Annual Report
Fiscal Year 2011

Commonwealth of Virginia
Health Benefits Program

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Introduction

2011 Highlights

Total operating expenses for the state health benefits program were up 2.9 percent in fiscal year 2011 compared to the year before, yet still lower than in FY 2009. Increased expenses were a reflection of higher outpatient hospital and physician costs, along with significant growth in catastrophic claims and very high cost specialty prescription drugs. The administrative expense portion, which had declined over the past two years, grew 0.5 of 1 percent.

To reduce medical expenses, the program has focused on wellness and preventive care, financial incentives, weight management and helping members to better control lifestyle-related and chronic illnesses. The program has:

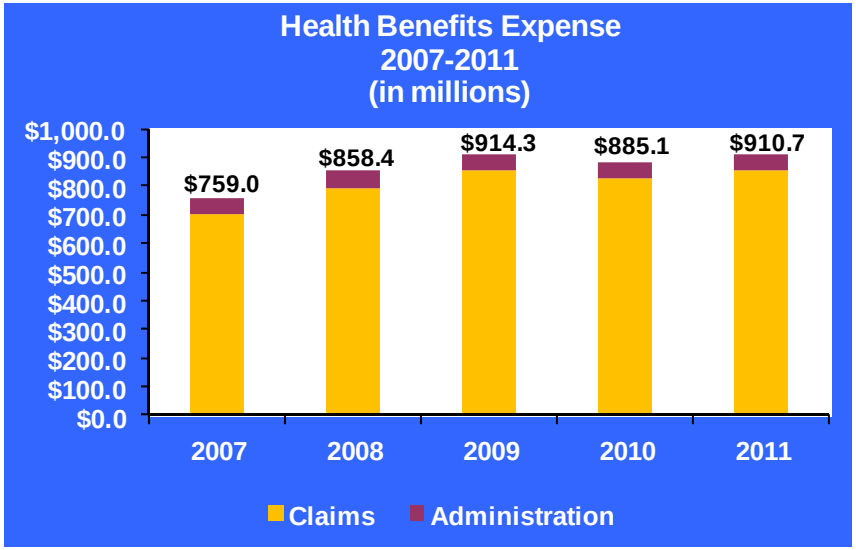
- Implemented a pre-bariatric surgery education program that is showing significant results in improving participant health outcomes;
- Added higher copayments for expensive specialty drugs, and has required physician approval for dispensing many high cost brand name drugs; and
- Eliminated coverage for high cost non-sedating antihistamines (NSAs) and drugs to treat erectile dysfunction.

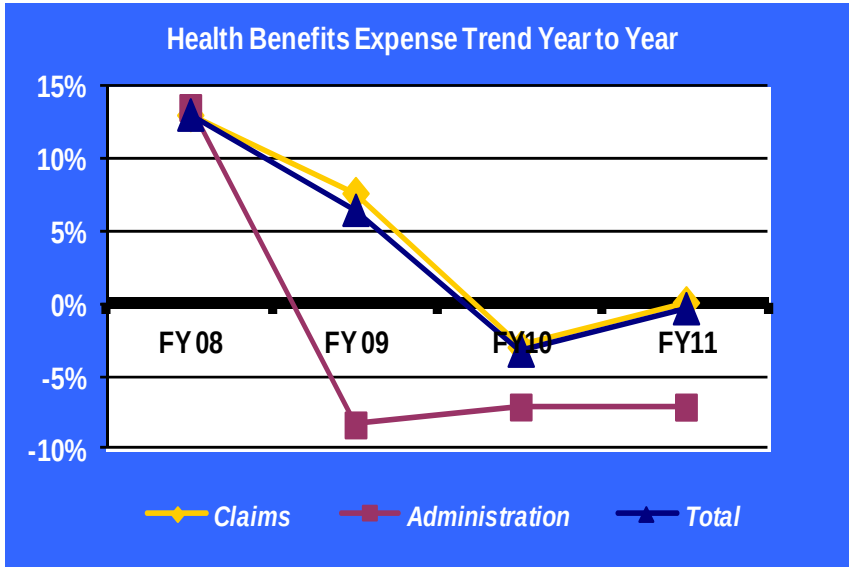
Also in 2011, the state program:

- Introduced telemedicine coverage, or the use of telecommunications technology to deliver health care services from providers off site. The goal is to improve member access to health care, especially in rural areas;
- Gave plan members the opportunity to add eligible dependents up to age 26 to their health coverage in response to national health reform. The result was 2,217 dependents from age 23 to 26 added during 2011 open enrollment for the next plan year;
- Continued to offer under the Public Private Education Act (PPEA) the COVA Connect plan in Hampton Roads as a pilot to improve member health outcomes and reduce overall health care costs.

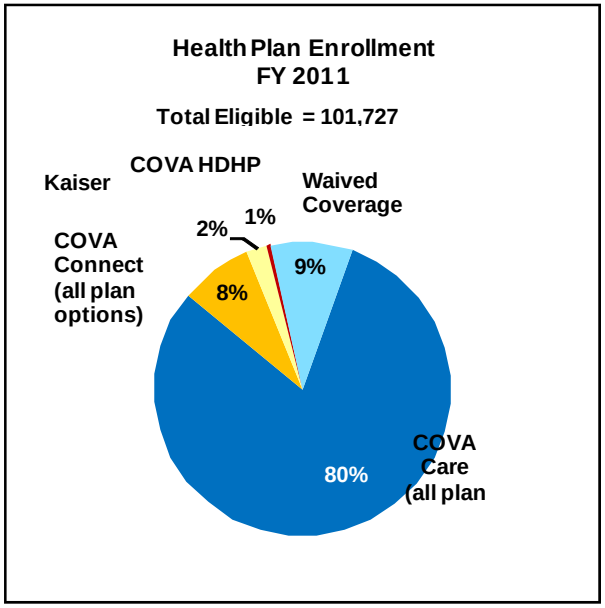
This report presents a financial overview of the state's self-insured health benefits plans, and where indicated, the regional, fully insured Kaiser Permanente HMO plan offered primarily in Northern Virginia. Unless otherwise indicated, this report is based on the experience of health plan members, including the active employee and non-Medicare eligible retiree group, during fiscal year 2011 from July 1, 2010 through June 30, 2011.

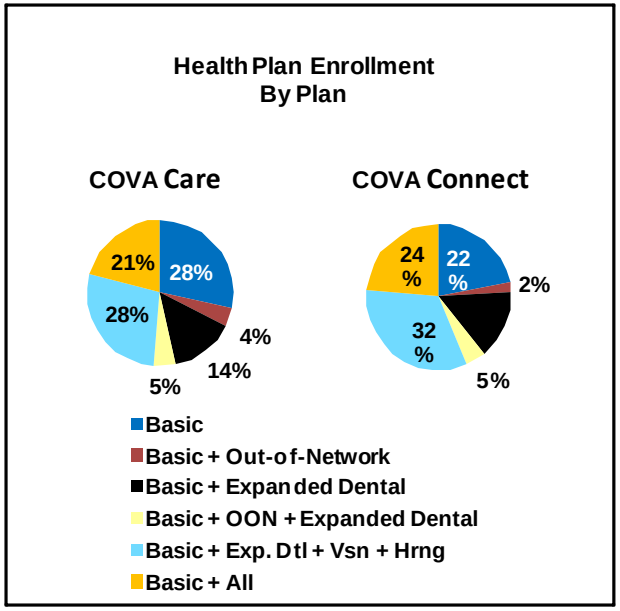
For COVA Care, Anthem Blue Cross and Blue Shield administered medical benefits; Delta Dental of Virginia administered dental benefits; Medco Health Solutions, Inc. administered the prescription drug program and ValueOptions, Inc. administered behavioral health benefits and employee assistance program services. All COVA HDHP benefits were administered by Anthem. For COVA Connect, medical, prescription drug and behavioral health benefits were administered by Optima Health; while dental benefits were administered by Delta Dental. For all plans, flexible benefits were administered by Fringe Benefits, a division of WageWorks.





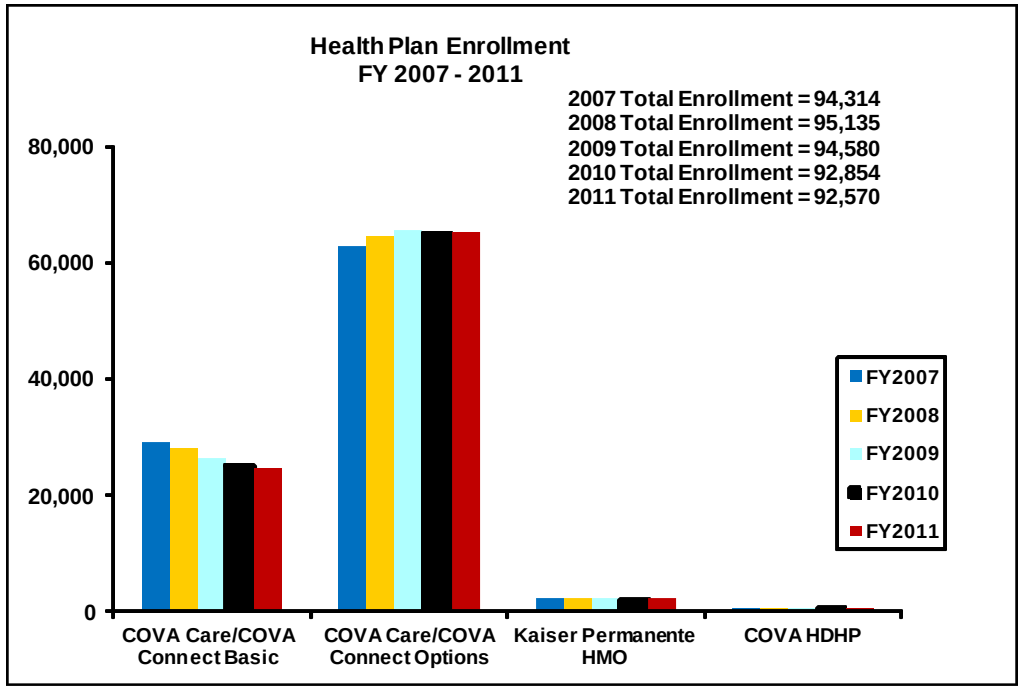
Plan Enrollment and Premiums

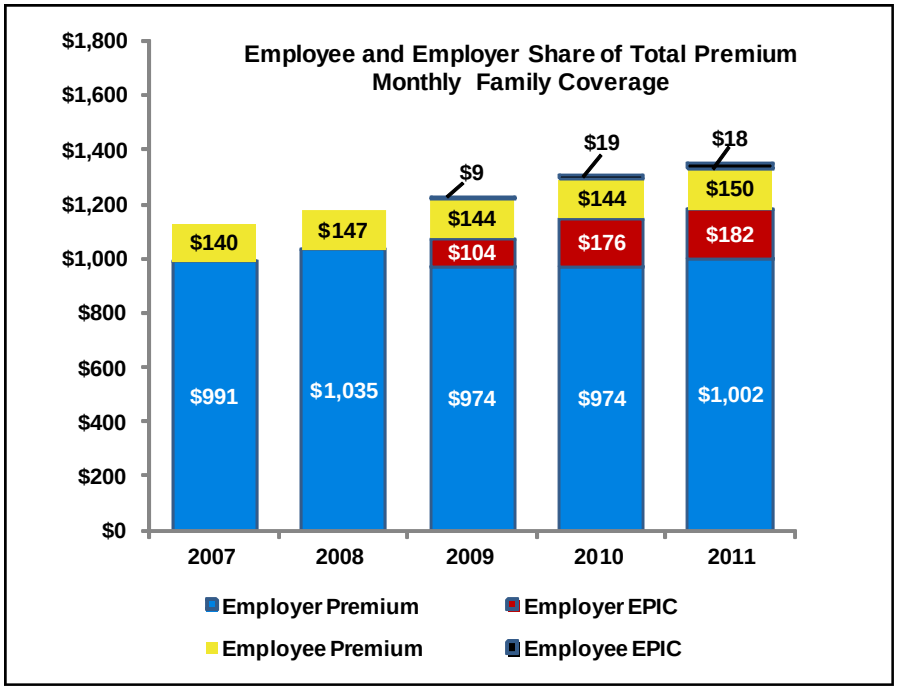




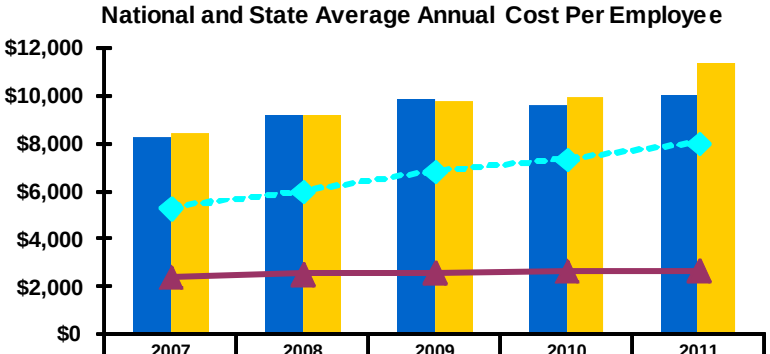
Total overall enrollment in the state health benefits program was down 1 percent in fiscal year 2011 compared to the previous year. Enrollment continues to decline in large part because of state budget workforce reductions. Eighty percent of members were enrolled in COVA Care, followed by the COVA Connect plan with 8 percent. While only 2 percent of members were enrolled in the Kaiser Permanente HMO, its enrollment grew 4 percent over 2010. About 9,200 or 9 percent of members waived coverage in the program. Additional coverage options were popular, with 44 percent of employees opting for the two buy-ups with the most coverage.

The plan pays a monthly premium per employee to fund the cost of program claims expense and administration. On average, the state pays 88 percent of the cost for state employee health care premiums, while the employee pays 12 percent. Employees pay the basic premium and may purchase additional coverage options. From 2009 to 2011, the state implemented an employee premium increase credit (EPIC) because of tight budget years. In 2007 and 2008, revenue exceeded total operating expenses.





Cost of Coverage

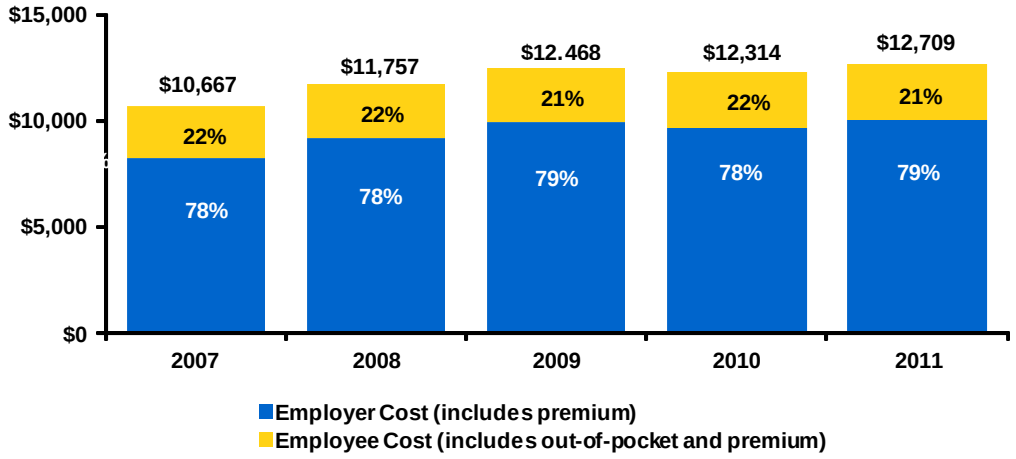


	2007	2008	2009	2010	2011
State Employer Cost Per Employee	$8,274	$9,224	$9,889	$9,656	$10,043 *
National Large Government Employers	$8,422	$9,226	$9,779	$9,996	$11,385
State Employee Cost	$2,393	$2,533	$2,580	$2,658	$2,666 *
National Average Employee Cost	$5,300	$6,000	$6,820	$7,330	$8,008

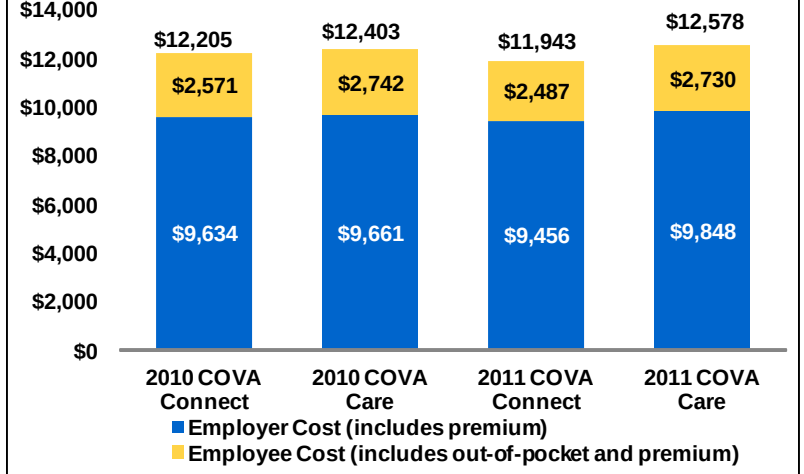
*Projected for 2011 by Milliman Medical Index. National data from Milliman and Mercer National Survey of Employer-Sponsored Health Plans.

The national average cost per employee for all employers providing health coverage is projected by Milliman Medical Index to rise to $11,385 in calendar year 2011. The state health benefits program's annual employer cost per employee in fiscal year 2011 was $10,043. While the state cost increased 4 percent from the previous year, it was 13 percent lower than the national projection. The Kaiser Permanente HM0 had an average cost per employee of $10,873, in part because of a 10 percent increase in claims costs, including one $2.3 million claim. COVA Care's cost per employee was $9,848 or a 2 percent increase from 2010, while COVA Connect's cost per employee was $9,456, or 2.6 percent lower than the year before.

Higher medical outpatient facility and physician costs, catastrophic claims expense and prescription drug costs were significant factors in the overall increase for 2011. Administrative expenses also grew following a decline in the previous year. The plan paid 1 percent more of the annual total health benefits cost, 79 percent, and the employee 1 percent less of the cost, 21 percent, than in 2010. Employees' share of the cost decreased as monthly premiums and most plan benefits remained the same as in the prior year.



*Employee contribution to premium varies by dependent coverage. In general, premium represents 12 percent of total employee cost.



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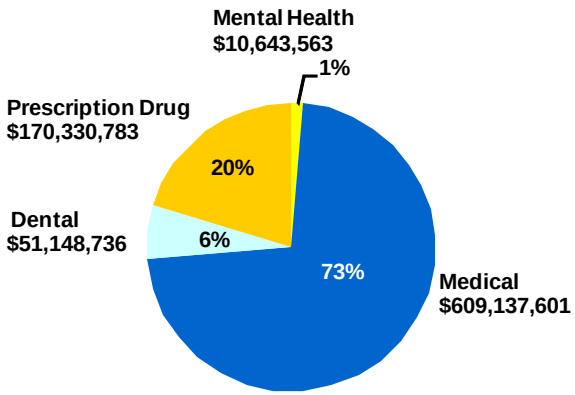
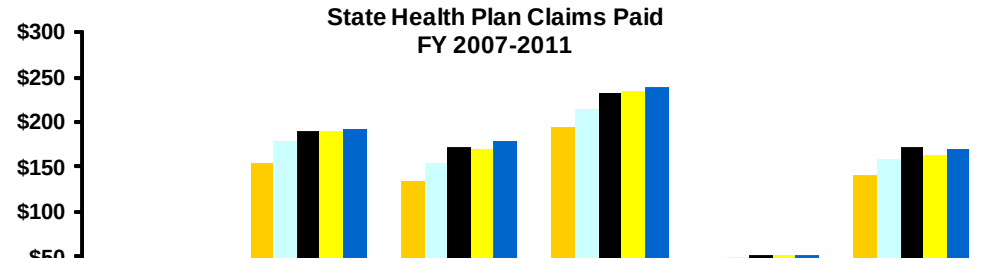
Claims Expense



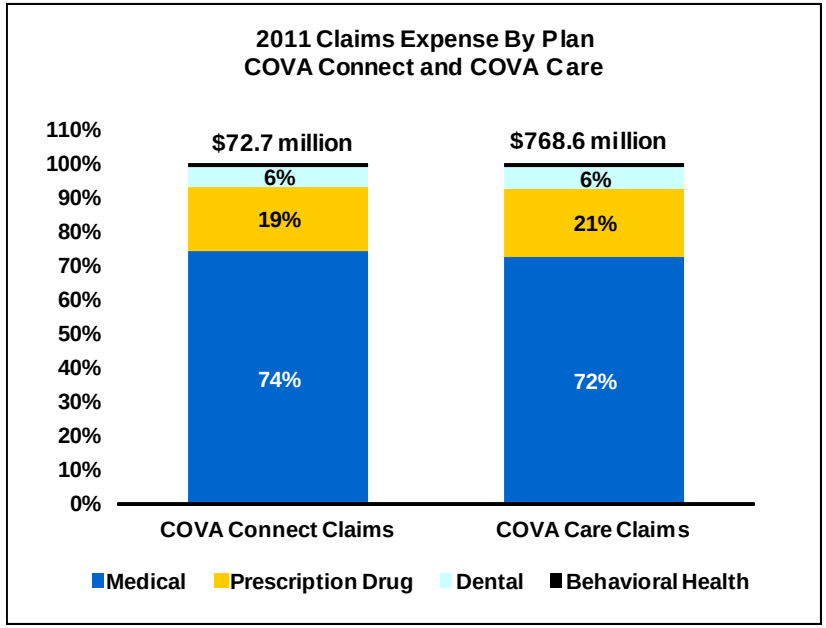
Approximately 6.8 million claims were processed for the self-insured state plans in FY 2011, up 3 percent from the previous year. Sixty-two percent of claims were medical, accounting for 73 percent of total plan claims expense.

Anthem, Medco, Delta Dental and ValueOptions processed 6.2 million claims in FY 2011 for COVA Care. An average of 82,400 employees and early retirees used the plan. Medical expenses were 72 percent and prescription drugs were 21 percent of total claims costs.

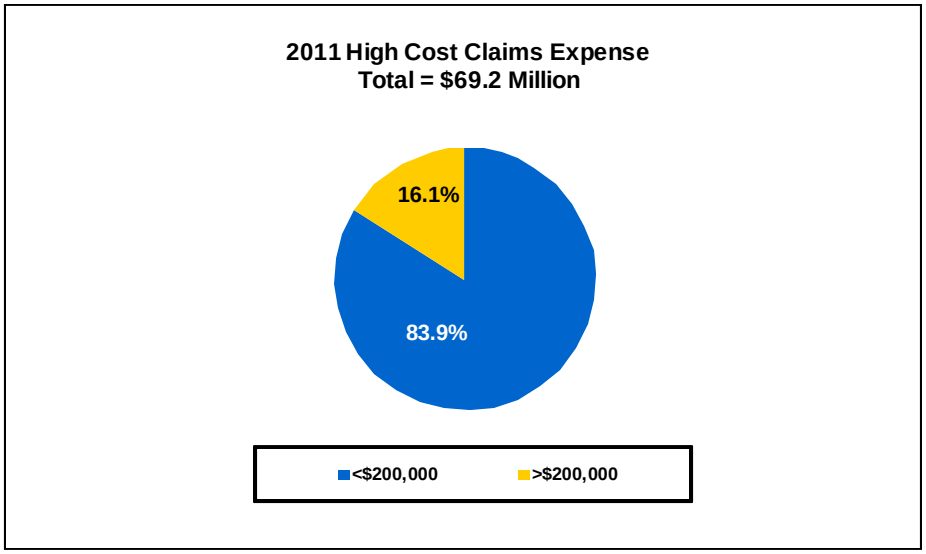
Optima Health and Delta Dental processed 589,700 claims for the COVA Connect plan in FY 2011. An average of 8,100 employees and early retirees used the plan during the year. Medical expense represented 74 percent and prescription drugs claims accounted for about one fifth of total claims expense.



	Mental Health	Inpatient Hospital	Outpatient Hospital	Physician	Dental	Prescription Drug
2007	$8.3	$154.3	$134.5	$193.2	$45.0	$141.2
2008	$9.1	$178.5	$154.0	$214.3	$48.1	$158.1
2009	$9.0	$189.2	$172.8	$231.7	$50.4	$172.7
2010	$9.4	$190.3	$168.6	$233.9	$51.5	$161.9
2011	$10.6	$192.0	$178.2	$238.8	$51.1	$170.3

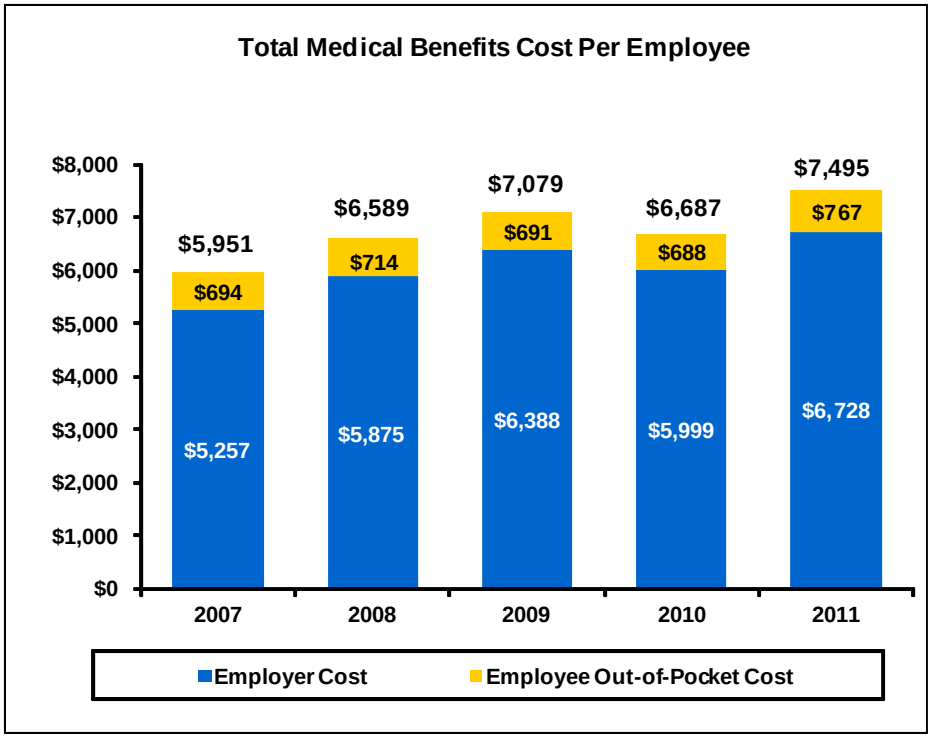


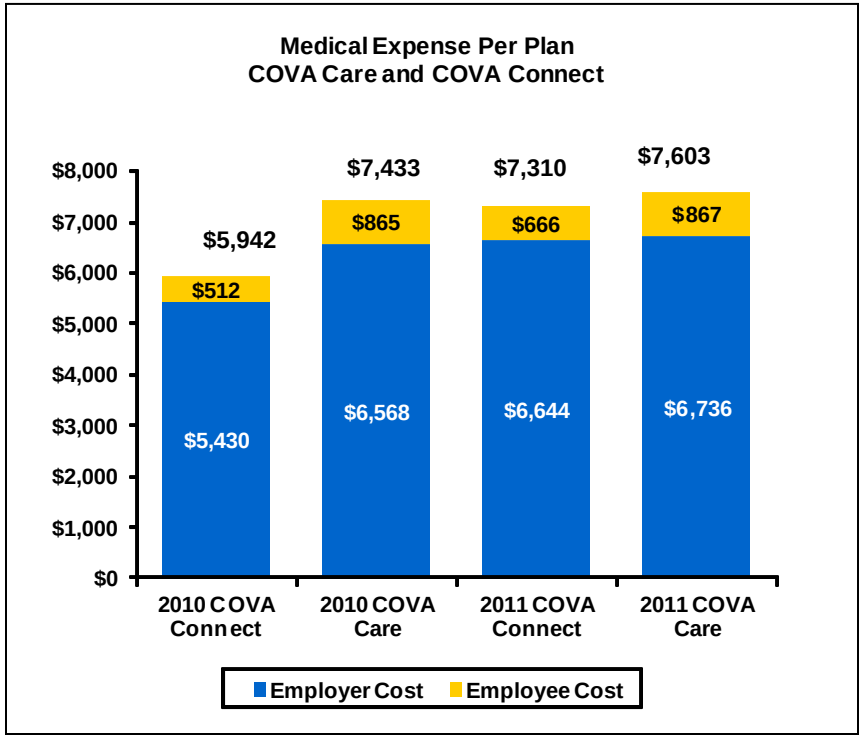
Medical Benefits



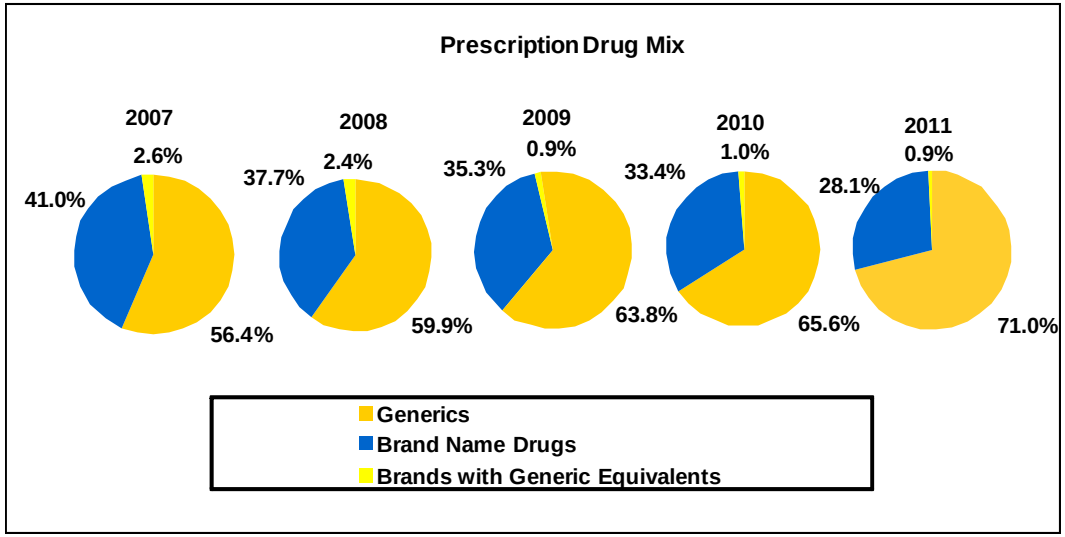
Total medical inpatient and outpatient facility and physician costs increased 2.7 percent in 2011, to $609 million from $593 million in 2010. Medical outpatient physician and outpatient hospital costs were the primary drivers of medical costs, increasing 3.6 percent to $417 million from $402.5 million the previous year.

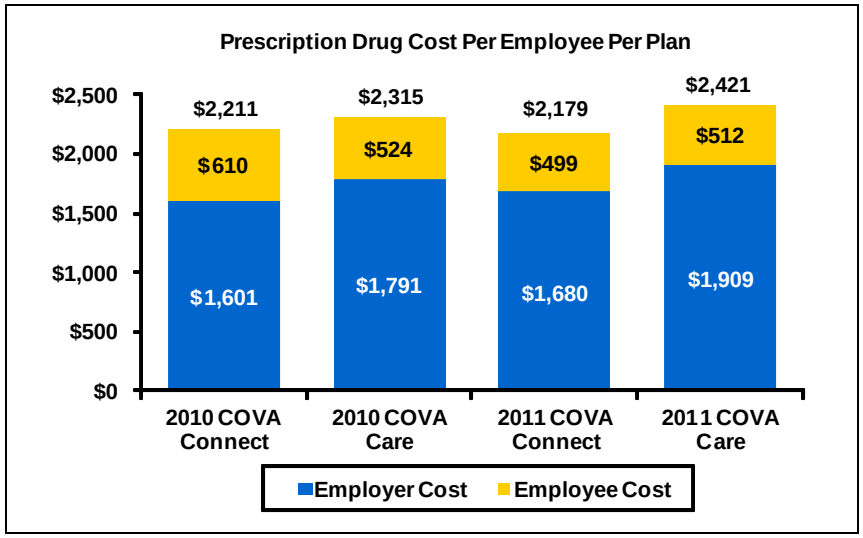
Outpatient visits numbered 1,215 per thousand members, 5 percent higher than the 1,154 per thousand of other employers with Anthem and Optima Health medical coverage. Catastrophic claims, which are claims greater than $200,000, totaled $69.2 million in 2011, up 16 percent over 2010. This increase is on top of a 45 percent increase since 2008. The state plan paid approximately 90 percent of total medical benefits cost in 2010, comparable to the amount paid in the past two years. Employees continued to pay 10 percent of the cost.

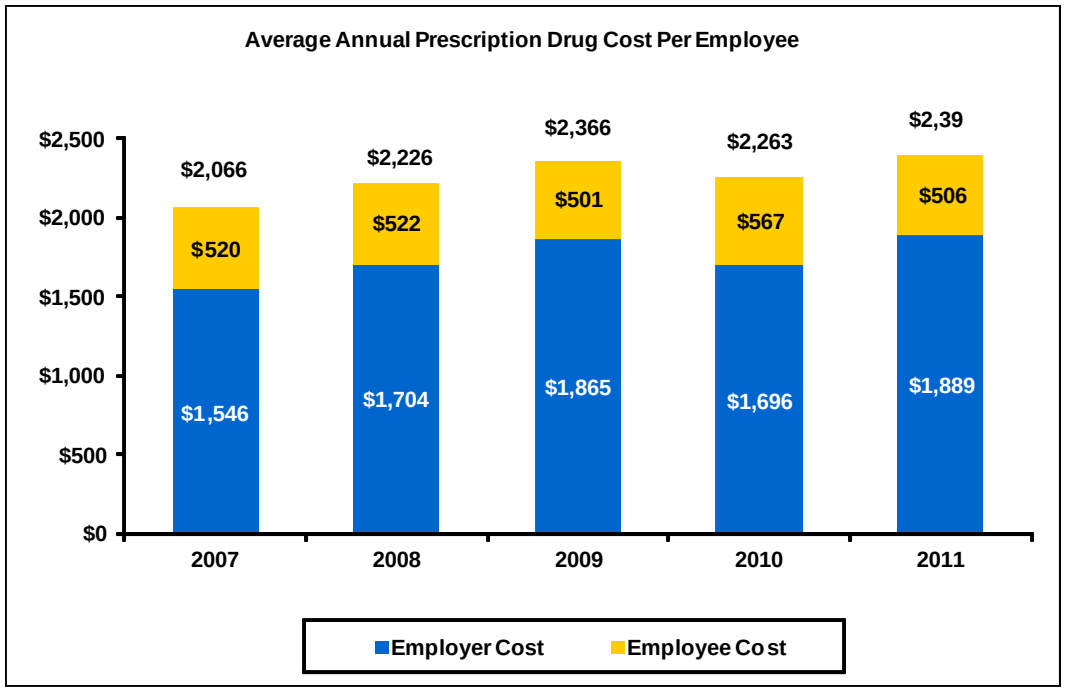




Prescription Drugs





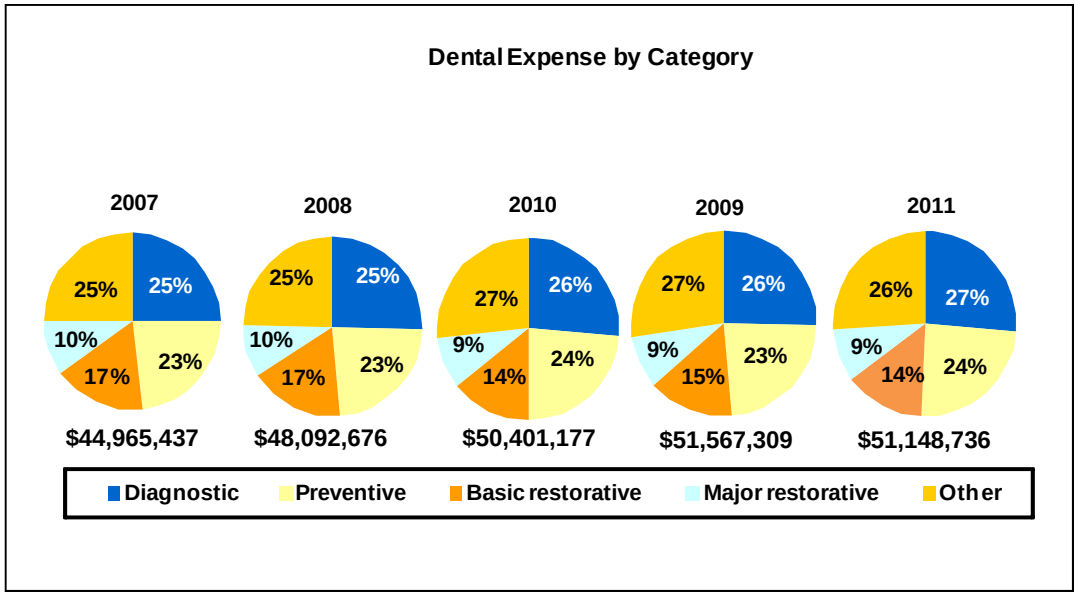


Total prescription drug costs for the state program were up 5 percent from 2010 to 2011. Several factors contributed to the rise in expenses. The number of members using higher-cost specialty drugs increased; manufacturers continued to increase prices as brand drugs approached patent expiration, and offered brand drug coupons to encourage use of brand-name products; and fewer members used the less expensive mail service option for routine medication supplies. Factors helping the plan control costs included a higher generic drug dispensing rate and continued measures to help stem drug costs such as prior authorization and step therapy.

The generic drug portion of the prescription drug mix increased 5.4 percent from 2010, to 71 percent. Drug patents continued to expire on many highly utilized brand name drugs, which helped to drive up the generic drug utilization rate. More than 9,000 prescriptions were filled for very high-cost specialty drugs, representing 19 percent of the state plan's drug cost for 2011, up 3 percent from 2010. Health plan members' share of total annual prescription drug costs fell 2 percent, to 23 percent from 25 percent the previous year.

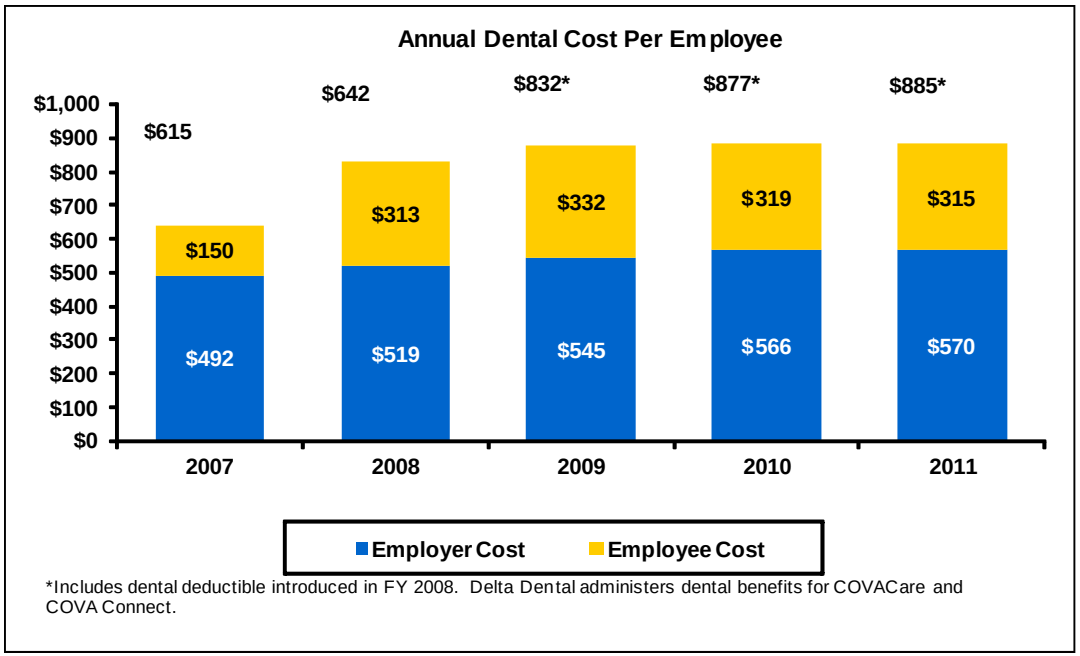
Elimination of coverage in 2011 for erectile dysfunction drugs and non-sedating antihistamines saved the program about $2.5 million.

Dental Benefits

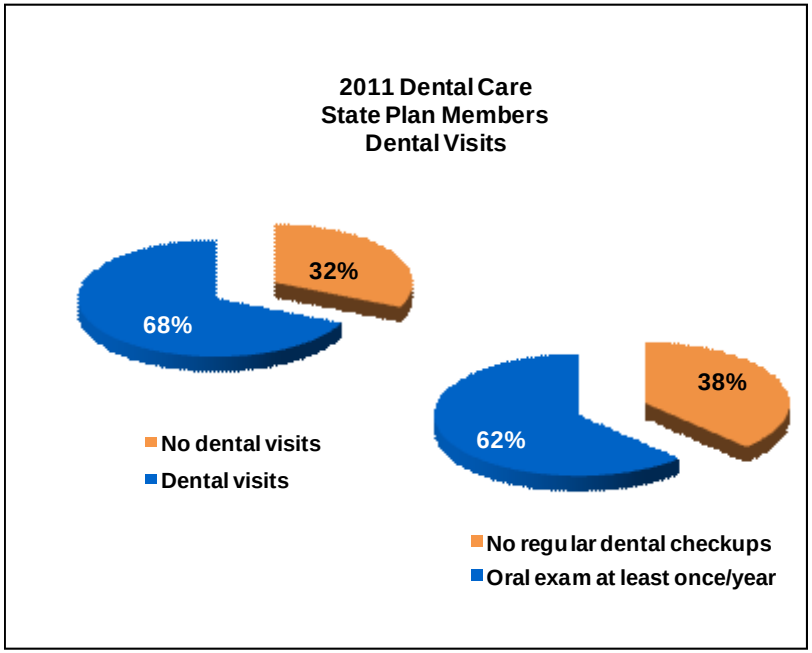


Dental claims costs were down 1 percent for the state program in 2011. Dental benefits continue to represent only 6 percent of total claims expense and are provided at a moderate cost to employees. About 363,000 dental claims were processed in 2011, down 4 percent from 377,000 the year before. Utilization and enrollment decreased slightly. The plan pays 100 percent for preventive and diagnostic services, which accounted in 2010 for a bit more than half of total plan dental claims expense.

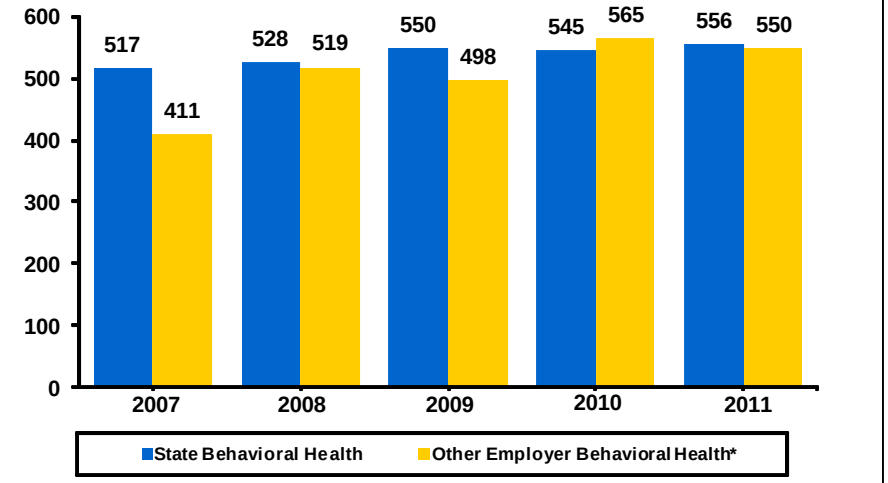
A utilization report by Delta Dental of Virginia, the dental benefits administrator, indicates that about 32 percent of plan members are not visiting the dentist at all and 38 percent do not have regular dental check-ups. Regular dental check-ups prevent major dental problems and reduce overall dental expense. There is a correlation between periodontal disease and certain other conditions, such as heart disease. Therefore, regular check-ups and cleanings lead to better health and lower claims costs. The Commonwealth is considering steps to improve member engagement in dental care.



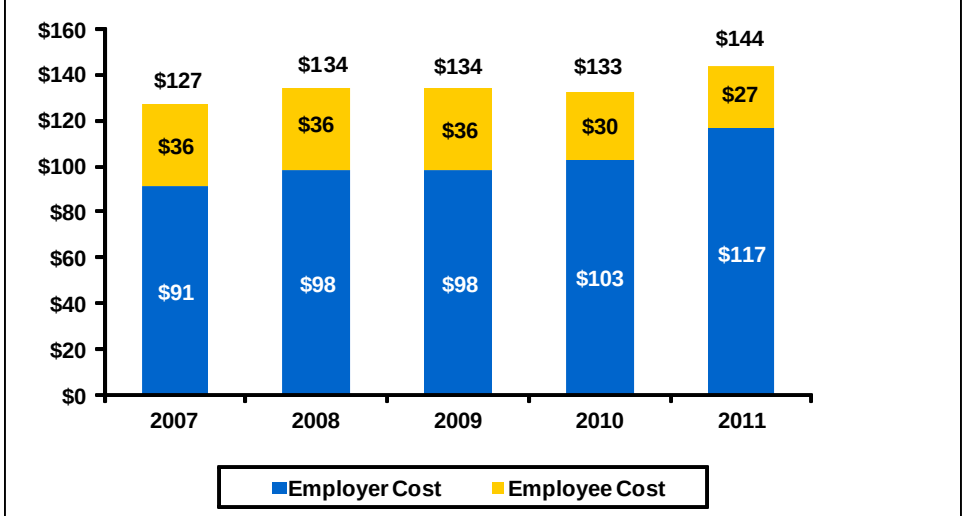
*Includes dental deductible introduced in FY 2008. Delta Dental administers dental benefits for COVACare and COVA Connect.

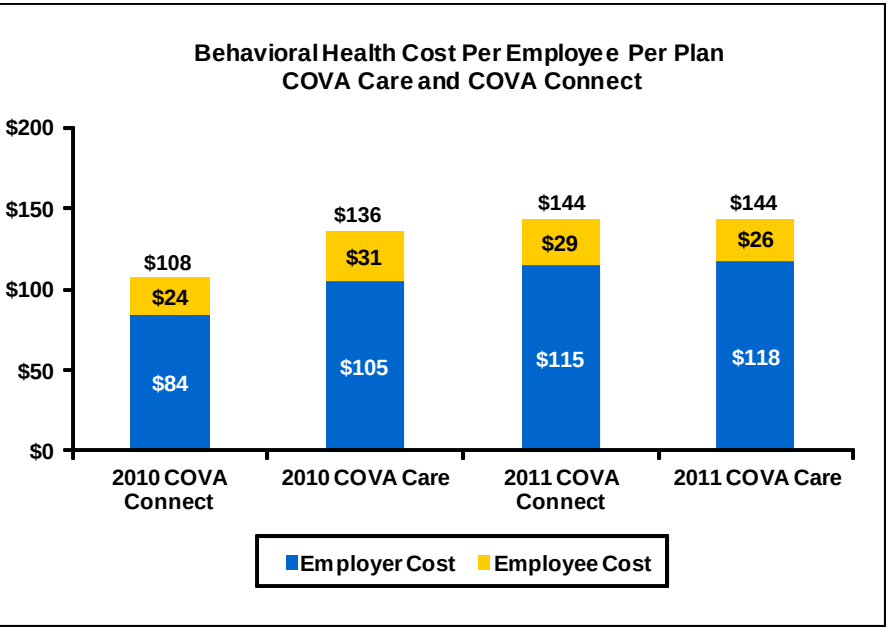


Behavioral Health



*Other employers with ValueOptions and Optima Health behavioral health benefits

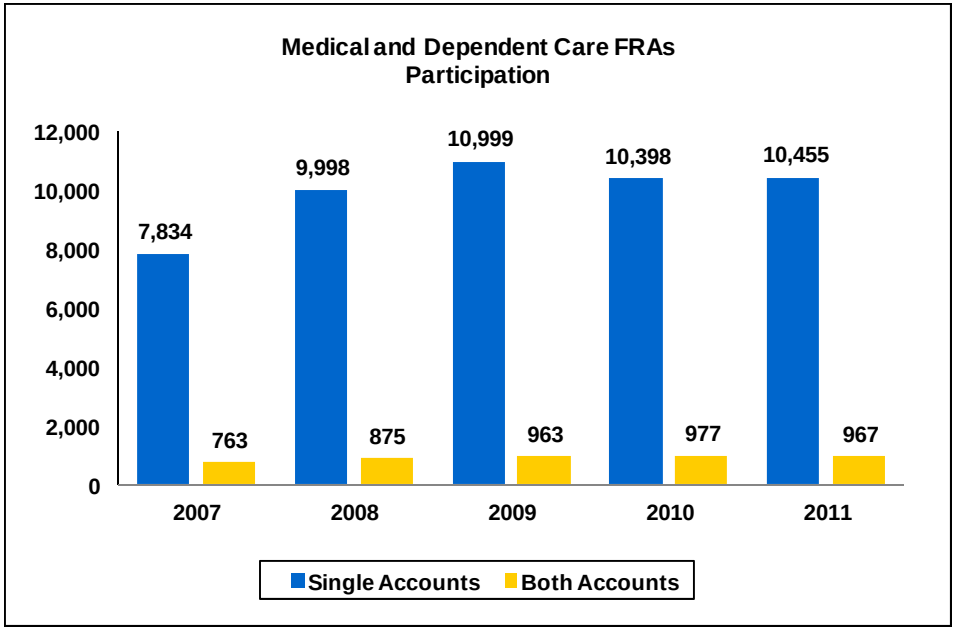


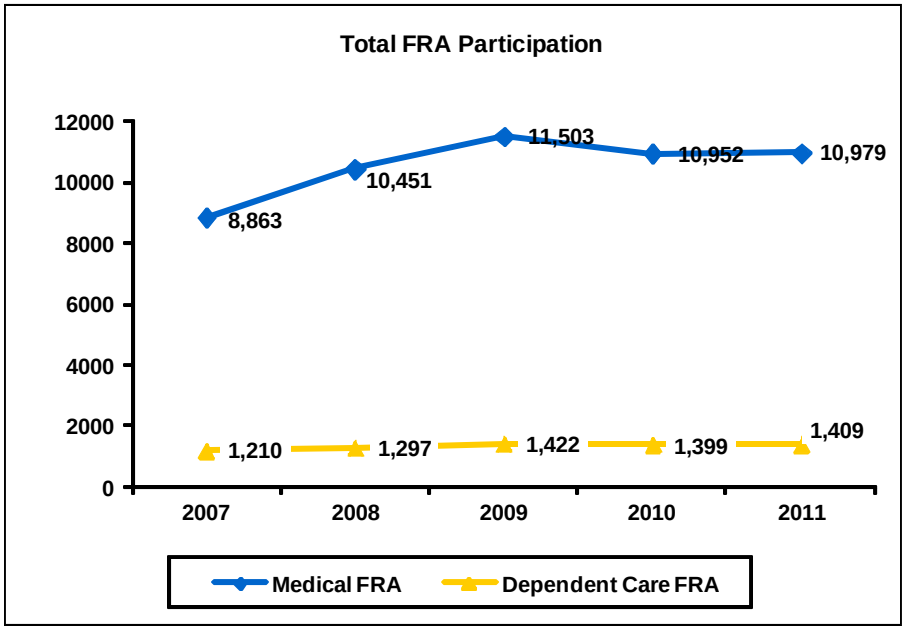


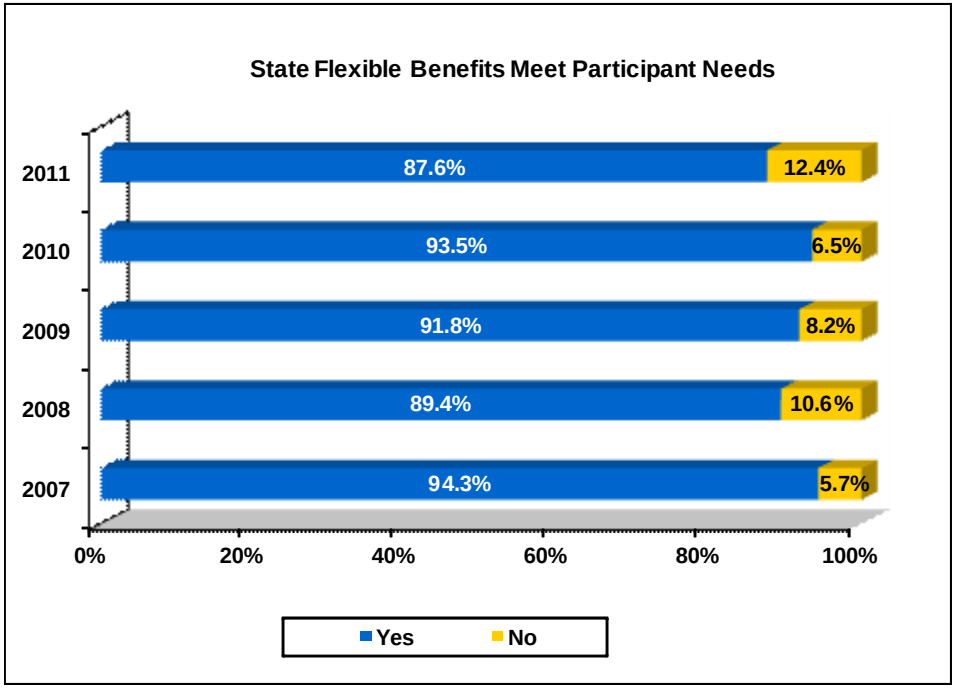
About 7 percent of those enrolled in the health plan used the behavioral health benefit during 2011. Seventy (70) percent of those employee claims related to mood and adjustment disorders, such as depression, anxiety and stress; the remainder were for other issues like substance abuse and schizophrenia. Total claims cost increased 13 percent to $10.6 million in 2011 from $9.4 million in 2009. Increased cost share for psychiatrist outpatient services, higher facility rates, more high cost members and greater use of outpatient services drove up overall expense. Fifty-six percent of claims expense was for outpatient services, 36 percent for inpatient treatment, and 7 percent for alternative levels of care.

The Employee Assistance Program (EAP) handled more than 4,100 total cases in 2011, down 11 percent from 4,600 cases in 2010. The annualized 5 percent utilization rate in 2011 remained above the 4.5 percent national rate. Fifty-four percent of members sought EAP services for relationship and job concerns, and 41 percent for emotional issues such as depression, anxiety and drug abuse. The economy continues to have an impact, with use of legal and financial services the highest in the program to date. Domestic relations represented 37 percent of total cases, followed by debt management at 12 percent, and civil matters and bankruptcy, both at 8 percent. The health benefits program and Virginia State Employee Loan Program partnered in 2011 to educate employees about financial EAP services, which helped to increase EAP utilization.

Flexible Reimbursement Accounts







A flexible reimbursement account (FRA) allows employees to set aside part of their income before taxes to pay for certain non-covered health, or day care expenses. Medical FRAs may be used for non-covered eligible health care expenses, while Dependent Care FRAs may be used to pay eligible costs for day care. Participation in medical flexible reimbursement accounts grew less than 1 percent from 2010 to 2011, after a 5 percent decrease the previous year. Dependent Care accounts also increased slightly following a decline of 1.6 percent from 2009 to 2010. The earlier declines in account use were due partially to an administrative fee reinstated during 2010 to make up for elimination of other program funds.

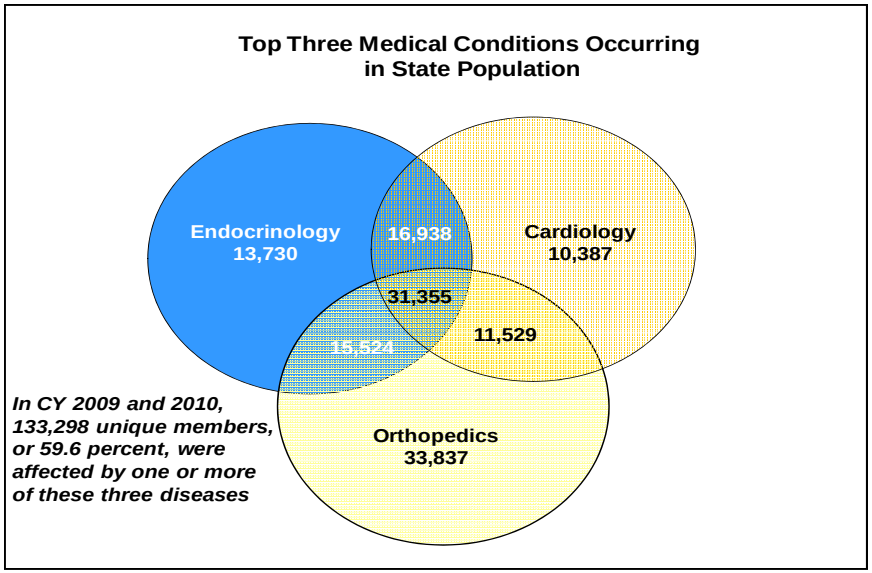
Flexible Benefits remain popular among participants, with at least 88 percent in the past five years indicating that the program meets their needs. In 2011, national health reform eliminated reimbursement of over-the-counter drugs using a Medical FRA. This new rule, along with a desire for higher contribution limits and fear of losing funds at the end of the plan year, were major reasons that dissatisfaction with flexible benefits nearly doubled, from 6.5 percent in 2010 to 12.4 percent in 2011. Since 2008, Medical FRA participants have had the option of using a stored value card, similar to a debit card, to pay for eligible expenses at the point of service. Less money is forfeited at the end of the plan year when participants use these cards, and forfeitures had been used in previous years to pay for the program.

Cost Drivers: The Health Plan "Top Ten"

Expensive procedures, treatment of chronic conditions and the cost of prescription drug therapy continue to have a major impact on the program. Other significant cost drivers relate to employee lifestyle, including smoking, level of physical activity and a high percentage of members who are overweight. Another factor is the average state employee age, which remains higher than the norm for other employers.

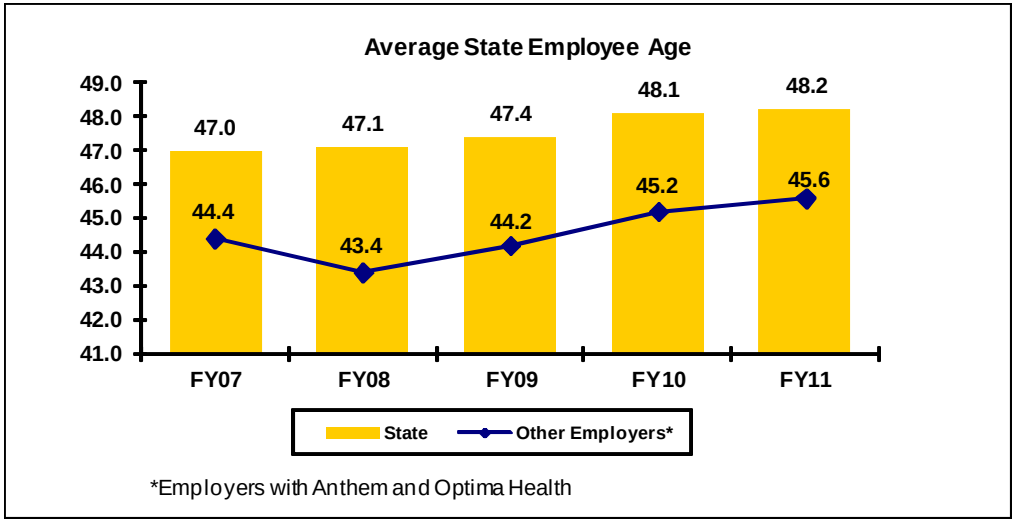
About $595 million, or 71 percent, of state plan expenses during 2011 came from claims for the top ten medical procedures, chronic conditions and prescription drugs. Total expense in these areas was up 3 percent from the previous year. High in the top 10 were conditions that correlate with heart attack and stroke, like cerebrovascular and coronary artery disease, circulatory disorders and hypertension. Many of these conditions are also identified with being overweight: diabetes, coronary artery disease, hypertension, musculoskeletal and digestive disorders.

The top three medical conditions occurring among state employees are all related to lifestyle. Being overweight, smoking and overeating contribute to diabetes, heart disease, arthritis and other musculoskeletal issues. The areas of endocrinology, cardiology and orthopedics cost the state program more than $200 million in 2011.



"Top Ten" Claims Expense		
Medical Procedures	**Chronic Conditions**	**Prescription Drugs**
1. Musculoskeletal	1. Coronary artery disease	*1. Nexium* (stomach acid)
2. Neoplasms (tumors)	2. Breast cancer	*2. Lipitor* (high cholesterol)
3. Circulatory	3. Cerebrovascular disease	*3. Enbrel* (rheumatoid arthritis)
4. V-Codes (health services not classified as disease or injury)	4. Diabetes	*4. Crestor* (high cholesterol)
5. Ill-defined symptoms (undetermined causes)	5. Hypertension	*5. Humira* (rheumatoid arthritis)
6. Digestive	6. Lung cancer	*6. Singulair* (asthma/allergy)
7. Genitourinary	7. Skin cancer	*7. Cymbalta* (depression)
8. Nervous system/sense organs	8. Obesity	*8. Copaxone* (multiple sclerosis)
9. Accidental injury	9. Oral cancer	*9. Actos* (diabetes)
10. Respiratory	10. Substance abuse	*10. Advair Diskus* (asthma/COPD)
57.7% of All Claims Expense	***8.5% of All Claims Expense***	***4.6% of All Claims Expense***

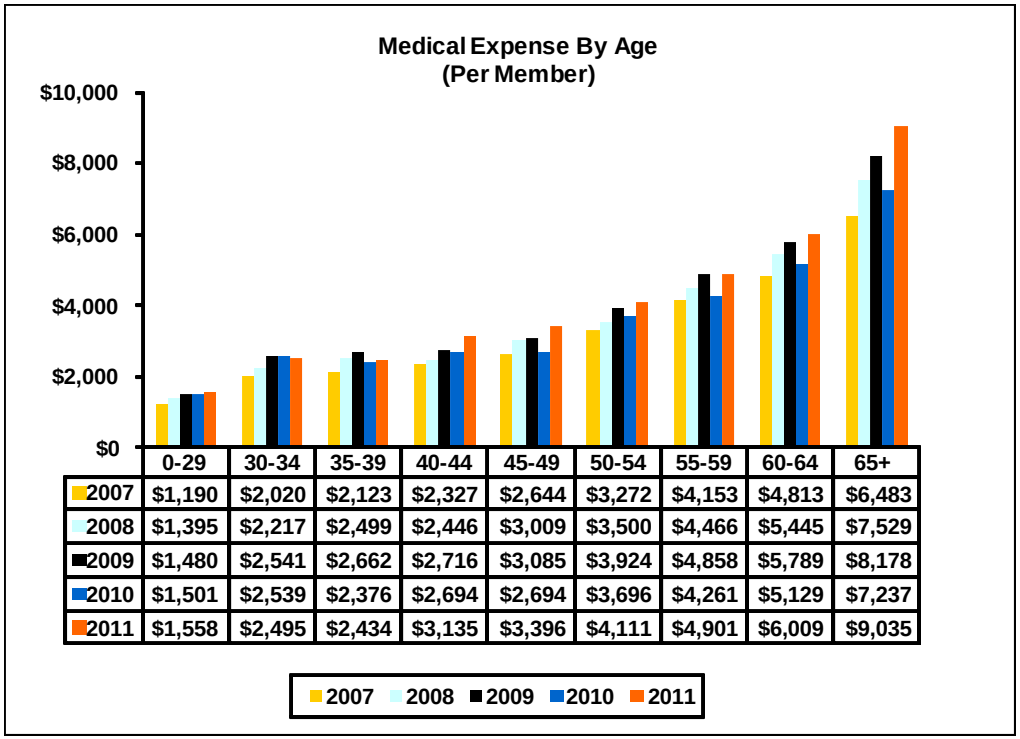
Cost Drivers: An Aging Population



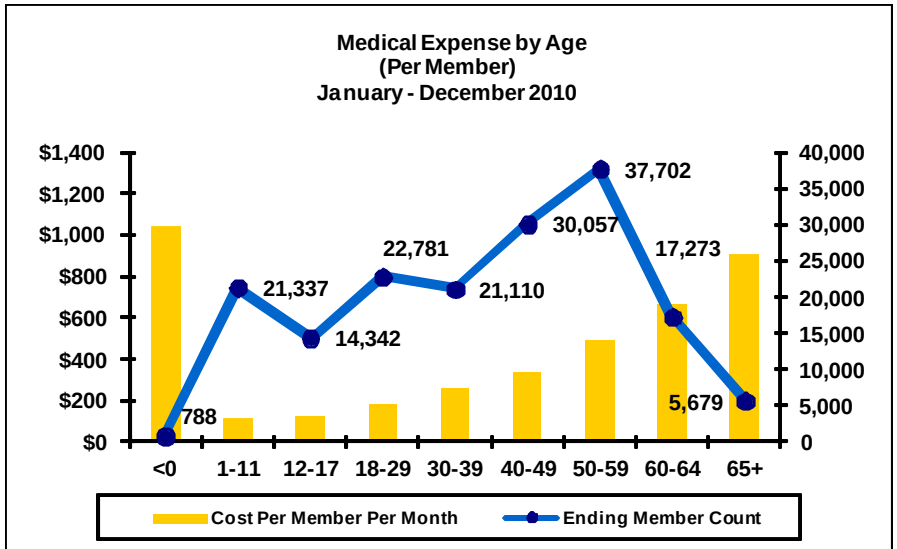
*Employers with Anthem and Optima Health

The average age of state employees continues to increase. According to the American Medical Association, many diseases correlate with an aging population. As people age, they are more likely to develop chronic conditions such as high cholesterol, high blood pressure, heart disease and diabetes.

The age gap continued in 2011 between the state workforce enrolled in the health benefits program, with an average age of 48.2, and employees at other employers, whose average age was 45.6. Employees in COVA Connect had an average age of 48.6, or almost one year older than those in COVA Care, at 47.8. Those over the age of 50 represented 35 percent of state health plan members in calendar year 2010, and were responsible for 59 percent of total medical expenses.



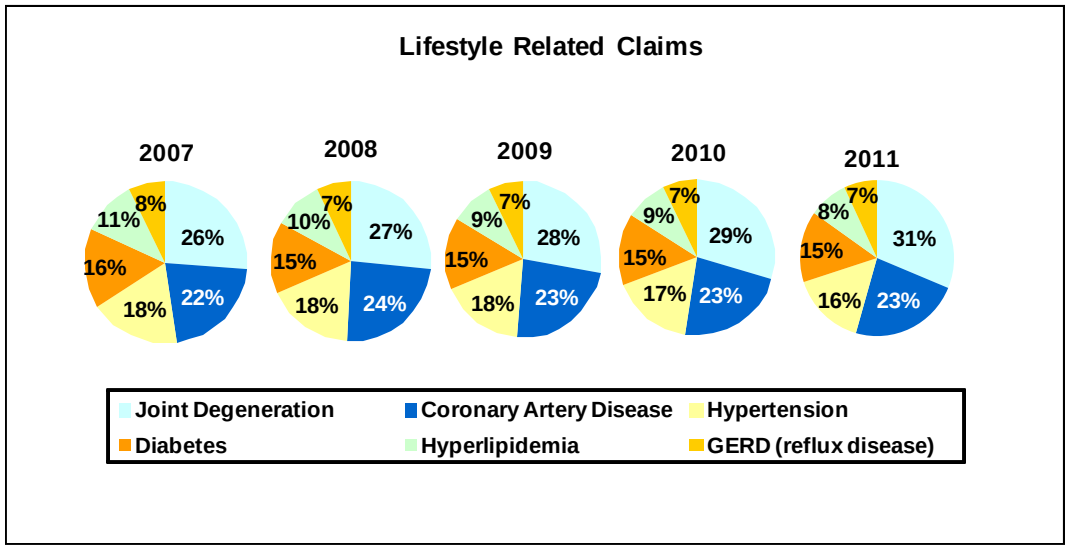
	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
2007	$1,190	$2,020	$2,123	$2,327	$2,644	$3,272	$4,153	$4,813	$6,483
2008	$1,395	$2,217	$2,499	$2,446	$3,009	$3,500	$4,466	$5,445	$7,529
2009	$1,480	$2,541	$2,662	$2,716	$3,085	$3,924	$4,858	$5,789	$8,178
2010	$1,501	$2,539	$2,376	$2,694	$2,694	$3,696	$4,261	$5,129	$7,237
2011	$1,558	$2,495	$2,434	$3,135	$3,396	$4,111	$4,901	$6,009	$9,035



35% of members are over 50 and drive 59% of the expense

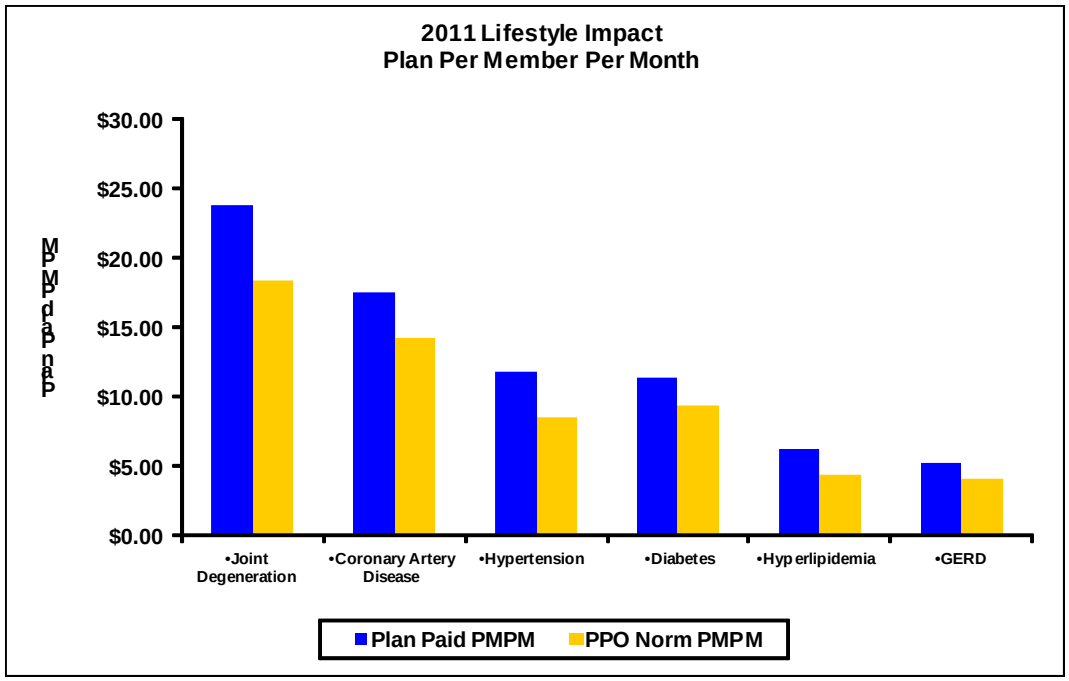
	<0	1-11	12-17	18-29	30-39	40-49	50-59	60-64	65+
% Membership	0.5%	12.5%	8.4%	13.3%	12.3%	17.6%	22.0%	10.1%	3.3%
% Expense	1.4%	4.1%	3.0%	7.0%	9.3%	16.6%	30.9%	19.3%	8.6%

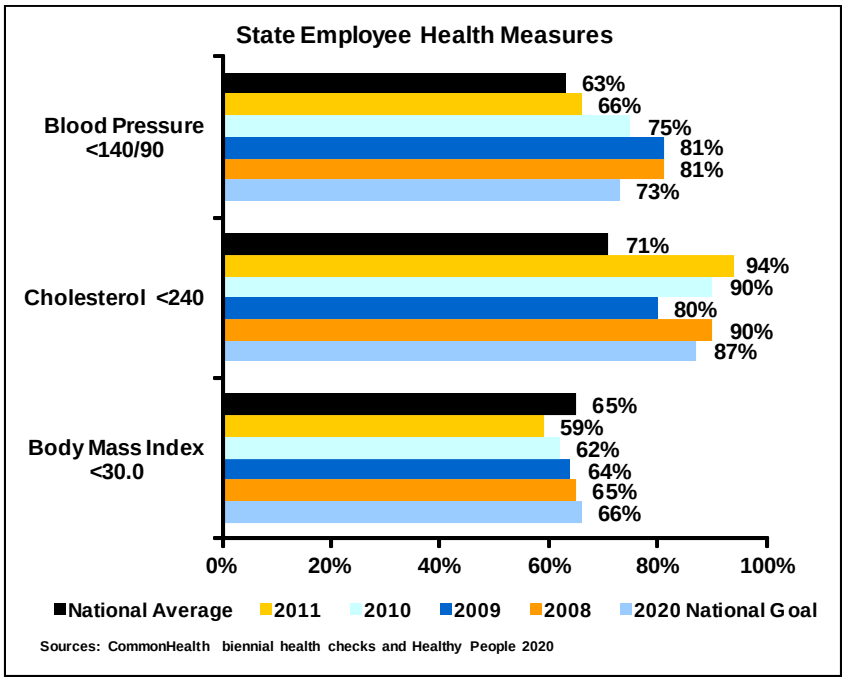
Lifestyle Influences



According to the National Institutes of Health, two-thirds of American adults and one in three children are overweight or obese. As the chart at the left indicates, six conditions that correlate with being overweight represented more than $161 million, or 26.5 percent, of the state plans' total medical expense in 2011.

About 7,100 employees in 2010 and 5,145 in 2011 took part in health screenings through the CommonHealth wellness program. While the group was better than the national average in normal cholesterol and blood pressure levels, it ranked 6 percent above average in body mass index of 30 or more, meaning that a higher percentage of state employees are seriously overweight or obese.

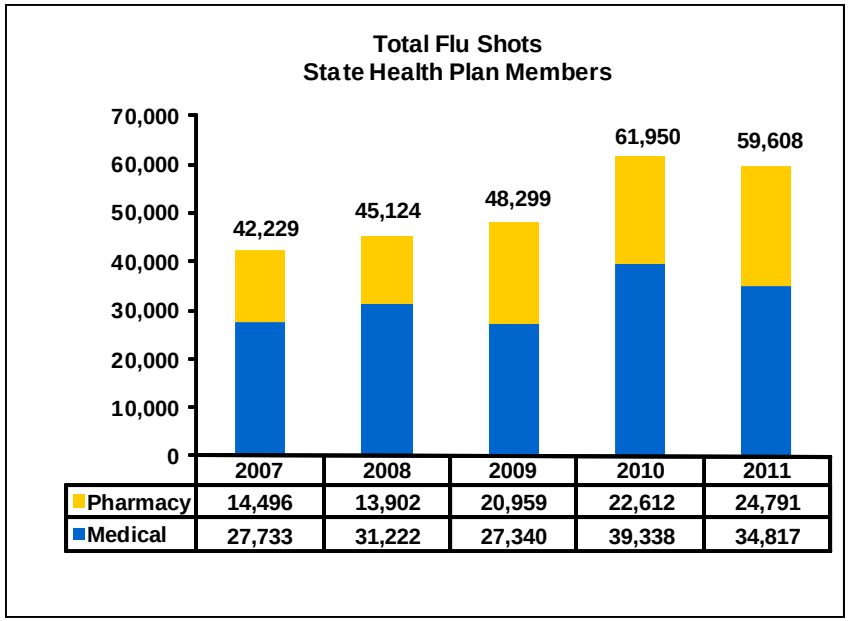


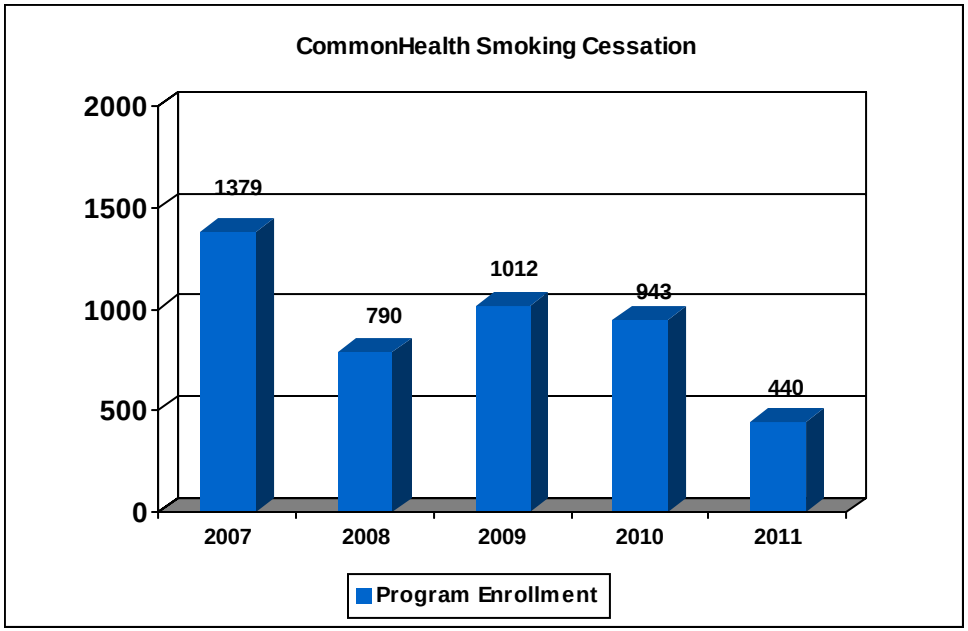


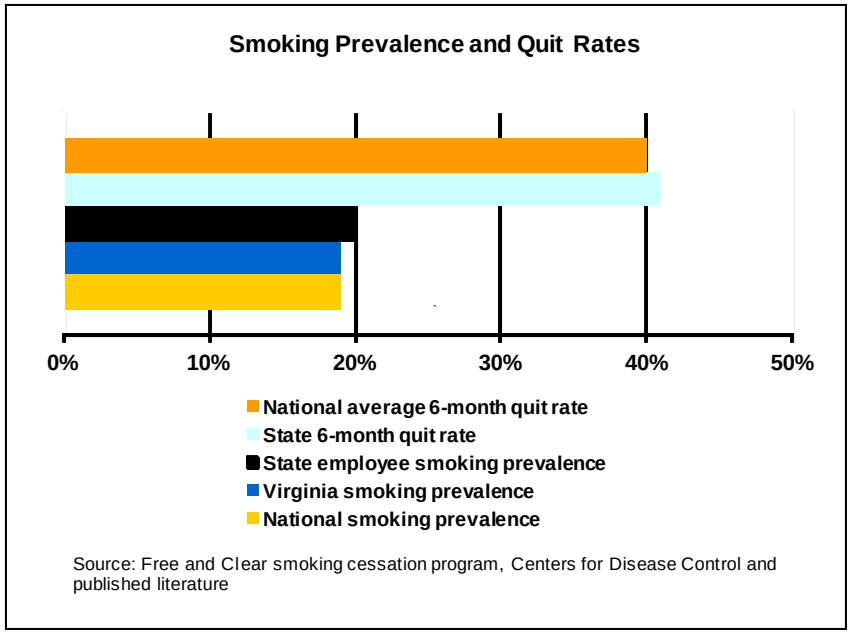
Employee Wellness

The Commonwealth is committed to helping employees lead healthier lives, and the *CommonHealth* employee wellness program is a major part of that pledge. The program promotes healthy employee lifestyles and encourages integration of health and physical activity into the work culture. Administration of CommonHealth changed in 2008 from a vendor to employee direction within the Department of Human Resource Management, saving the state $4 million in a tight budget environment. During 2011, state executive agencies continued to report employee participation in *CommonHealth* as a measure on the Governor's Management Scorecard, with total participation at 21 percent. The program focused during the year on the importance of an active lifestyle, ways to combat stress and home safety.

Having a flu shot is a relatively simple way for employees to stay healthy. In 2011, more members received free flu shots at pharmacies yet the number who visited doctor's offices for their shots dropped significantly. This resulted in a 4 percent overall decrease in flu shots compared to 2010, although participation was 23 percent higher in 2011 than in 2009. Enrollment in the "Quit for Life" smoking cessation program dropped significantly in 2011 to a 0.49 percent rate, yet is still within the national norm of 0.31 percent to 1.55 percent of the total eligible population. In addition,1,481 prescriptions for smoking cessation drugs were filled through the state health plan.

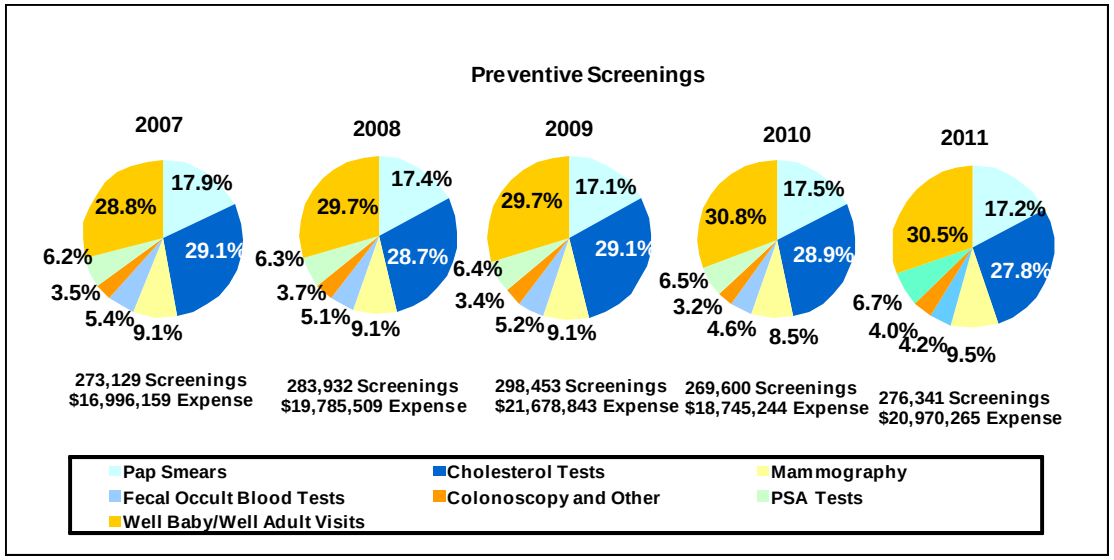


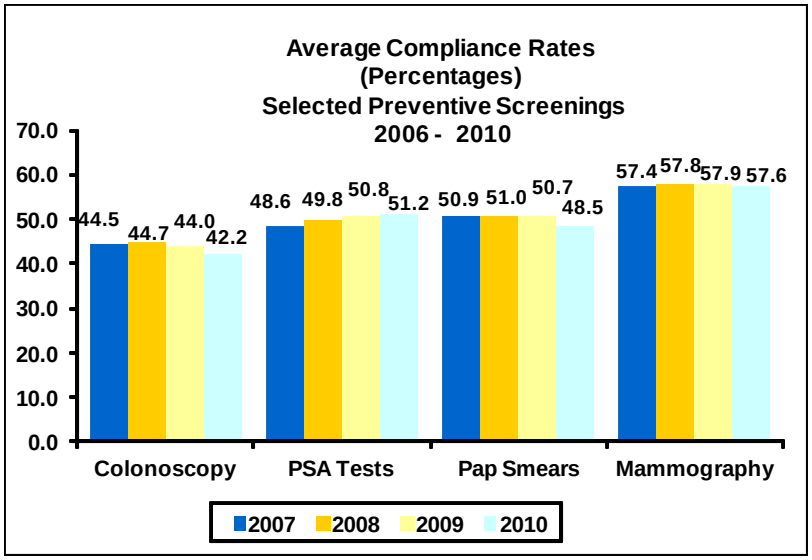


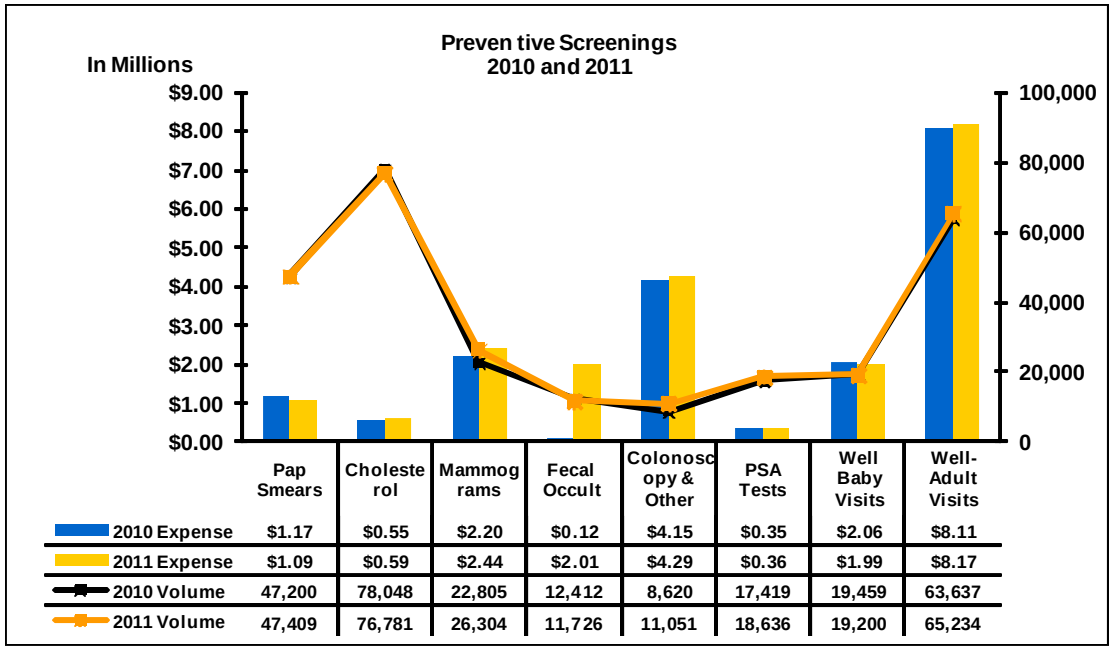


Source: Free and Clear smoking cessation program, Centers for Disease Control and published literature

Preventive Care







	Pap Smears	Cholesterol	Mammograms	Fecal Occult	Colonoscopy & Other	PSA Tests	Well Baby Visits	Well-Adult Visits
2010 Expense	$1.17	$0.55	$2.20	$0.12	$4.15	$0.35	$2.06	$8.11
2011 Expense	$1.09	$0.59	$2.44	$2.01	$4.29	$0.36	$1.99	$8.17
2010 Volume	47,200	78,048	22,805	12,412	8,620	17,419	19,459	63,637
2011 Volume	47,409	76,781	26,304	11,726	11,051	18,636	19,200	65,234

In 2011, the Commonwealth continued to provide annual wellness visits and preventive care screenings at no cost to members. Annual physicals, mammograms, and prostate specific antigen (PSA) tests are examples of services in these categories. Outpatient wellness visits and preventive screenings in 2011 were about 4 percent of total medical expenses, or slightly higher than for the previous year. Baby and adult wellness checkups and cholesterol tests represented 58 percent of total screening volume, compared to 60 percent in 2010. For both years, about one-third of preventive care screenings were pap smears, mammograms and PSA tests.

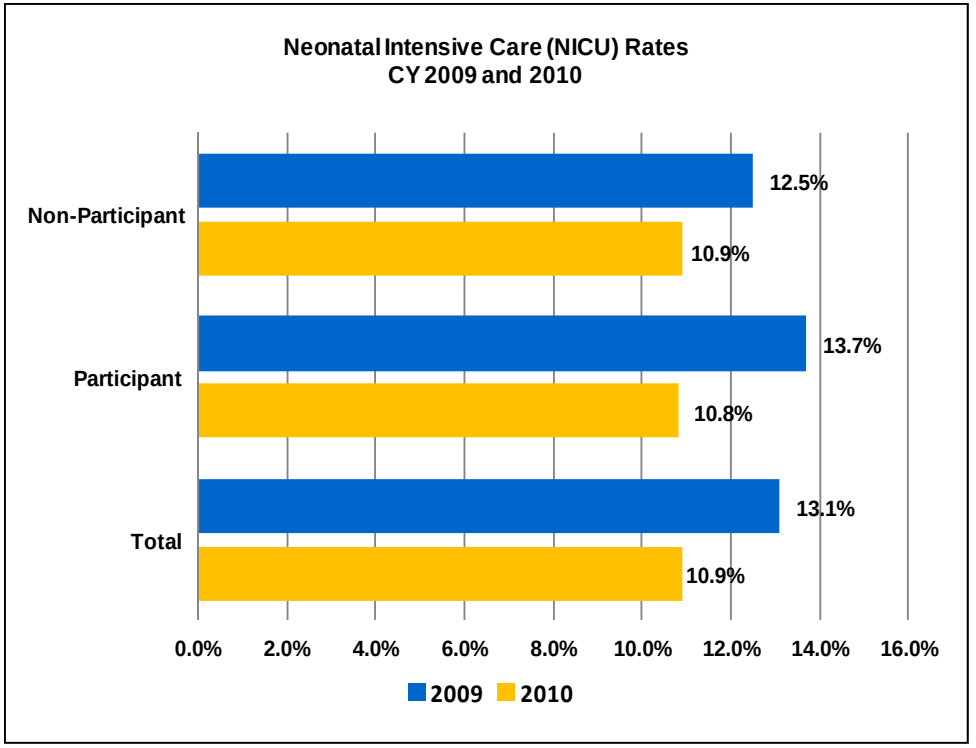
The average screening compliance rate over the past few years has been highest for mammography, at approximately 58 percent of women in the applicable population. Eighty-three percent of those eligible, or 156,385 members, had routine wellness services during 2011. That compares to 84 percent, or 157,714 members, in 2010.

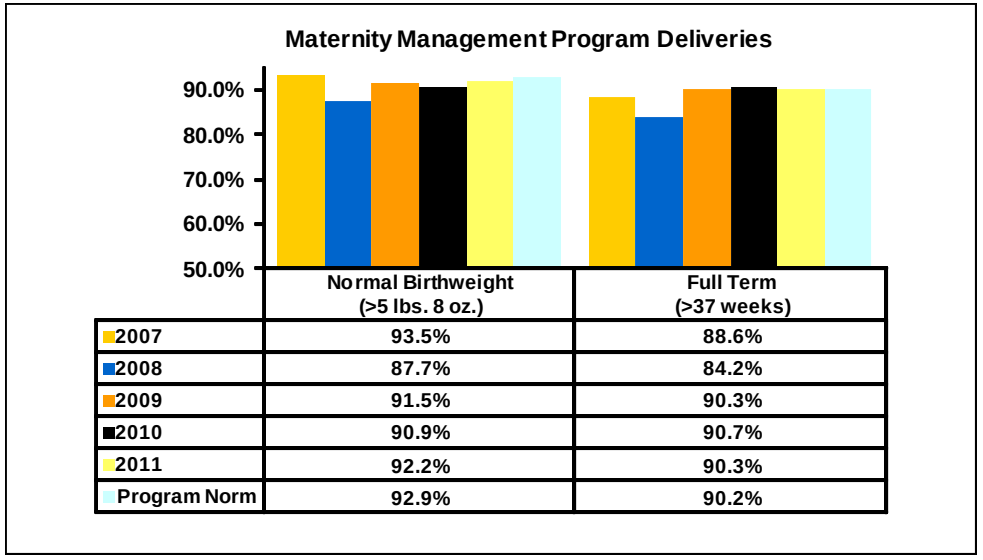
Maternity Management

Over 1,400 state plan members delivered babies during 2011. Forty-seven percent of those women participated in the maternity management program, offered to members at no additional cost to help expectant mothers deliver healthy babies. The high participation rate for this program is attributed to an incentive that waives the maternity inpatient copayment for participants who complete the program requirements. Over 90 percent of participants reported full-term deliveries (>=37 weeks) and normal birth weight (>=2500 grams) infants. About 76 percent registered in the first trimester, compared to Anthem's book of business norm of 44 percent. In addition, the amount paid per member was 4 percent less for incentive participants and 2 percent less for participants than for women who did not participate in maternity management.

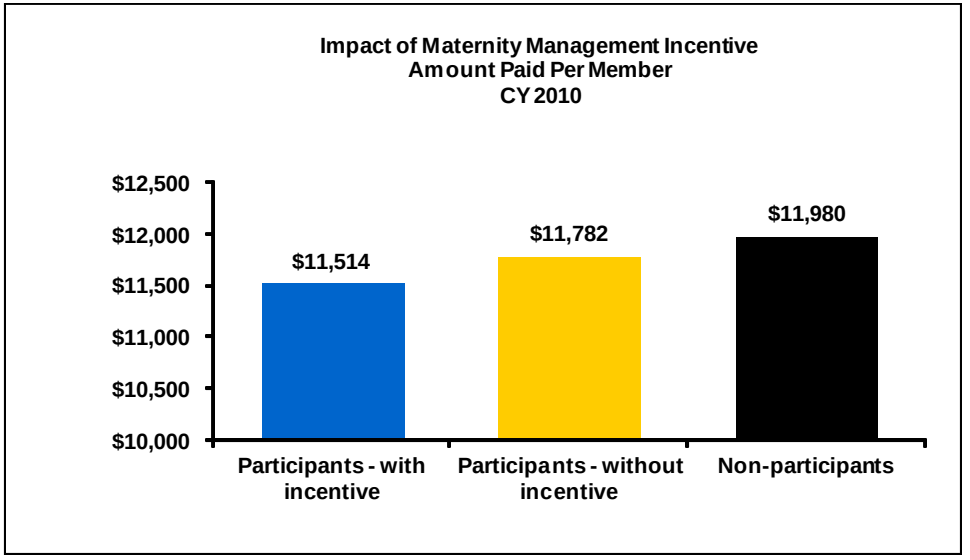
Birth weight plays a major role in a child's overall lifetime health and special prenatal care during pregnancy can prevent premature birth. Premature babies require expensive medical care at birth and over their lifetimes. There were 113 premature births among plan members in the 2011 fiscal year, up 27 percent from 89 in 2010, and costing $1.7 million. Slightly less than half (47%) were born to mothers enrolled in maternity management. The top seven most expensive premature infants had combined claims costs of $1.3 million.

Among participants in maternity management, the percentage of babies treated in the neonatal intensive care unit has decreased 3 percent compared to a 2 percent decline overall.

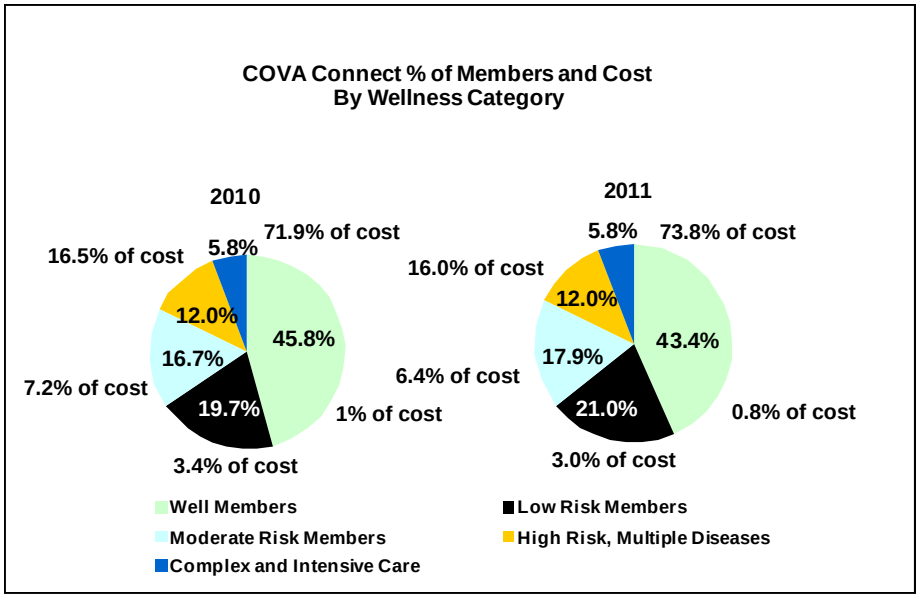


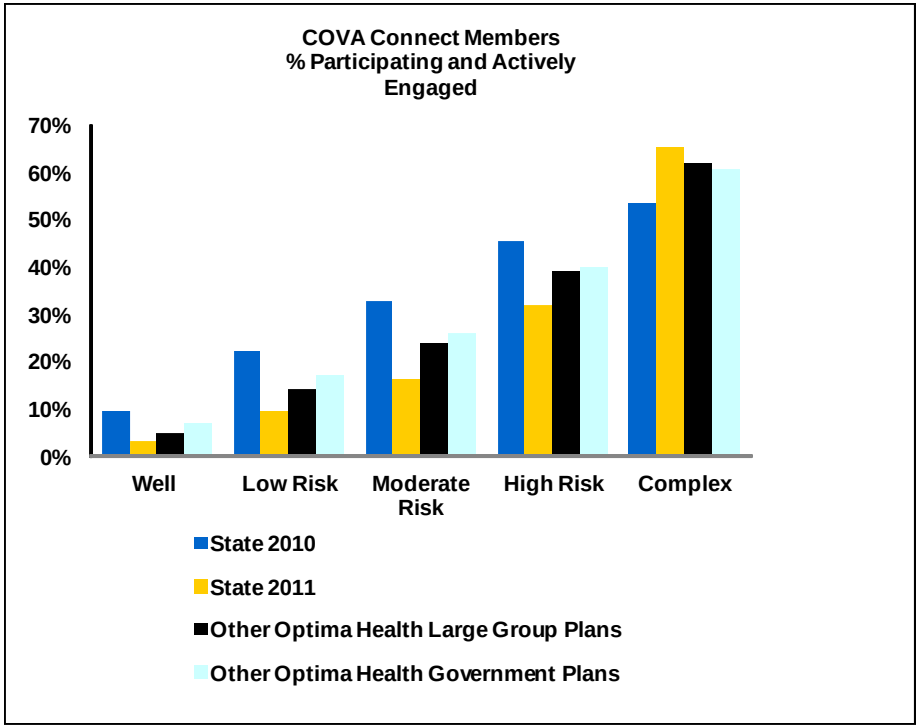


	Normal Birthweight (>5 lbs. 8 oz.)	Full Term (>37 weeks)
2007	93.5%	88.6%
2008	87.7%	84.2%
2009	91.5%	90.3%
2010	90.9%	90.7%
2011	92.2%	90.3%
Program Norm	92.9%	90.2%



Public Private Education Act (PPEA) Partnership





In 2011, the Department of Human Resource Management continued the COVA Connect pilot program under the Public Private Education Act (PPEA), passed by the General Assembly nine years ago to encourage public-private partnerships in order to increase government efficiency. The program is administered by Optima Health in specific Hampton Roads area zip codes. It is aimed at developing a healthier state workforce by integrating multiple aspects of health care management, such as the latest technology, health advocacy and one-stop customer service.

As part of the PPEA, a COVA Connect group health profile was created in FY 2010. The profile evaluates the health of the population as a whole and stratifies members into risk categories. For FY 2011, the well member group declined to 43 percent of the COVA Connect population, comparable to Optima Health's municipal employer plans. The members at the greatest risk for illness made up 73 percent of COVA Connect's costs, 1 percent higher than Optima's book of business. The predominant risks for the COVA Connect population are cardiac illness, diabetes and respiratory disease.

The engagement rate is defined as at least two successful contacts with the member. About two-thirds of the 5.8 percent of members in the complex category were actively engaged with a health coach to assist them with health improvement, focusing on areas such as exercise, nutrition and smoking cessation. This rate is higher than the 61 to 62 percent rate of other Optima Health large group and government plans.

All members were contacted by a clinical advocate to help them manage their health care. Among those identified with chronic conditions, the percentage of compliance with medication standards was the highest for diabetes at 28.7 percent, comparable to other employers in Optima Health's book of business. A financial incentive pilot program was launched to encourage COVA Connect members to take a health risk assessment and participate in programs to better manage chronic illness. Four hundred fifty one individuals completed online personal health profiles in 2011, a 50 percent increase from the 301 the year before. About 1,900 were actively engaged in disease management during 2011, or 46 percent more than the 1,300 in 2010.

Change management issues were evident during the introduction of the pilot program and have improved over time. About 56 percent of COVA Connect members were satisfied with the overall health plan in 2011, up 5 percent from the satisfaction rate in 2010.

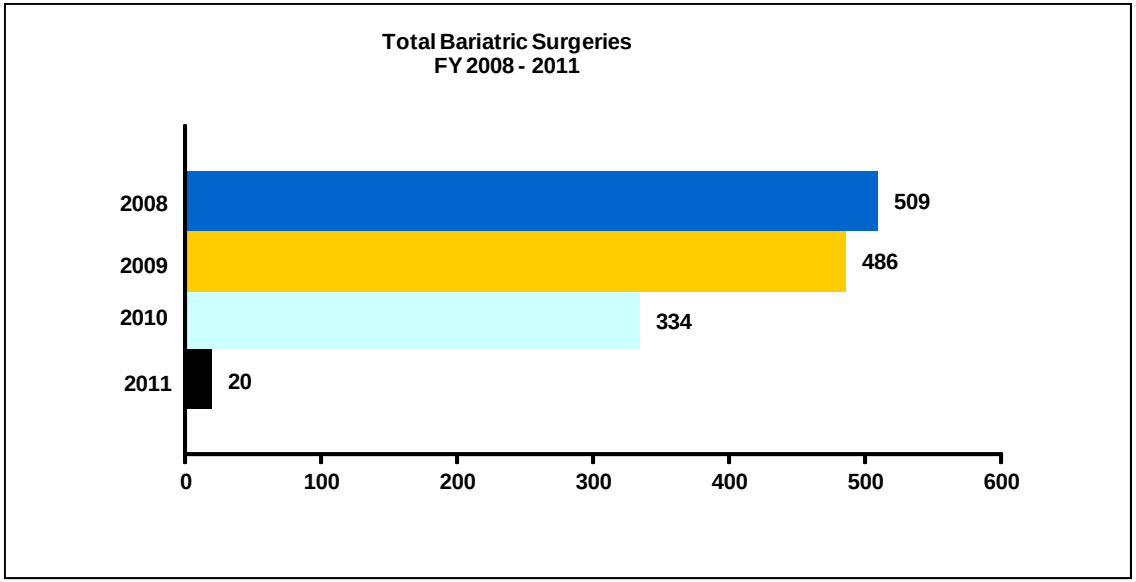
Pre-Bariatric Surgery Pilot Program

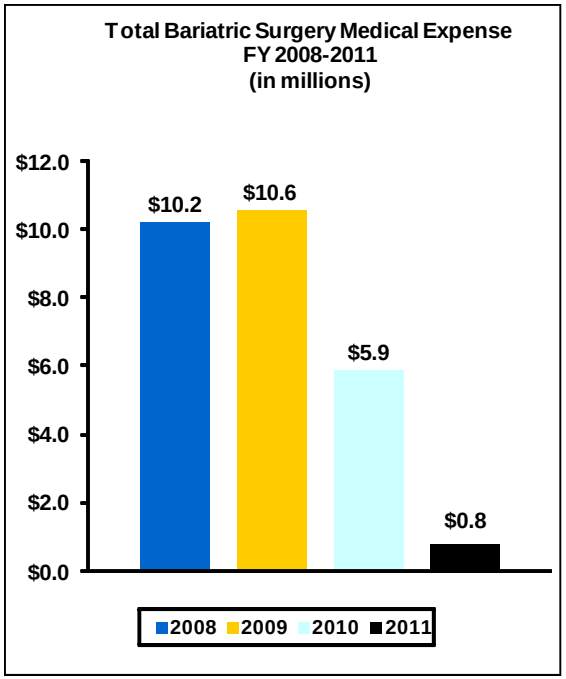
As part of plan funding issues, a proposal was made during the 2009 legislative session to eliminate coverage for gastric bypass surgery. As an alternative, the General Assembly requested a new 12-month pre-surgery pilot program that was launched in February 2010 and continued in fiscal year 2011. Claims expense for this type of surgery, including traditional bariatric surgical procedures, gastric bypass and lap band surgery, had grown to $10.6 million by FY 2009. Costs were projected at $12 million by the end of the 2011 plan year. The pilot's goals were to improve these patients' chances for successful surgery and to prepare them for the lifestyle changes associated with having the procedure.

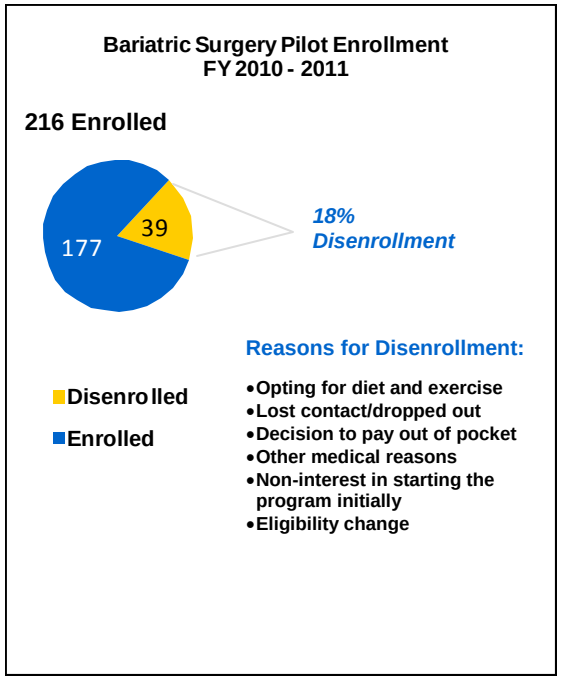
The pilot addresses the challenges that some patients face of losing weight and then gaining it back, and for the health plan in increased cost for potentially ineffective surgery. It includes prior medical authorization for the surgery and participation in a disease management program. In addition, weight management, nutritional counseling, and personalized coaching and support services are provided through the behavioral health benefit. If surgery is approved, the program offers continued support after surgery to ensure the best possible health outcomes. As a bonus, members who participate in after care for 12 months receive a refund of half of their inpatient hospital copayment for the surgery. They receive the balance for participating another 12 months.

From FY2008 to FY2010, there were 1,389 bariatric surgery cases. By June 2010, 58 plan members were participating in the pilot program and during 2011 the number increased to 216. Participants lost more than 359 pounds during the year.

After 75 days in the program, there is a statistically significant, positive correlation between the length of member engagement and the decrease in a participant's BMI. Many participants without large weight loss are becoming aware of their relationship with food and what needs to change. Facilitation by weight management coaches has addressed topics such as behavior change, healthy eating and movement. Because of the 12-month waiting period, there were 94.1 percent fewer bariatric surgery cases in FY 2011 than the year before, 20 compared to 334 cases. An analysis of bariatric surgery claims and claims cost from FY 2008 through FY 2011 shows that the initiation of the pilot has resulted in a 92.2 percent decrease in expense, from $10.2 million in 2008 to $800,000 in 2011.





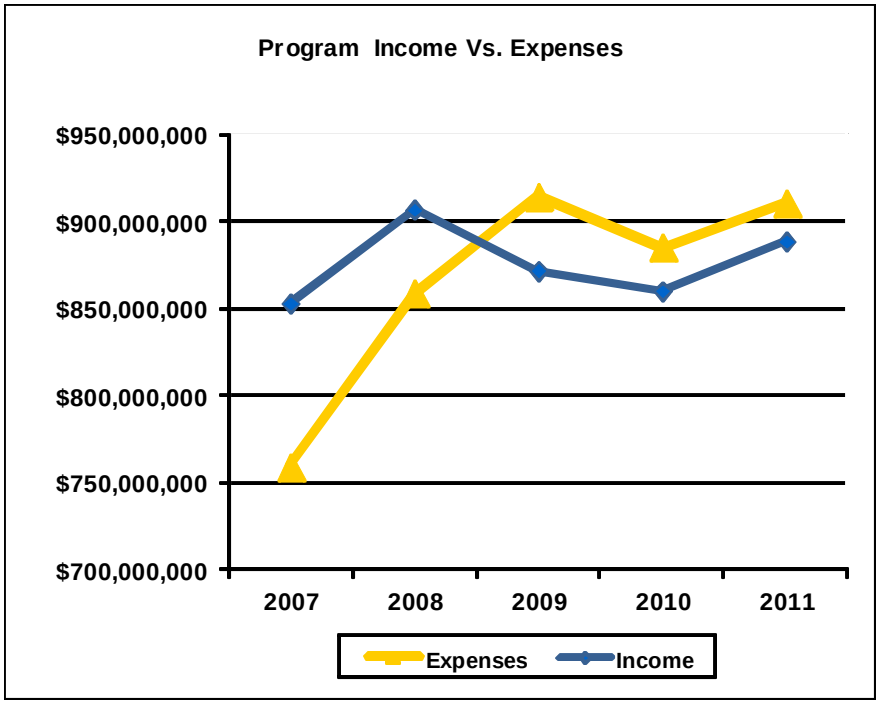


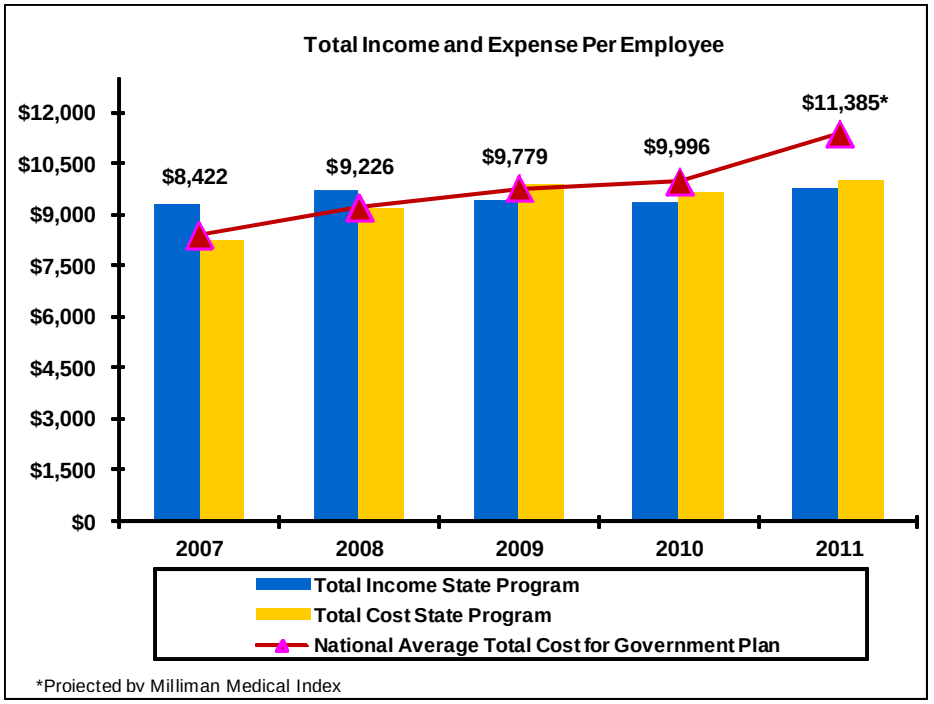
Operating Statement

PROGRAM TOTAL	FISCAL YEAR 2007	FISCAL YEAR 2008	FISCAL YEAR 2009	FISCAL YEAR 2010	FISCAL YEAR 2011
Annual Income (*Premiums, Interest, Other*)	$852,955,127	$906,826,957	$871,914,528	$860,279,484	$888,755,794
Annual Expenses (*Claims, Contract Administration, Other*)	$759,038,420	$858,812,728	$914,296,899	$885,109,068	$910,706,267
Income Less Expenses	$93,916,707	$48,014,229	($42,382,371)	($24,829,584)	($21,950,473)

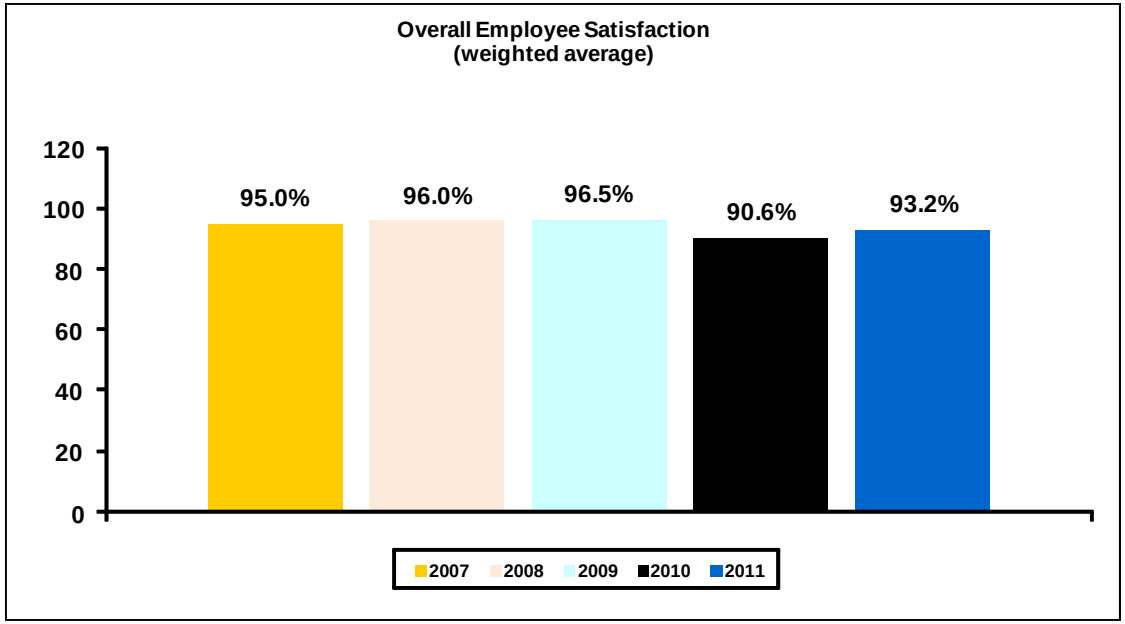
Premiums provide 95 percent of the health program's income, and claims payments represent 94 percent of expenses. Other revenue includes income from prescription drug rebates and incentives, while other expenses include the cost of contract administration.

Cost containment measures combined with a slower rate nationally of health care increases led to program surpluses from 2005-08. Since 2009, deficits have resulted from the use of program reserves to fund an employee and employer premium increase credit (EPIC) during tight budget years.



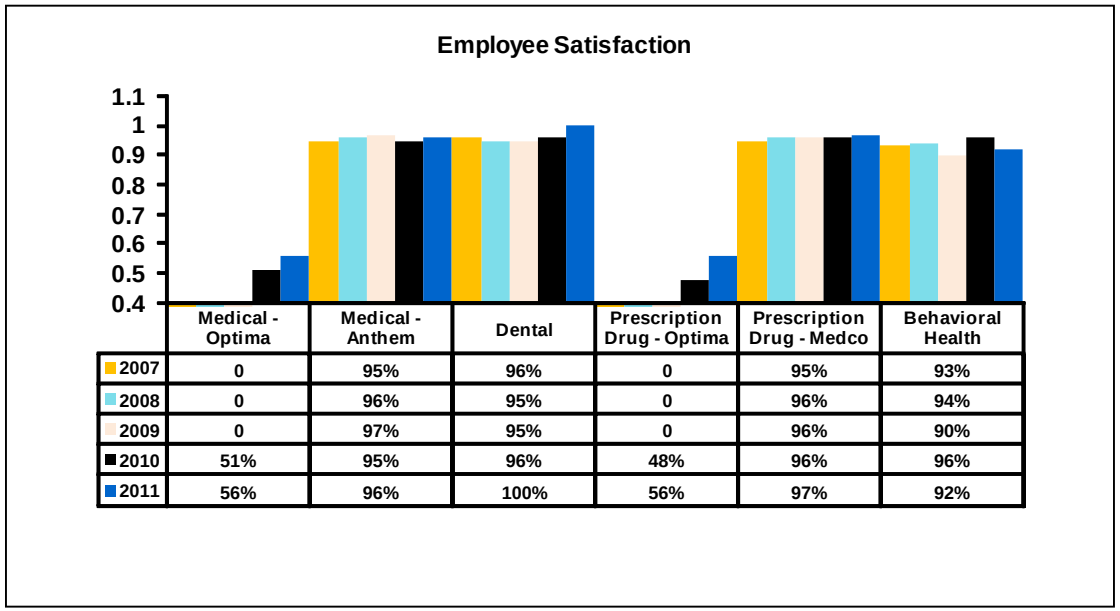


Employee Satisfaction



Input from employees is vital for the health benefits program to measure its progress in improving both the quality and the effectiveness of covered services. Employees' level of satisfaction is measured through periodic surveys. State employees rate specific aspects of their health care. The medical plan satisfaction results are from the standard Healthcare Effectiveness Data and Information Set (HEDIS®) 2011 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult Commercial Survey done in cooperation with the National Committee for Quality Assurance. Other measurements are from the administrator surveys for dental, prescription drug, behavioral health and employee assistance program services.

Overall satisfaction with the health plan rose 2.9 percent to 93.2 percent in 2011, from 90.6 percent in 2010. After their initial dissatisfaction with COVA Connect, employees are getting used to the plan's medical and pharmacy benefits. The state plans' dental benefits received the highest rating in 2011, at 100 percent. Ratings for both COVA Care medical and pharmacy benefits increased 1 percent over 2010, and COVA Connect satisfaction increased by 5 percent.



	Medical - Optima	Medical - Anthem	Dental	Prescription Drug - Optima	Prescription Drug - Medco	Behavioral Health
2007	0	95%	96%	0	95%	93%
2008	0	96%	95%	0	96%	94%
2009	0	97%	95%	0	96%	90%
2010	51%	95%	96%	48%	96%	96%
2011	56%	96%	100%	56%	97%	92%