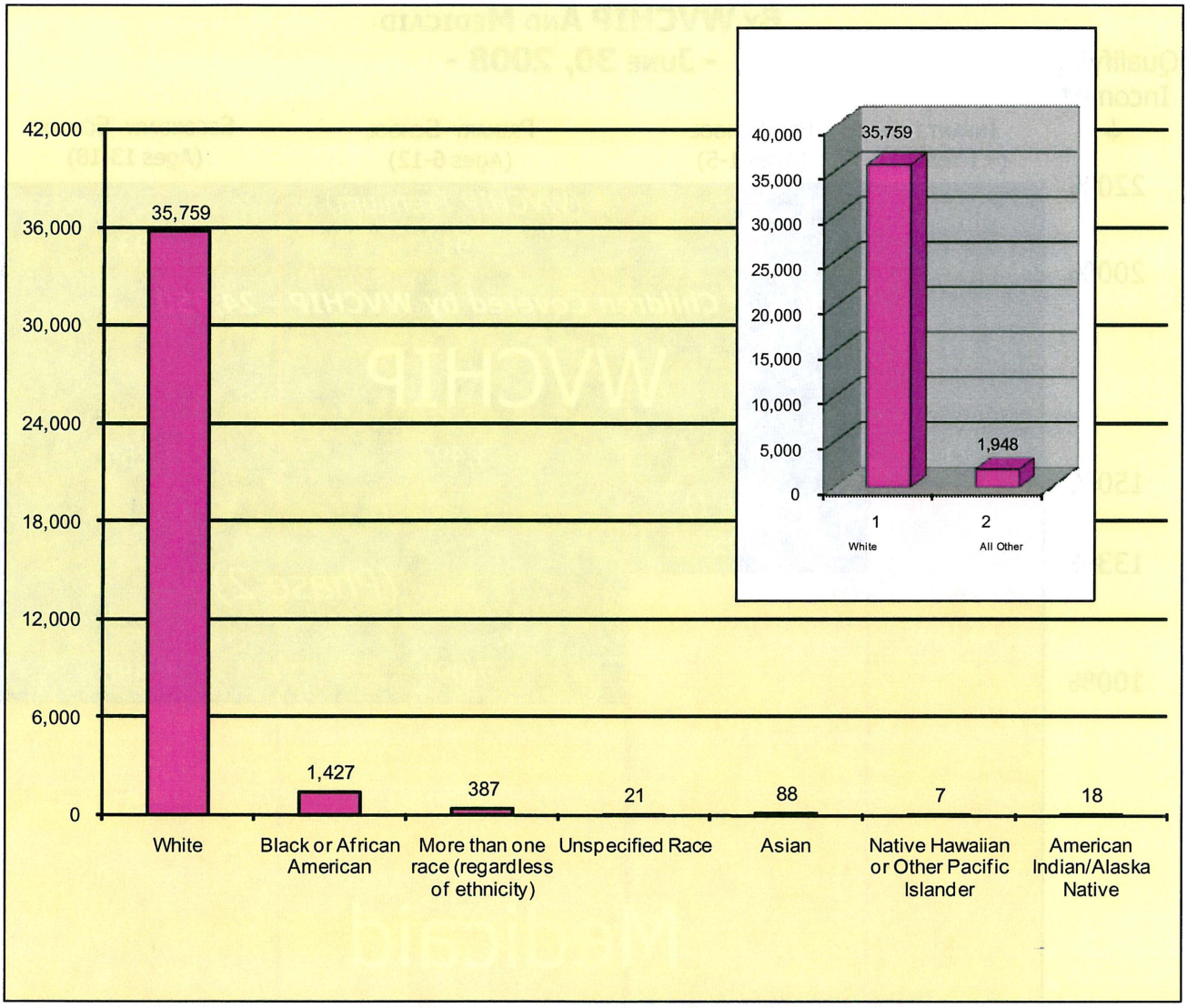
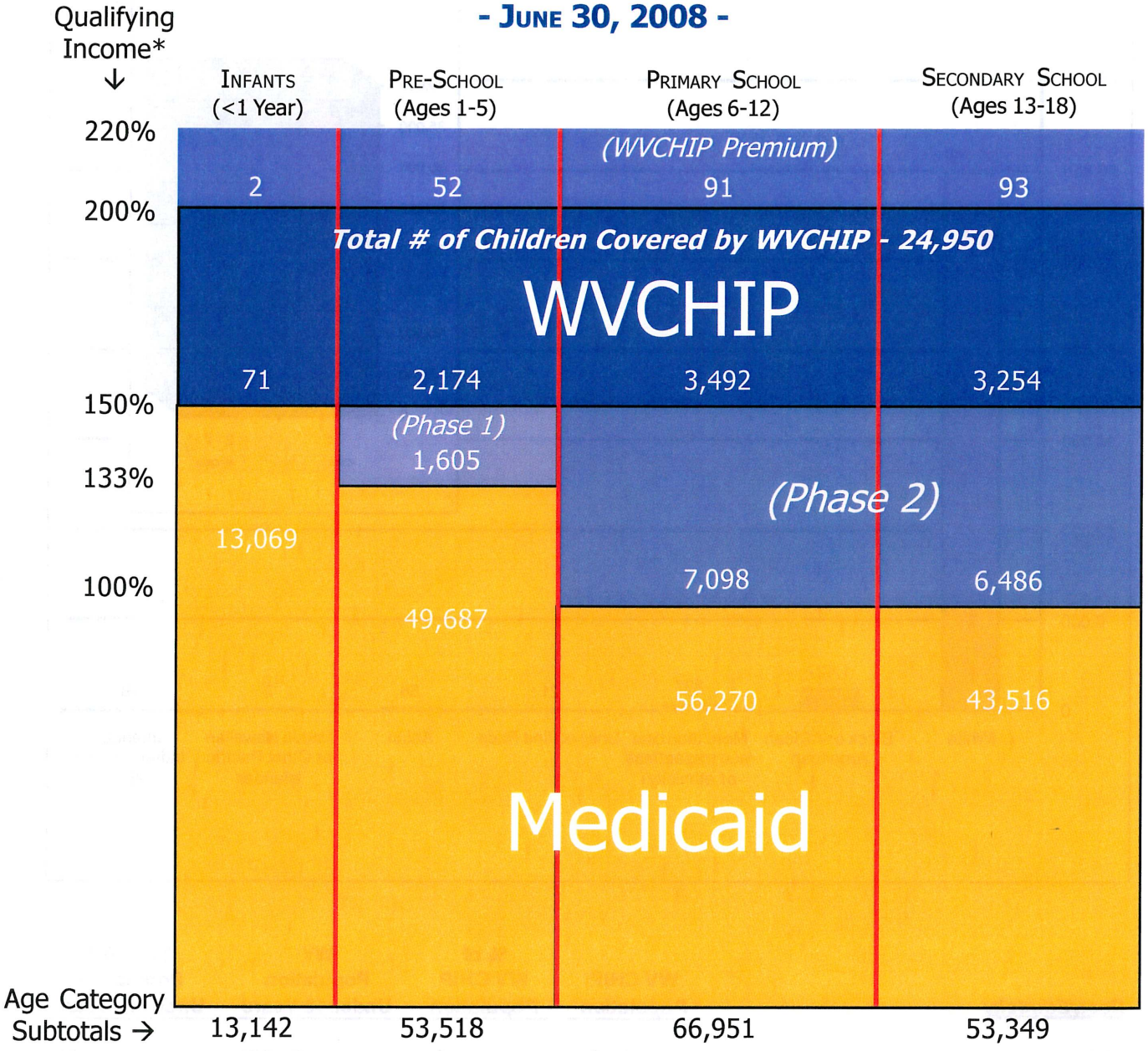


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	35,759	94.8%	383,524	94.3%
Black or African American	1,427	3.8%	12,954	3.2%
More than one race (regardless of ethnicity)	387	1.0%	3,643	0.9%
Asian	88	0.2%	2,024	0.5%
Unspecified Race	21	0.1%	810	0.2%
Native Hawaiian or Other Pacific Islander	7	0.0%	81	0.0%
American Indian/Alaska Native	18	0.0%	810	0.2%
Total	**37,707**	**100.0%**	**403,846**	**99.3%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2008 -



*Household incomes through 220% of the Federal Poverty Level (FPL)

Total WVCHIP Enrollment **24,418** **Total WV Medicaid Enrollment** **162,542**

Total # of Children Covered by WVCHIP and Medicaid - 186,960

Table 8: Annual Re-Enrollment and Non-Responses Upon Renewal
July 2007 through June 2008

Closure Range by County

Lowest% of AG's Closed - 17.3%

Highest % of AG's Closed - 39.5%

Average % of AG's Closed - 29.9%

County	# of Renewal Forms Mailed Monthly To CHIP Households	# of Closure Notices Mailed For Non-Returned Forms	# of Households Re-Opened (as either CHIP or Medicaid)	% of Households Re-Opened After Closure	# of Households Closed with No Response	% of Households Closed
Lewis	255	77	33	42.9%	44	17.3%
Pendleton	106	38	17	44.7%	21	19.8%
Tucker	162	66	32	48.5%	34	21.0%
Monroe	188	70	26	37.1%	44	23.4%
Taylor	197	77	30	39.0%	47	23.9%
Mason	283	102	33	32.4%	69	24.4%
Mineral	385	141	47	33.3%	94	24.4%
Doddridge	114	45	17	37.8%	28	24.6%
Roane	268	92	26	28.3%	66	24.6%
Clay	160	70	30	42.9%	40	25.0%
Marion	687	251	76	30.3%	175	25.5%
Wyoming	377	140	43	30.7%	97	25.7%
Boone	283	95	22	23.2%	73	25.8%
Pocahontas	127	50	17	34.0%	33	26.0%
Summers	200	69	17	24.6%	52	26.0%
Hancock	356	154	60	39.0%	94	26.4%
Wirt	117	47	16	34.0%	31	26.5%
Wood	978	398	129	32.4%	269	27.5%
Ohio	413	154	38	24.7%	116	28.1%
Gilmer	92	39	13	33.3%	26	28.3%
Wetzel	195	78	22	28.2%	56	28.7%
Upshur	371	163	55	33.7%	108	29.1%
Greenbrier	530	221	66	29.9%	155	29.2%
Logan	473	192	53	27.6%	139	29.4%
Randolph	414	166	43	25.9%	123	29.7%
Calhoun	127	54	16	29.6%	38	29.9%
McDowell	983	430	132	30.7%	298	30.3%
Jackson	340	136	32	23.5%	104	30.6%
Preston	487	213	64	30.0%	149	30.6%
Brooke	273	114	30	26.3%	84	30.8%
Nicholas	419	186	56	30.1%	130	31.0%
Morgan	354	151	41	27.2%	110	31.1%
Braxton	173	76	22	28.9%	54	31.2%
Harrison	856	368	97	26.4%	271	31.7%
Mingo	614	274	79	28.8%	195	31.8%
Mercer	273	118	31	26.3%	87	31.9%
Lincoln	373	175	54	30.9%	121	32.4%
Monongalia	237	96	19	19.8%	77	32.5%
Cabell	841	379	103	27.2%	276	32.8%
Raleigh	1,182	488	99	20.3%	389	32.9%
Putnam	558	251	67	26.7%	184	33.0%
Wayne	522	237	64	27.0%	173	33.1%
Webster	173	95	37	38.9%	58	33.5%
Marshall	353	148	29	19.6%	119	33.7%
Grant	163	79	24	30.4%	55	33.7%
Hardy	116	51	11	21.6%	40	34.5%
Pleasants	87	40	10	25.0%	30	34.5%
Fayette	870	398	96	24.1%	302	34.7%
Ritchie	138	69	20	29.0%	49	35.5%
Barbour	286	137	34	24.8%	103	36.0%
Hampshire	256	123	30	24.4%	93	36.3%
Tyler	96	47	11	23.4%	36	37.5%
Berkeley	1,055	551	145	26.3%	406	38.5%
Jefferson	373	181	35	19.3%	146	39.1%
Kanawha	1,836	940	214	22.8%	726	39.5%
Totals	**22,145**	**9,600**	**2,663**	**27.7%**	**6,937**	**31.3%**
12-Mo. Ave.		***800***	***222***	***27.7%***	***578***	***31.3%***

Table 9: Enrollment Changes By County
As % Difference from July 2007 through June 2008

County	Total Enrollees June 2007	Total Enrollees June 2008	Difference	% Change
Hardy	136	155	19	12%
Ritchie	141	155	14	9%
Ohio	482	526	44	8%
Taylor	215	234	19	8%
Braxton	211	228	17	7%
Monongalia★	673	723	50	7%
Wood★	1,081	1,155	74	6%
Barbour	304	317	13	4%
Mason	326	339	13	4%
Berkeley★	1,164	1,209	45	4%
Logan	518	537	19	4%
Pocahontas	151	156	5	3%
Morgan	220	227	7	3%
Wayne	563	580	17	3%
Wyoming	444	456	12	3%
Marion	784	792	8	1%
Greenbrier	577	580	3	1%
Lincoln	405	407	2	0%
Cabell★	958	958	0	0%
Putnam★	620	619	-1	0%
Kanawha★	2,082	2,078	-4	0%
Upshur	402	401	-1	0%
Raleigh★	1,295	1,289	-6	0%
Mercer★	1,075	1,060	-15	-1%
Tucker	175	170	-5	-3%
Boone	326	315	-11	-3%
Tyler	109	105	-4	-4%
Jackson	383	366	-17	-5%
Nicholas	456	435	-21	-5%
Randolph	487	461	-26	-6%
Harrison★	968	916	-52	-6%
Summers	222	210	-12	-6%
Doddridge	127	120	-7	-6%
Calhoun	139	131	-8	-6%
Monroe	258	242	-16	-7%
Jefferson★	425	398	-27	-7%
Preston	558	514	-44	-9%
Lewis	313	288	-25	-9%
Hancock	412	378	-34	-9%
Webster	204	187	-17	-9%
Marshall	413	377	-36	-10%
Clay	194	177	-17	-10%
Brooke	303	276	-27	-10%
Wirt	130	118	-12	-10%
McDowell	429	389	-40	-10%
Mingo	427	384	-43	-11%
Mineral	295	264	-31	-12%
Wetzel	240	212	-28	-13%
Roane	306	268	-38	-14%
Hampshire	297	259	-38	-15%
Fayette	1,000	871	-129	-15%
Pleasants	102	87	-15	-17%
Gilmer	105	88	-17	-19%
Grant	179	135	-44	-33%
Pendleton	130	96	-34	-35%
Totals	**24,939**	**24,418**	**-521**	**-2%**
12-Mo. Ave.			***-43***	***-4%***

MEDIAN

★ Denotes targeted counties as shown on the map on page 41.

Table 10: Enrollment Changes By County

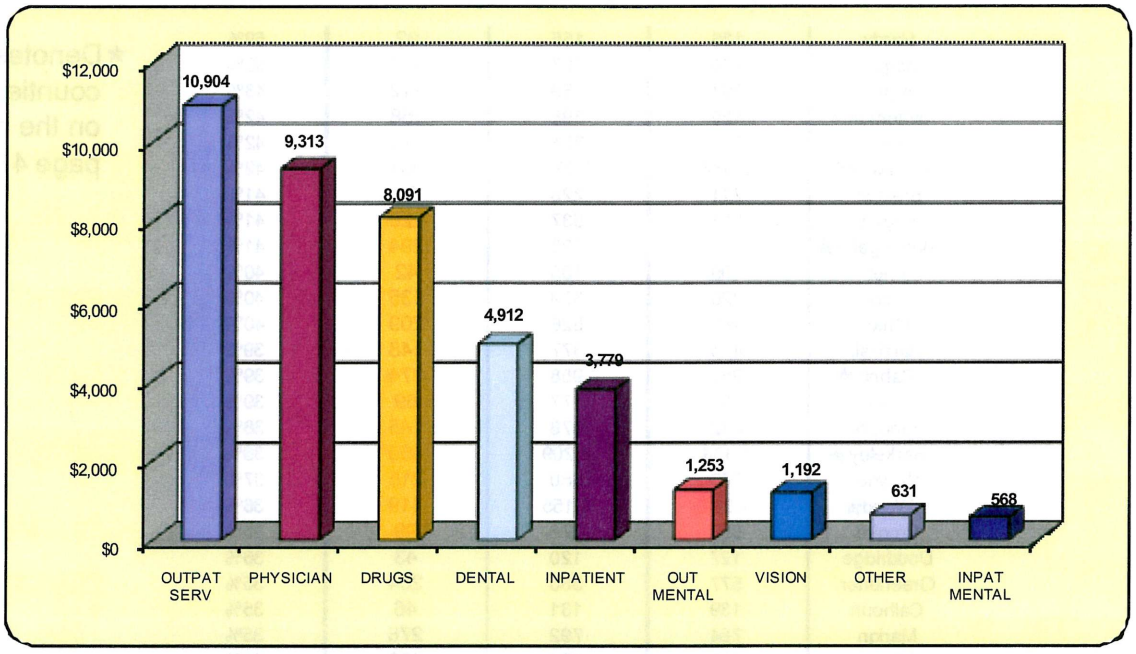
As % of Children Never Before Enrolled from July 2007 through June 2008

County	Total Enrollees June 2007	Total Enrollees June 2008	New Enrollees Never in Program	New Enrollees As % of Jun-08
Hardy	136	155	92	59%
Morgan	220	227	117	52%
Hampshire	297	259	112	43%
Jefferson★	425	398	168	42%
Mineral	295	264	110	42%
Kanawha★	2,082	2,078	863	42%
Braxton	211	228	94	41%
Logan	518	537	220	41%
Monongalia★	673	723	294	41%
Tyler	109	105	42	40%
Mason	326	339	135	40%
Ohio	482	526	209	40%
Marshall	413	377	148	39%
Cabell ★	958	958	374	39%
Clay	194	177	69	39%
Hancock	412	378	145	38%
Berkeley★	1,164	1,209	459	38%
Wayne	563	580	215	37%
Wood★	1,081	1,155	419	36%
Brooke	303	276	99	36%
Doddridge	127	120	43	36%
Greenbrier	577	580	204	35%
Calhoun	139	131	46	35%
Marion	784	792	276	35%
Mingo	427	384	133	35%
Pleasants	102	87	30	34%
Wetzel	240	212	73	34%
McDowell	429	389	132	34%
Raleigh★	1,295	1,289	436	34%
Upshur	402	401	132	33%
Lewis	313	288	94	33%
Jackson	383	366	119	33%
Nicholas	456	435	141	32%
Mercer★	1,075	1,060	341	32%
Roane	306	268	86	32%
Grant	179	135	43	32%
Putnam★	620	619	196	32%
Monroe	258	242	76	31%
Harrison★	968	916	281	31%
Boone	326	315	96	30%
Barbour	304	317	96	30%
Pocahontas	151	156	47	30%
Randolph	487	461	137	30%
Fayette	1,000	871	258	30%
Summers	222	210	60	29%
Lincoln	405	407	114	28%
Gilmer	105	88	24	27%
Wyoming	444	456	124	27%
Pendleton	130	96	26	27%
Taylor	215	234	63	27%
Wirt	130	118	30	25%
Preston	558	514	127	25%
Ritchie	141	155	38	25%
Webster	204	187	38	20%
Tucker	175	170	34	20%
Totals	**24,939**	**24,418**	**8,578**	**35%**
12-Mo. Ave.			**715**	***35%***

MEDIAN

★Denotes targeted counties as shown on the map on page 41.

Table 11: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

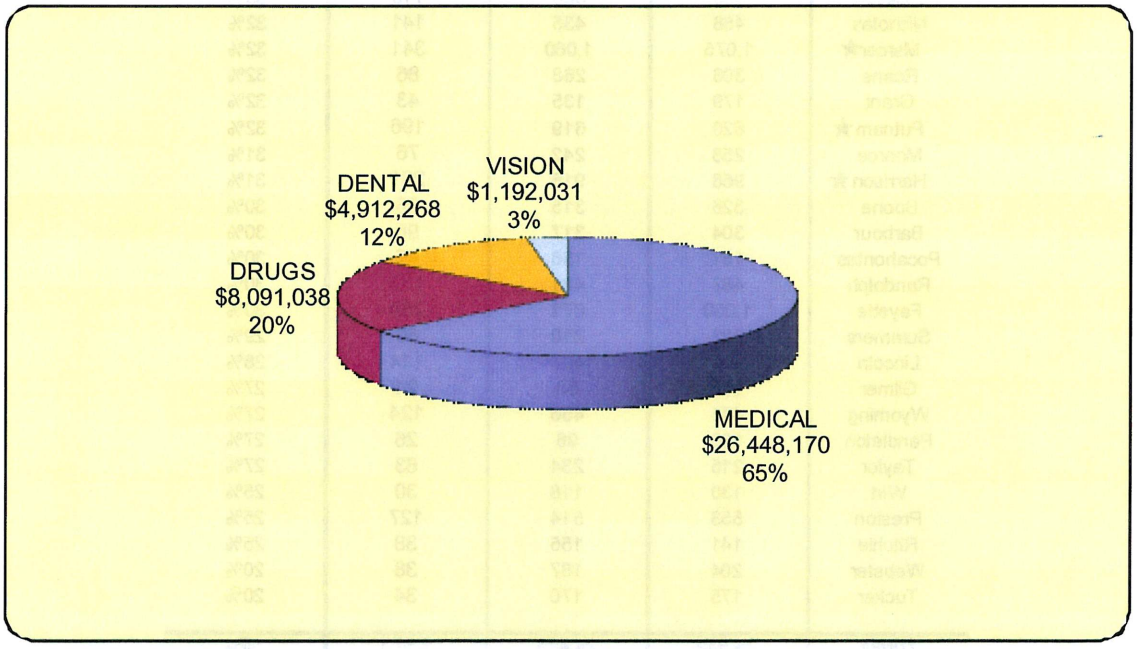


Table 12: Total Program Expenditures

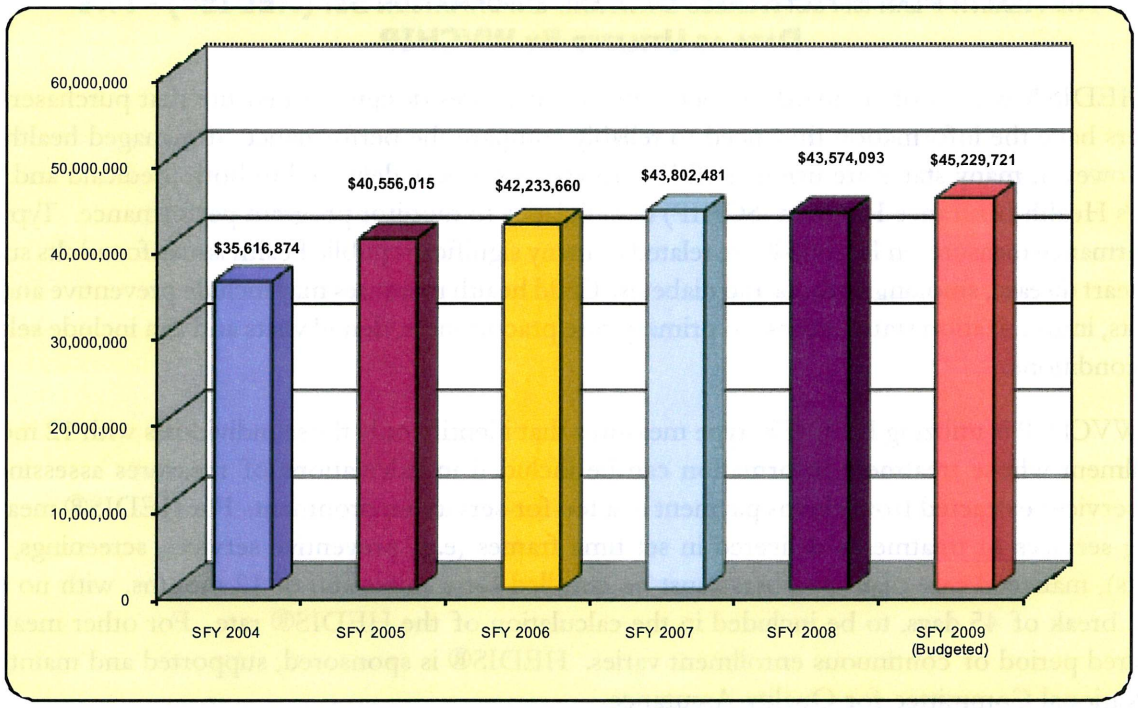
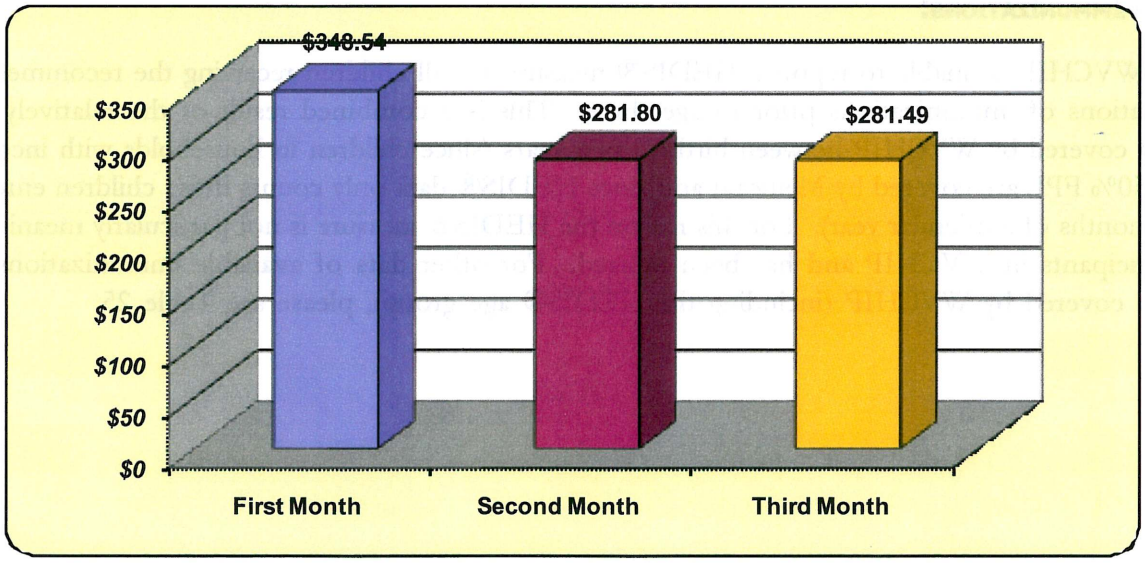


Table 13: Average Claimant Costs in First Three Months

Showing Pent Up Demand For Services Upon Enrollment



The Health Plan Effectiveness Data and Information Set (HEDIS®) - Type Data as Utilized By WVCHIP

HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. However, many states are using HEDIS® to assess services delivered to both Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries to monitor program performance. Typically, the performance measures in HEDIS® are related to many significant public health issues for adults such as cancer, heart disease, smoking, asthma and diabetes. Child health measures may include preventive and well child visits, immunization status, access to primary care practitioners, dental visits and can include selected chronic conditions.

WVCHIP is utilizing HEDIS®-type measures that identify only those individuals with 12 months of enrollment whose treatment information can be included in calculations of measures assessing the level of services extracted from claims payment in a fee-for-service environment. For HEDIS® measures involving services or treatments delivered in set time frames (e.g., preventive services, screenings, well-care visits), managed care plan members must be enrolled for a minimum of 12 months, with no more than one break of 45 days, to be included in the calculation of the HEDIS® rate. For other measures, the required period of continuous enrollment varies. HEDIS® is sponsored, supported and maintained by the National Committee for Quality Assurance.

The following tables present HEDIS® results for WVCHIP enrollees during calendar year 2007 *(See Tables 14 - 20).*

Note on Immunizations:

WVCHIP is unable to report a HEDIS® measure for all children receiving the recommended combinations of immunizations prior to age three. This is a combined result of the relatively few children covered by WVCHIP between birth to two years (since children in households with incomes up to 150% FPL are covered by Medicaid and since HEDIS® data only counts those children enrolled for 12 months of a calendar year). For this reason the HEDIS® measure is not particularly meaningful for participants in WVCHIP and has been deleted. For other data of available immunizations for children covered by WVCHIP (including the HEDIS® age group), please see Table 25.

HEDIS-Type Data
January 1, 2007 to December 31, 2007

Table 14: Dental Visits

This measure estimates the number of children enrolled for the entire 2007 calendar year, ages 4 through 18, that had a dental visit during the year.

Age Group	Number of Continuously Enrolled Children	Number Having Dental Checkup Visit	% Having Dental Checkup Visit	% Prior Year 06	% Prior Year 05
4 to 6 Years	578	564	97.58%	97.51%	97.09%
7 to 10 Years	2,860	2,781	97.24%	96.70%	97.20%
11 to 14 Years	2,968	2,856	96.23%	95.52%	95.28%
15 to 18 Years	2,488	2,343	94.17%	94.72%	94.39%
Total	**8,894**	**8,544**	**96.06%**	**95.84%**	**95.81%**

Table 15: Vision Visits

This measure estimates the number of children enrolled for the entire 2007 calendar year who received a vision visit.

Age Group	Number of Continuously Enrolled Children	Number Having Vision Checkup Visit	% Having Vision Checkup Visit	% Prior Year 06	% Prior Year 05
Under 1 Year	3	-	0.00%	0.00%	0.00%
1 to 5 Years	1,072	153	14.27%	12.24%	15.24%
6 to 11 Years	3,561	1,094	30.72%	30.64%	31.09%
12 to 18 Years	4,755	1,715	36.07%	35.72%	33.77%
Total	**9,391**	**2,962**	**31.54%**	**30.99%**	**30.43%**

HEDIS-Type Data
January 1, 2007 to December 31, 2007

Tables 16 & 17: Well Child and Adolescent Well Visits

These measures estimate the number of children enrolled for the entire 2007 calendar year from ages birth through six years and from 12 to 21 years of age who have had a well child visit with a physician coded as preventive office visits only.

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Having Well Visit	% Prior Year 06	% Prior Year 05
Less Than Or Equal To 15 Months	17	16	94.12%	100.00%	100.00%
Third Year Of Life	231	206	89.18%	94.93%	93.89%
Fourth Year Of Life	274	243	88.69%	92.86%	94.51%
Fifth Year Of Life	304	256	84.21%	96.01%	94.76%
Sixth Year Of Life	320	265	82.81%	94.64%	94.65%
Total	**1,146**	**986**	**86.04%**	**94.73%**	**94.53%**

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Having Well Visit	% Prior Year 06	% Prior Year 05
12 To 19 Years of Age	4,755	2,868	60.32%	83.05%	82.85%
Total	**4,755**	**2,868**	**60.32%**	**83.05%**	**82.85%**

Table 18: Access To Primary Care

This measure estimates the number of children enrolled for the entire 2007 calendar year from ages 1 to 11 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	% Having Primary Care Visit	% Prior Year 06	% Prior Year 05
12 to 24 Months	66	65	98.48%	92.06%	97.10%
25 Months to 6 Years	1,006	953	94.73%	95.06%	95.29%
7 to 11 Years	3,561	3,131	87.92%	87.04%	87.79%
Total	**4,633**	**4,149**	**89.55%**	**89.42%**	**90.05%**

HEDIS-Type Data
January 1, 2007 to December 31, 2007

Table 19: Proper Use of Asthma Medications

This measure estimates the number of children enrolled for the entire 2007 calendar year as well as the complete year prior with persistent asthma who were prescribed appropriate medication.

Age Group	Asthma Patients	Number with Proper Use of Medications	Medications Rate	% Prior Year 06	% Prior Year 05
5 to 9 Years	373	344	92.23%	92.76%	92.76%
10 to 18 Years	545	480	88.07%	89.16%	89.16%
Total	**918**	**824**	**89.76%**	**92.25%**	**90.48%**

Table 20: Diabetic Care

This measure estimates the number of children enrolled for the entire 2007 calendar year 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; and an eye exam and a screen for kidney disease.

Age Group	Diabetic Patients	HB1C Test	Rate of HB1C Test	Eye Examinations	Rate of Eye Examinations	LDLC Test	Rate of LDLC Test
4 to 5 Years	1	0	0.00%	1	100.00%	0	0.00%
6 to 11 Years	26	22	84.62%	25	96.15%	1	3.85%
12 to 18 Years	37	34	91.89%	34	91.89%	12	32.43%
Total	**64**	**56**	**87.50%**	**60**	**93.75%**	**13**	**20.31%**
Total % Prior Year 06	**59**	**54**	**91.53%**	**57**	**96.61%**	**13**	**22.03%**
Total % Prior Year 05	**47**	**38**	**80.85%**	**44**	**93.62%**	**11**	**23.40%**

Selected Utilization Data as Health Status Indicators

WVCHIP currently operates exclusively in a fee-for-service payment structure. The data in Tables 21 - 25 reflect preventive services as extracted from claims payments. The selected preventive services are:

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

Unlike the HEDIS®-type data in the preceding Tables 14 - 20, 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 21:
Health Status Indicators
January 1, 2007 to December 31, 2007

Vision Services

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year	Per Member Per Year 06	Per Member Per Year 05
0 to 364 Days	80	3	0.04	252.01	3.15	3.69	1.88
1 to 2 Years	1617	68	0.04	5,168.45	3.20	2.32	2.49
3 Years	810	80	0.10	6,194.92	7.65	6.30	6.02
4 to 5 Years	1795	285	0.16	22,526.32	12.55	11.17	12.92
6 to 11 Years	9197	2767	0.30	216,587.67	23.55	24.00	23.08
12 to 18 Years	11508	3785	0.33	295,016.40	25.64	25.17	24.69
Overall	**25,007**	**6,988**	**0.28**	**545,745.77**	**21.82**	**21.52**	**20.99**

Table 22:
Health Status Indicators
January 1, 2007 to December 31, 2007

Dental Services

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year	Per Member Per Year 06	Per Member Per Year 05
0 to 364 Days	80	1	0.01	25.00	0.31	-	0.53
1 to 2 Years	1617	374	0.23	39,203.65	24.24	28.30	31.78
3 Years	810	686	0.85	78,853.52	97.35	143.45	114.99
4 to 5 Years	1795	2447	1.36	265,208.92	147.75	178.94	172.02
6 to 11 Years	9197	13504	1.47	1,334,679.49	145.12	175.10	182.24
12 to 18 Years	11508	13706	1.19	1,542,404.73	134.03	177.18	174.02
Overall	**25,007**	**30,718**	**1.23**	**3,260,375.31**	**130.38**	**165.08**	**164.71**

Table 23:
Health Status Indicators
January 1, 2007 to December 31, 2007

Well Child Visits

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year	Per Member Per Year 06	Per Member Per Year 05
0 to 364 Days	80	458	5.73	40,360.35	504.50	322.78	393.71
1 to 2 Years	1617	2395	1.48	225,200.07	139.27	142.78	148.38
3 Years	810	589	0.73	49,296.61	60.86	54.05	56.20
4 to 5 Years	1795	1412	0.79	133,528.73	74.39	76.63	75.18
6 to 11 Years	9197	3341	0.36	308,787.28	33.57	33.03	30.61
12 to 18 Years	11508	4021	0.35	353,118.87	30.68	29.13	25.57
Overall	**25,007**	**12,216**	**0.49**	**1,110,291.91**	**44.40**	**43.33**	**41.69**

Table 24:
Health Status Indicators
January 1, 2007 to December 31, 2007

Access to Primary Care Services

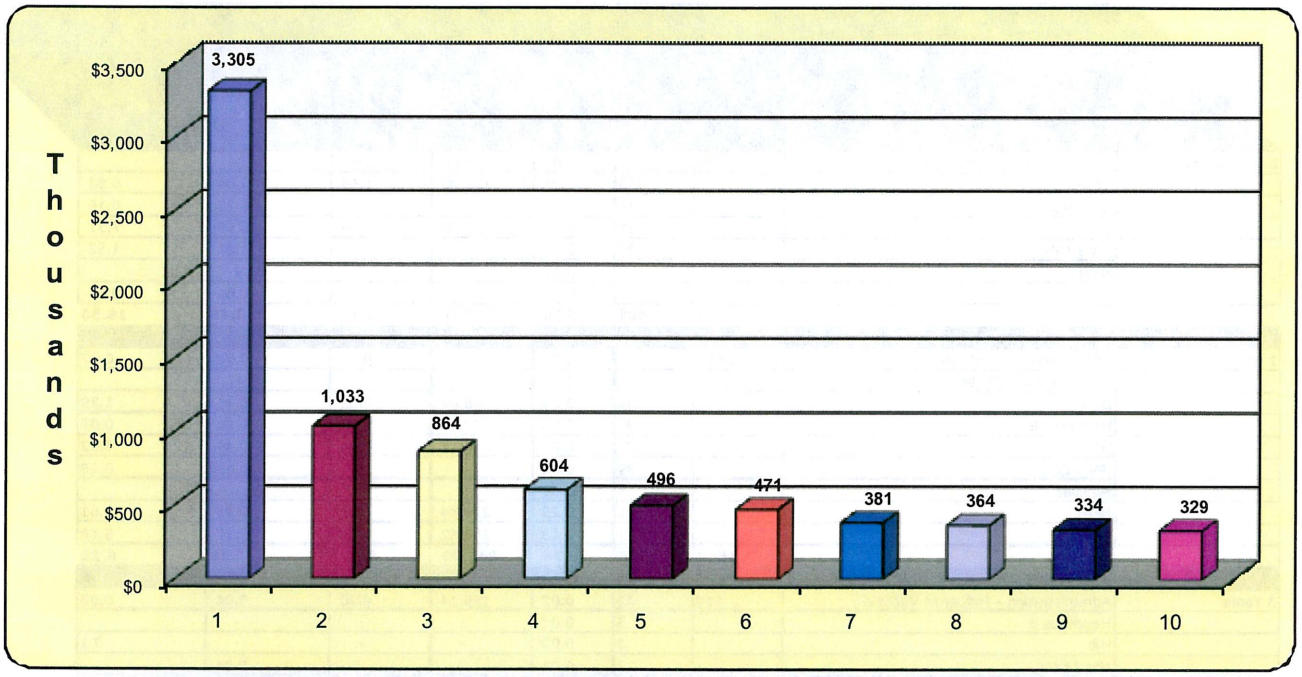
Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year	Per Member Per Year 06	Per Member Per Year 05
0 to 364 Days	80	1037	12.96	73,455.61	918.20	535.91	673.06
1 to 2 Years	1617	9588	5.93	628,421.09	388.63	393.55	382.79
3 Years	810	3585	4.43	216,164.92	266.87	247.60	249.21
4 to 5 Years	1795	8174	4.55	513,707.68	286.19	273.59	283.10
6 to 11 Years	9197	31534	3.43	2,032,207.82	220.96	210.75	203.00
12 to 18 Years	11508	36784	3.20	2,316,150.92	201.26	194.03	186.49
Overall	**25,007**	**90,702**	**3.63**	**5,780,108.04**	**231.14**	**222.10**	**216.83**

TABLE 25:
HEALTH STATUS INDICATORS
JANUARY 1, 2007 TO DECEMBER 31, 2007

IMMUNIZATIONS SERVICES

Age Group	Immunization Type	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year	Per Member Per Year 06	Per Member Per Year 05
0 to 364 Days	Administration - Influenza Vaccine	80	3	0.04	34.00	0.43		
	DTaP		163	2.04	132.00	1.65	2.34	6.82
	Hepatitus B		18	0.23	-	-	0.23	0.16
	Hib		196	2.45	51.36	0.64	0.96	7.31
	IPV / OPV		39	0.49	-	-	1.31	1.52
	MMR		1	0.01	-	-		
	VZV		1	0.01	-	-	0.61	0.68
		80	**421**	**5.26**	**217.36**	**2.72**	**5.45**	**16.50**
1 to 2 Years	Administration - Influenza Vaccine	1617	18	0.01	169.76	0.10	0.08	0.07
	Diphtheria and Tetanus		1	0.00	-	-	-	
	DTaP		44	0.03	48.84	0.03	0.41	1.28
	Hepatitus B		36	0.02	27.88	0.02	0.02	0.07
	Hib		475	0.29	68.11	0.04	0.44	0.83
	IPV / OPV		39	0.02	-	-	0.14	0.18
	Measles		1	0.00	-	-	-	
	MMR		371	0.23	273.44	0.17	2.23	0.61
	VZV		211	0.13	256.62	0.16	3.27	5.18
		1617	**1196**	**0.74**	**844.65**	**0.52**	**6.58**	**8.23**
3 Years	Administration - Influenza Vaccine	810	13	0.02	159.14	0.20	0.04	0.03
	Hepatitus B		3	0.00	-	-	-	
	Hib		3	0.00	-	-	-	0.1
	IPV / OPV		7	0.01	-	-	0.04	
	MMR		7	0.01	-	-	0.12	0.02
	VZV		8	0.01	-	-	0.38	0.32
		810	**41**	**0.05**	**159.14**	**0.20**	**0.59**	**0.62**
4 to 5 Years	Administration - Influenza Vaccine	1795	16	0.01	156.85	0.09	0.04	0.04
	Diphtheria and Tetanus		7	0.00	17.00	0.01	-	
	DTaP		9	0.01	-	-	-	0.46
	Hepatitus B		6	0.00	27.88	0.02	0.04	
	Hib		11	0.01	-	-	0.01	0.01
	IPV / OPV		650	0.36	179.08	0.10	0.28	0.66
	MMR		657	0.37	544.37	0.30	1.75	0.78
	VZV		281	0.16	61.00	0.03	1.11	0.54
		1795	**1637**	**0.91**	**986.18**	**0.55**	**3.24**	**2.49**
6 to 11 Years	Administration - Influenza Vaccine	9197	55	0.01	568.49	0.06	0.04	0.03
	Diphtheria and Tetanus		10	0.00	-	-	-	0.00
	DTaP		13	0.00	-	-	0.00	0.00
	Hepatitus B		12	0.00	-	-	0.01	0.00
	Hib		5	0.00	-	-	-	
	IPV / OPV		31	0.00	-	-	-	0.00
	MMR		28	0.00	50.12	0.01	-	0.00
	Tetanus		9	0.00	42.84	0.00	0.01	0.03
	VZV		668	0.07	622.12	0.07	0.60	0.05
		9197	**831**	**0.09**	**1283.57**	**0.14**	**0.66**	**0.13**
12 to 18 Years	Administration - Hepatitus B	11508	2	0.00	24.00	0.00	0.00	0.00
	Administration - Influenza Vaccine		73	0.01	770.00	0.07	0.04	0.03
	Administration - Pneumococcal Vaccine		1	0.00	12.00	0.00	0.00	
	Diphtheria and Tetanus		15	0.00	-	-	-	0.00
	DTaP		14	0.00	-	-	0.00	
	Hepatitus B		212	0.02	67.00	0.01	0.04	0.08
	Hib		10	0.00	-	-	-	
	IPV / OPV		4	0.00	-	-	0.00	
	MMR		19	0.00	-	-	0.01	0.00
	Tetanus		53	0.00	156.35	0.01	0.07	0.07
	VZV		234	0.02	306.93	0.03	0.21	0.05
		11,508.00	**637.00**	**0.06**	**1,336.28**	**0.12**	**0.37**	**0.23**
	Overall	**25,007.00**	**4,763.00**	**0.19**	**4,827.18**	**0.19**	**1.11**	**0.96**

Table 26: Top Ten Physician Services
By Amounts Paid



Key

		CPT Code*
1	Office Visit Limited - Est. Patient	(99213)
2	Office Visit Intermediate - Est. Patient	(99214)
3	Individual Psychotherapy	(90806)
4	ER Exam - Intermediate - New Patient	(99283)
5	ER Exam - Extended - New Patient	(99284)
6	Office Visit Brief - Est. Patient	(99212)
7	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
8	Periodic Comprehensive Wellness Exam Age 5-11 - Est. Patient	(99393)
9	Psychiatric Diagnostic Interview/Exam	(90801)
10	Periodic Comprehensive Wellness Exam Age 1-4 - Est. Patient	(99392)

**As described in Current Procedure Terminology 2006 by the American Medical Association.*

Table 26: 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:** 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 - 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)*

5 **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)*

6 **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)*

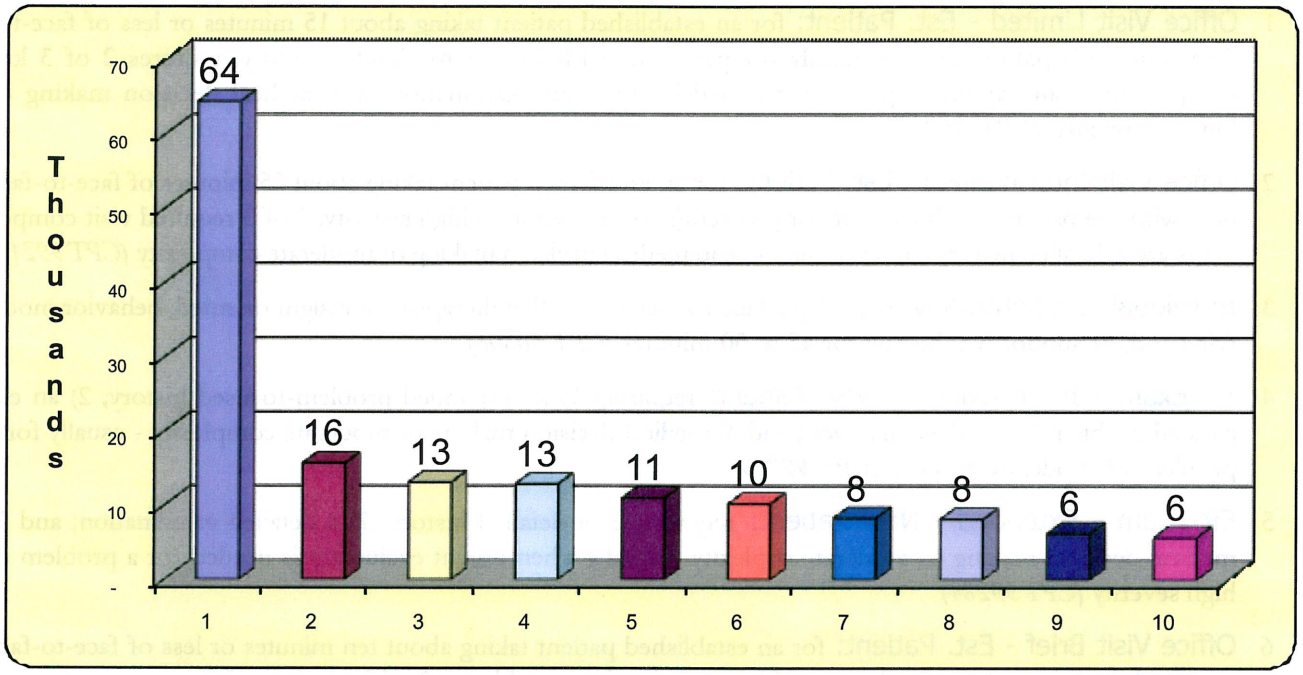
7 **Ophthalmological Exam - Comprehensive - Est. Patient:** for an established patient at an intermediate level in a face-to-face encounter by the physician for a general evaluation of the complete visual system including history, general medical observation, external and ophthalmological examinations,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

8 **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)*

9 **Psychiatric Diagnostic Interview/Exam:** an examination which includes a history, mental status, and a disposition; may include communication with family or other sources, ordering and interpreting other medical or diagostic studies *(CPT 90801)*

10 **Periodic Comprehensive Wellness Exam Age 1-4 - 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 99392)*

Table 27: Top Ten Physician Services
By Number of Transactions



Key

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

**As described in Current Procedure Terminology 2006 by the American Medical Association.*

Table 27: 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 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)*

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

4 **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)*

5 **Individual Psychotherapy:** 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)*

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

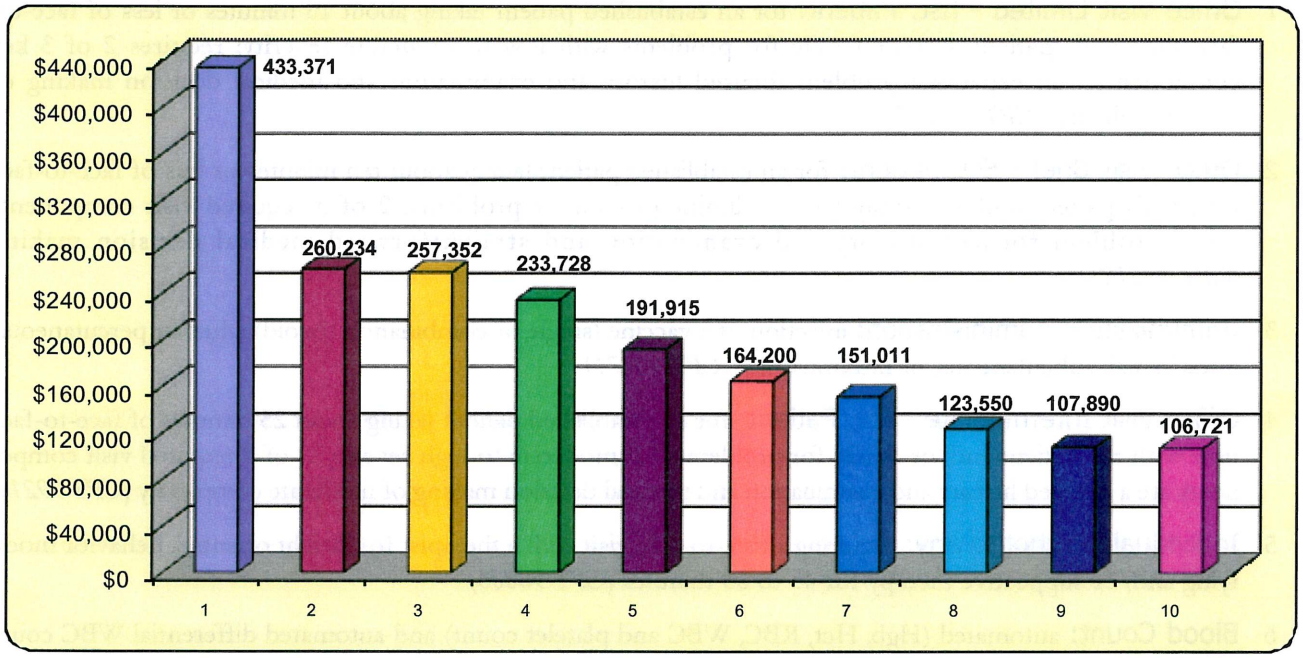
7 **ER Exam - Intermediate - New Patient:** requiring 1) an expanded problem-focused history; 2) an expanded problem focused examination; and 3) medical decision making of moderate complexity - usually for a problem of moderate severity *(CPT 99283)*

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

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

10 **Pharmacologic Management:** a psychiatric review of prescription and use with no more than minimal psychotherapy required *(CPT 90862)*

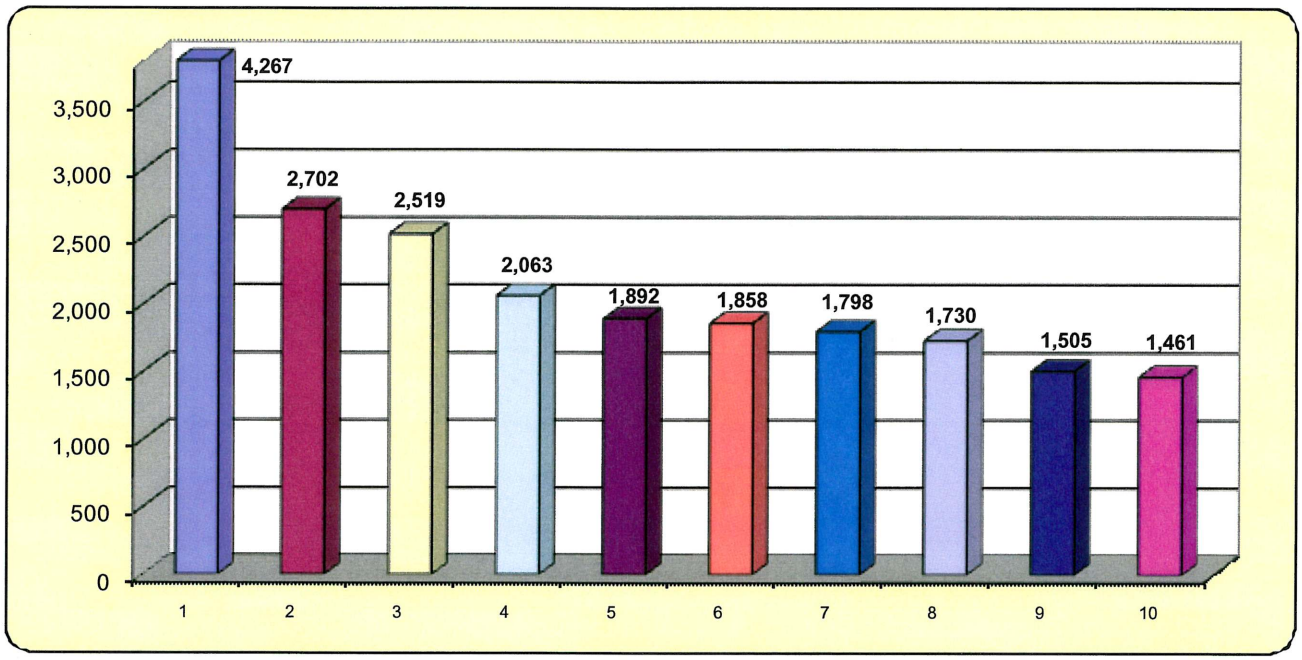
Table 28: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Singulair 5MG	-	Asthma
2	Concerta 36MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
3	Humatrope 24MG	-	Growth Hormone
4	Adderall XR 20MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
5	Singulair 10MG	-	Asthma
6	Adderall XR 30MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
7	Concerta 54MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
8	Singulair 4MG	-	Asthma
9	Pulmicort 0.5MG/2ML	-	Asthma
10	Strattera 40MG	-	Attention Deficit Hyperactivity Disorder (ADHD)

Table 29: Top Ten Prescription Drugs
By Number of Rx



Key

	Drug Brand Name	Major Use Indication
1	Singulair 5MG	- Asthma
2	Loratadine 10MG	- Allergies
3	Azithromycin 250MG	- Antibiotic
4	Fluticasone 50MCG	- Allergies
5	Singulair 10MG	- Asthma
6	Concerta 36MG Tablet	- Attention Deficit Hyperactivity Disorder (ADHD)
7	Amoxicillin 250MG/5ML	- Antibiotic
8	Albuterol 90 MCG	- Asthma
9	Adderall XR 20MG	- Attention Deficit Hyperactivity Disorder (ADHD)
10	Amoxicillin 400MG/5ML	- Antibiotic