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# **Annual Report Fiscal Year 2012**

**Commonwealth of Virginia  
Health Benefits Program**

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# Introduction

## 2012 Highlights

In fiscal year 2012, the state health benefits program approached \$1 billion in total operating expenses. Total costs were up 3.5 percent in fiscal year 2012 compared to the year before, and 6.5 percent higher than in FY 2010. Increased expenses reflected continued growth in outpatient hospital and physician costs, along with a significant increase in catastrophic claims and very high cost specialty prescription drugs. The administrative expense portion, which had declined in 2009 and 2010, rose 3.9 percent in 2012 after a very slight increase in 2011.

To improve overall health and reduce medical expenses, the program continues to focus on wellness and preventive care, financial incentives, weight management and helping members to better control lifestyle-related and chronic illnesses. In FY 2012, the program:

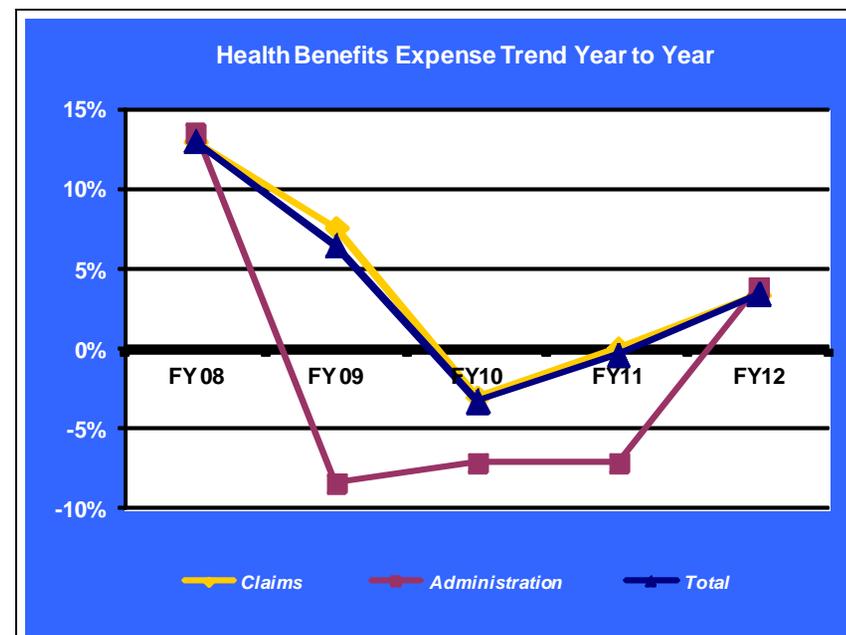
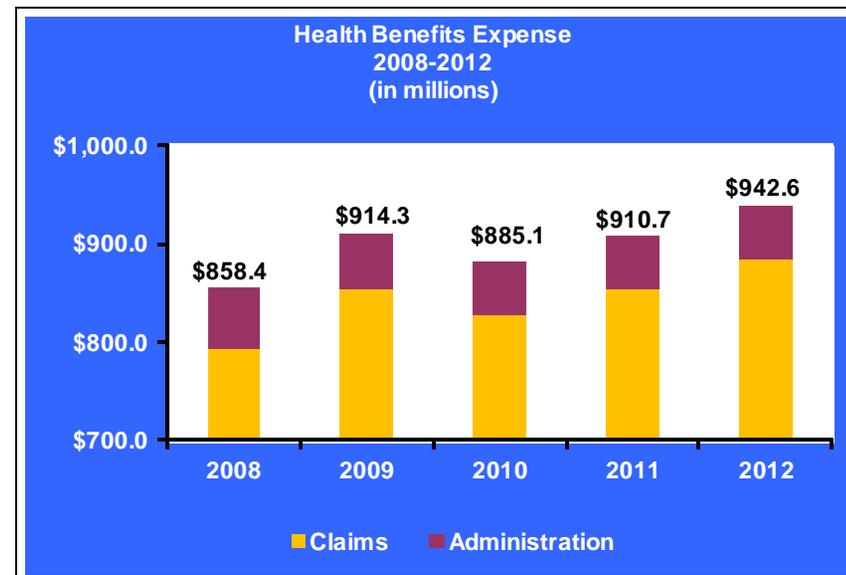
- Continued a successful pre-bariatric surgery education program that has shown a reduction in costs and progress in improving participant health outcomes;
- Offered additional preventive care paid at 100 percent as part of national Affordable Care Act (ACA) implementation; and
- Introduced a diabetes management pilot program for COVA Connect which has reduced emergency room use and helped increase medication compliance.

Also in 2012, the state program:

- Implemented other provisions of ACA, including coverage for 2,217 dependents from ages 23 to 26 and changes to the medical appeals and claims process;
- Added a TRICARE voluntary supplement for military retirees as mandated by the General Assembly; and
- Continued to offer under the Public Private Education Act (PPEA) the COVA Connect plan in Hampton Roads as a pilot to try to improve member health outcomes and reduce overall health care costs.

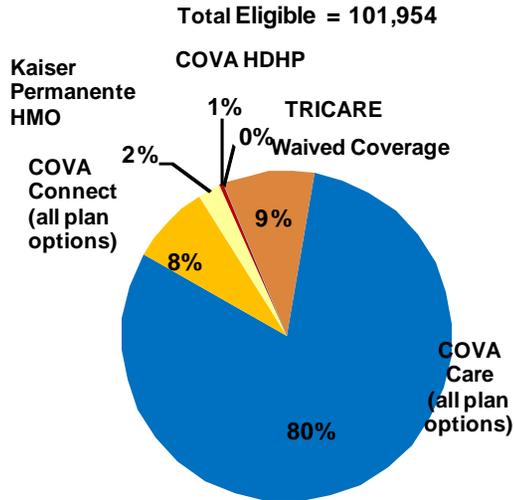
This report presents a financial overview of the state's self-insured health benefits plans, and where indicated, the regional, fully insured Kaiser Permanente HMO plan offered primarily in Northern Virginia. Unless otherwise indicated, this report is based on the experience of health plan members, including the active employee and non-Medicare eligible retiree group, during fiscal year 2012 from July 1, 2011 through June 30, 2012.

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. Anthem administered all COVA HDHP benefits. For COVA Connect, medical, prescription drug and behavioral health benefits were administered by Optima Health; and Delta Dental administered dental benefits. For all plans, flexible benefits were administered by WageWorks.



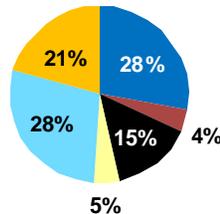
# Plan Enrollment and Premiums

**Health Plan Enrollment FY 2012**

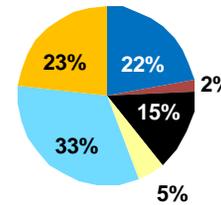


**Health Plan Enrollment By Plan FY 2012**

**COVA Care**



**COVA Connect**



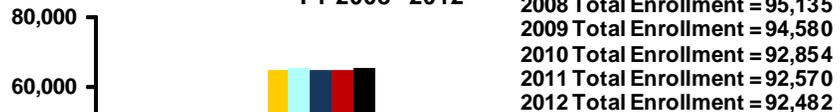
- Basic
- With Out-of-Network
- With Expanded Dental
- With Out-of-Network and Expanded Dental
- With Vision, Hearing and Expanded Dental
- With Vision, Hearing, Expanded Dental and Out-of-Network

Total overall enrollment in the state health benefits program declined 1 percent in fiscal year 2012 from the previous year, driven primarily by state workforce reductions. In both fiscal years 2011 and 2012, 80 percent of members were enrolled in COVA Care, followed by the COVA Connect plan with 8 percent. The Kaiser Permanente HMO's enrollment was stable. Similar to 2011, about 9,200 or 9 percent of members waived coverage in the program during 2012. A survey of 5,650 waived employees showed that of those disclosing their status, 91 percent had other coverage.

Most employees signed up for additional coverage options in 2012, with 48 percent of employees opting for the two buy-ups with the most coverage.

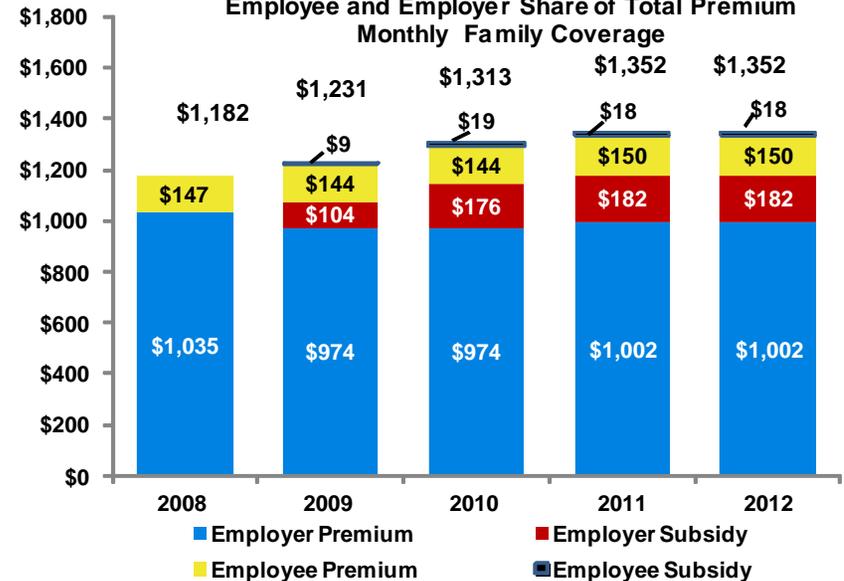
The plan pays a monthly premium per employee to fund the cost of program claims expense and administration. On average, the state pays 88 percent of state employee health care premiums, while the employee pays 12 percent. Employees pay the basic premium and the total cost for additional coverage options. From 2009 to 2012, the state implemented an employer and employee premium subsidy because of tight budget years. In 2012, program reserves continued to absorb part of employee and employer premium expenses.

**Health Plan Enrollment FY 2008 - 2012**



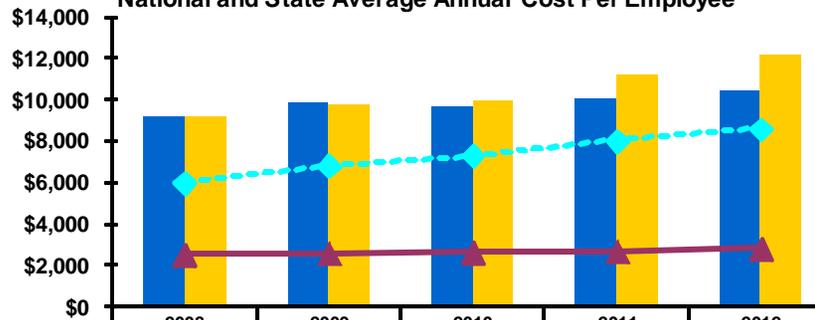
	COVA Care/COVA Connect Basic	COVA Care/COVA Connect Options	Kaiser Permanente HMO	COVA HDHP	TRICARE
FY2008	27,942	64,610	2,074	509	0
FY2009	26,429	65,512	2,104	535	0
FY2010	25,213	65,005	2,127	509	0
FY2011	24,745	65,111	2,207	507	0
FY2012	24,297	65,353	2,202	589	41

**Employee and Employer Share of Total Premium Monthly Family Coverage**



# Cost of Coverage

National and State Average Annual Cost Per Employee



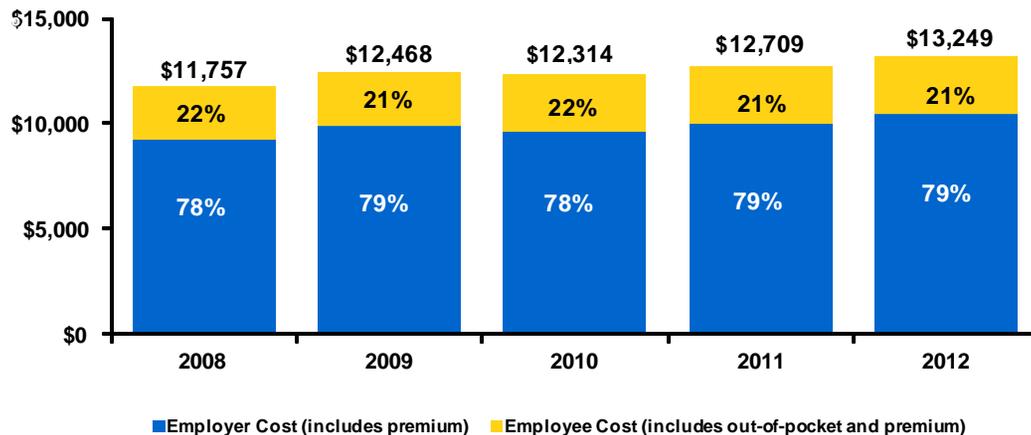
	2008	2009	2010	2011	2012
State Employer Cost Per Employee	\$9,224	\$9,889	\$9,656	\$10,043	\$10,431
National Large Government Employer Cost Per Employee	\$9,226	\$9,779	\$9,996	\$11,251	\$12,144*
State Employee Cost	\$2,533	\$2,580	\$2,658	\$2,666	\$2,818
National Average Employee Cost	\$6,000	\$6,820	\$7,330	\$8,008	\$8,584*

\*Projected for 2012 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 \$12,144 in calendar year 2012. The state health benefits program's annual employer cost per employee in fiscal year 2012 was \$10,431. While the state cost increased 4 percent from the previous year, it was 14 percent lower than the national projection. The COVA Care plan's cost per employee was \$10,431 or a 6 percent increase from 2011, while COVA Connect's cost per employee was \$10,430, or 10 percent higher than the year before. The increase in COVA Connect's expense was due in part to higher physician costs for emergency room, skilled nursing, ancillary and other services.

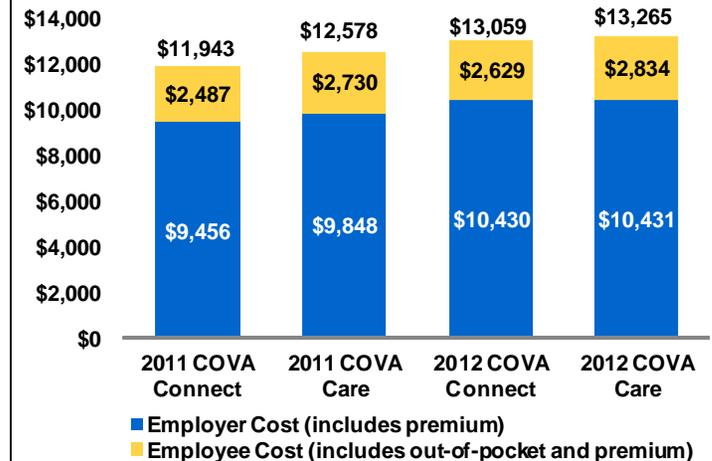
Higher medical outpatient facility and physician costs, catastrophic claims expense and prescription drug costs continued to be significant factors in the overall increase for 2012. Administrative expenses also continued to grow. The plan paid 79 percent of the annual total health benefits cost, and the employee 21 percent, the same as during the prior year. Employees' share of the total cost, including premiums, deductibles, copayments and coinsurance, increased almost 6 percent from 2011. Total health benefits cost per employee rose 4 percent compared to the previous year.

Total State Health Benefits Cost Per Employee\*



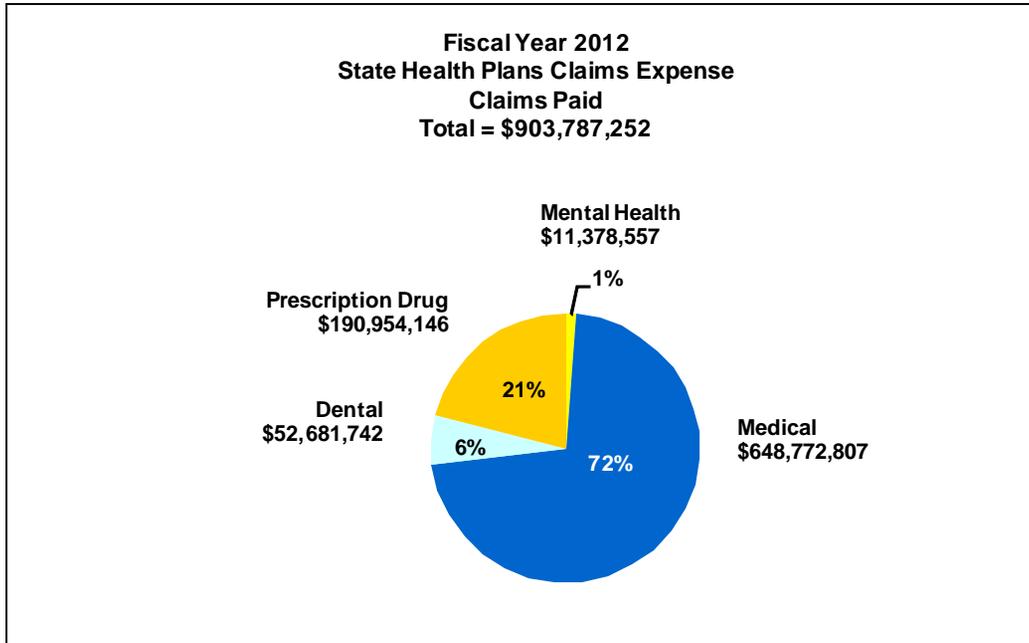
\*Employee contribution to premium varies by dependent coverage. In general, premium represents 12 percent of total employee cost.

State Cost Per Employee Per Plan  
COVA Care and COVA Connect\*



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

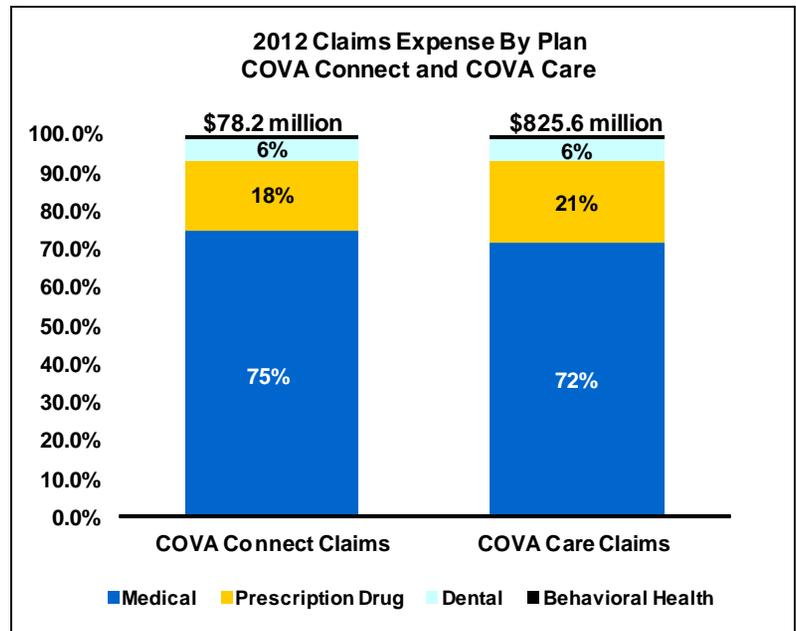
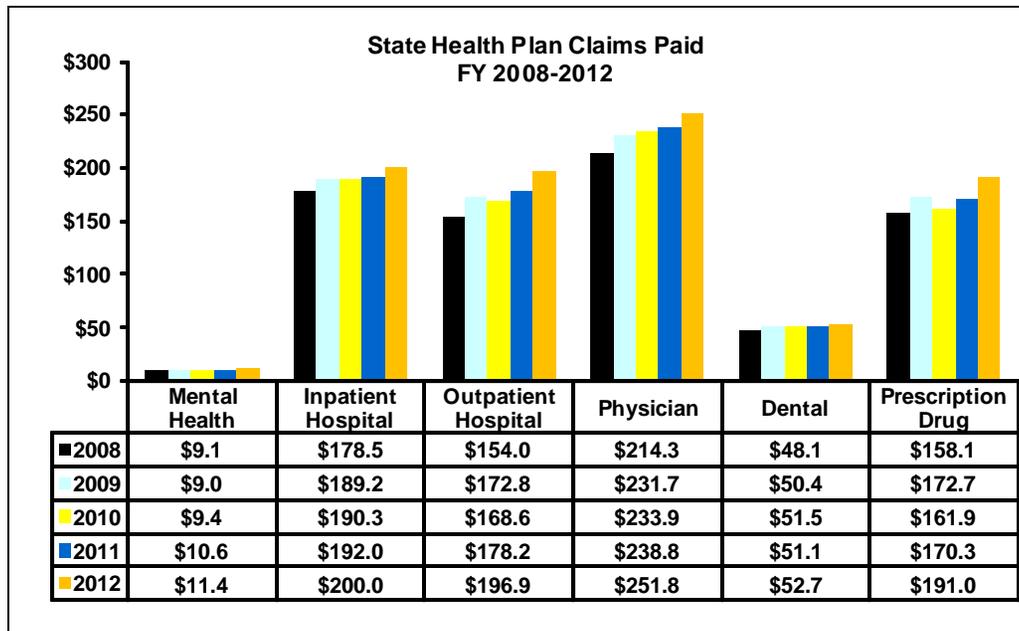
# Claims Expense



Approximately 6.7 million claims were processed for the self-insured state plans in FY 2012, slightly less than the 6.8 million claims for the previous year. Even though the program had fewer claims, total expense increased, due in part to lower plan utilization and higher administrative expenses. Fifty-eight percent of claims were medical, accounting for 72 percent of total plan claims expense.

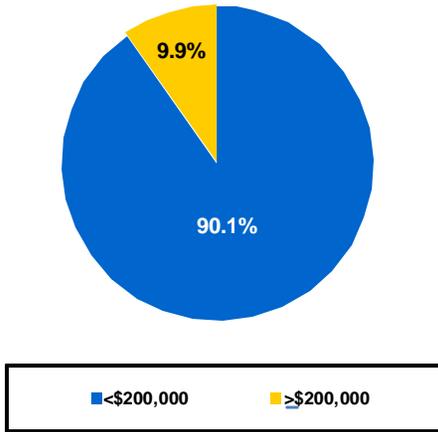
Anthem, Medco, Delta Dental and ValueOptions processed 6.3 million claims in FY 2012 for COVA Care. An average of 82,300 employees and early retirees used the plan. Medical expenses were 72 percent and prescription drugs were 21 percent of total claims costs.

Optima Health and Delta Dental processed 432,300 claims for the COVA Connect plan in FY 2012. An average of nearly 8,100 employees and early retirees used the plan during the year. Medical expense represented 75 percent and prescription drugs claims accounted for 18 percent of total claims expense.



# Medical Benefits

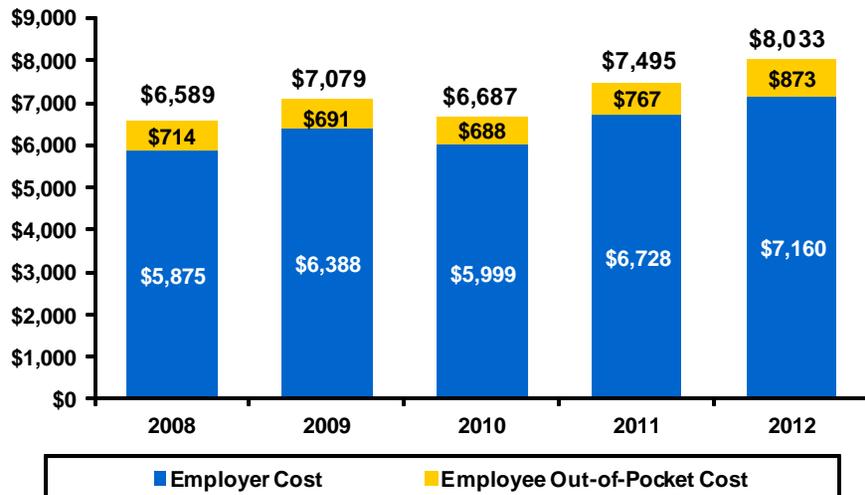
**2012 High Cost Claims Expense**  
Total = \$64.4 Million



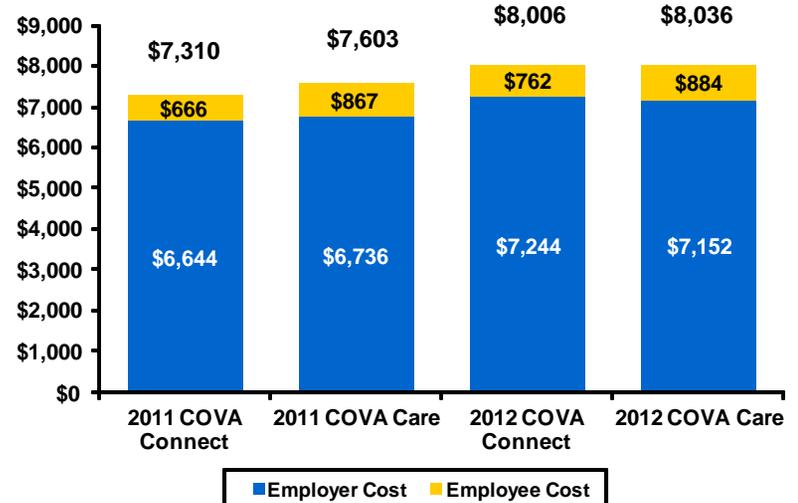
Total medical inpatient and outpatient facility and physician costs increased 6.5 percent in 2012, to \$648.8 million from \$609.1 million in 2011. The two largest components of medical costs were outpatient hospital costs and inpatient catastrophic claims, which increased 10.1 percent to \$261 million from \$237 million the previous year. Inpatient claims increased 4 percent. Physician costs rose 5.4 percent, to \$251.7 million from \$238.8 million in the prior period. In order to reduce overall medical costs, care has shifted to outpatient services which in general are less expensive than inpatient procedures.

While outpatient hospital expense increased significantly, outpatient visits per thousand members declined 1.3 percent, to 1,199 per thousand visits from the 1,215 per thousand in 2011. Catastrophic claims, which are claims greater than \$200,000, totaled \$64.4 million in 2012, up 10.1 percent over the \$58.5 million cost in 2011. These claims were driven primarily by treatment for cancer and conditions related to heart disease. The state plan paid approximately 89 percent of total medical benefits cost in 2012, down 1 percent from the amount paid in the previous year. This cost was transferred to employees, who paid 1 percent more, or 11 percent. COVA Connect had lower medical employee cost than COVA Care, due in part to demographic and socioeconomic factors, and negotiated discounts.

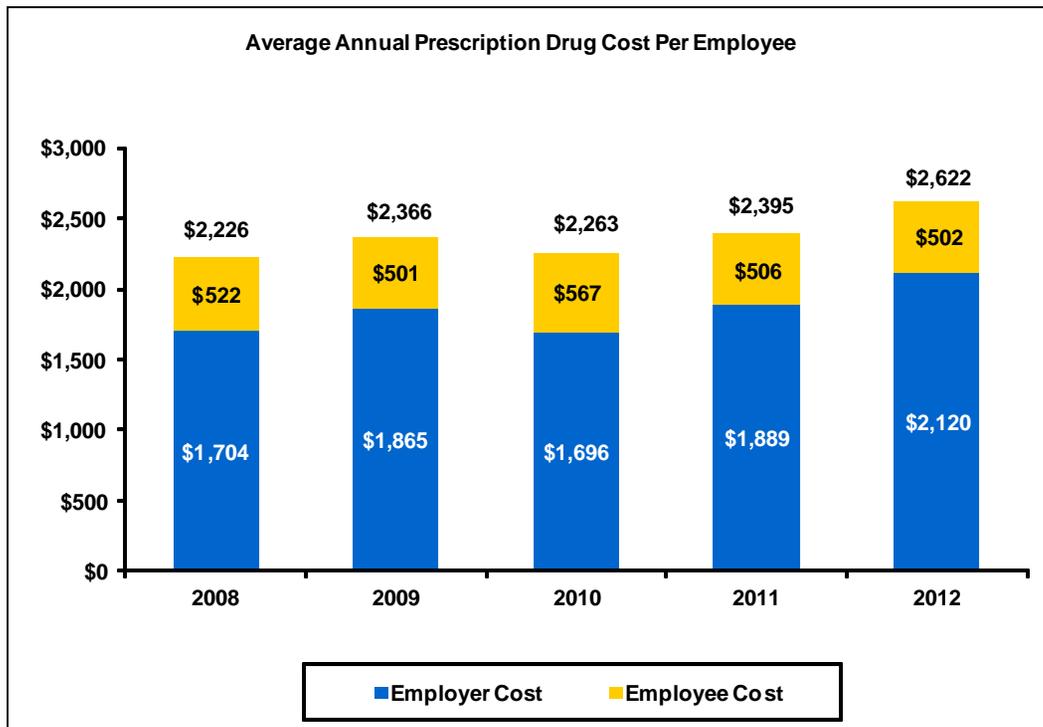
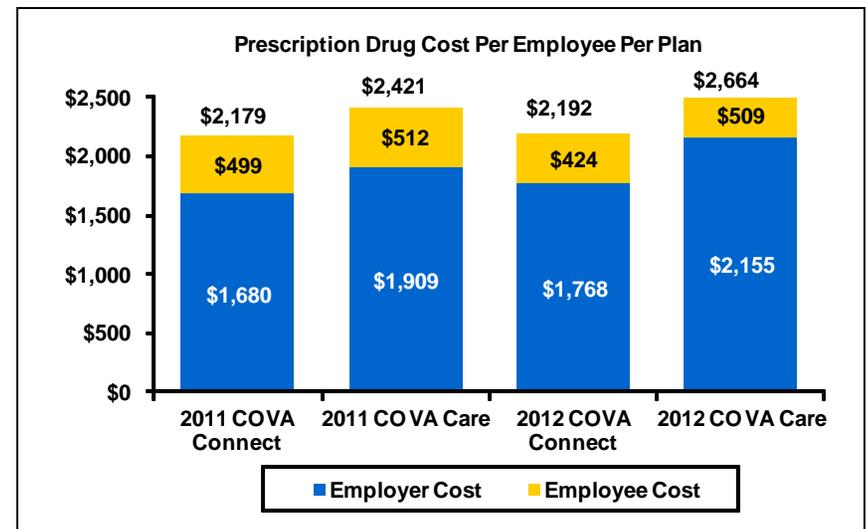
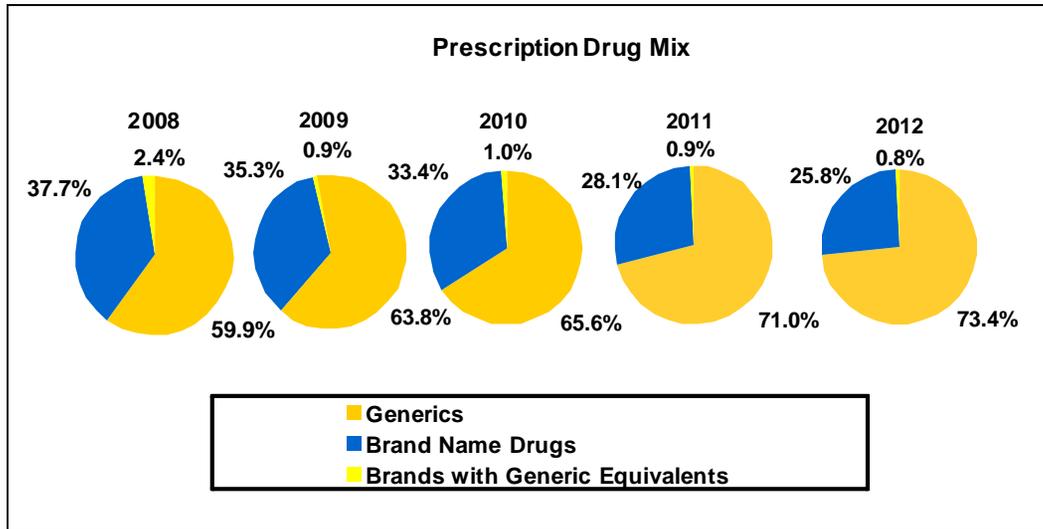
**Total Medical Benefits Cost Per Employee**



**Medical Expense Per Plan**  
COVA Care and COVA Connect



# Prescription Drugs

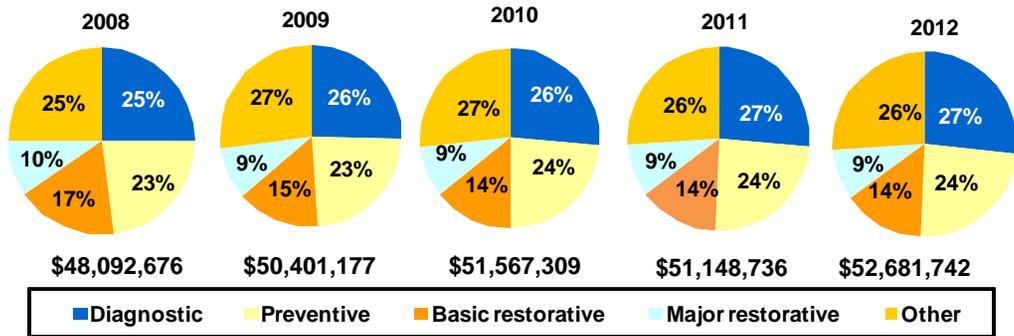


Total prescription drug costs for the state program were up 12 percent from 2011 to 2012. The number of members using higher-cost specialty drugs increased, fewer members used the less expensive mail service for routine medications, and inflation remained a major driver of trend. A significant factor in inflation were manufacturer price increases as brand drugs approached patent expiration, and brand drug coupons offered to encourage use of brand-name products. 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. COVA Connect employee costs for prescription drugs were less than for COVA Care, driven in part by demographic and socioeconomic factors, negotiated discounts and more veterans in the population using other sources.

The generic drug portion of the prescription drug mix increased 2.4 percent from 2011, to 73.4 percent. Drug patents continued to expire on many highly utilized brand name drugs, such as Lipitor and Plavix, which helped to drive up the generic drug utilization rate. More than 9,800 prescriptions were filled for very high-cost specialty drugs, representing 21.7 percent of the state plan's drug cost for 2012, up 2.5 percent from 2011. Specialty drug costs were up 27 percent in 2012, to \$38.4 million from \$30.2 million the prior year. Health plan members' share of total annual prescription drug costs fell 2 percent, to 19 percent from 21 percent the previous year.

# Dental Benefits

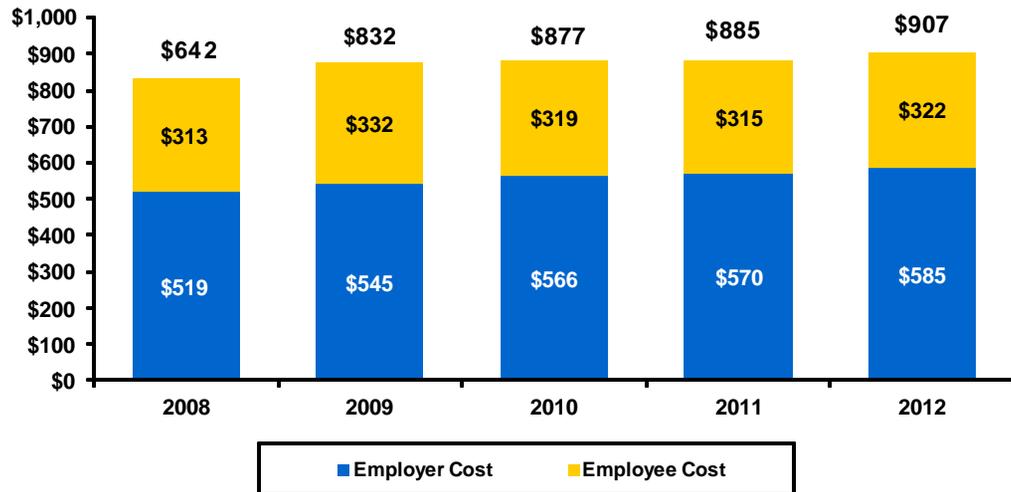
Dental Expense by Category



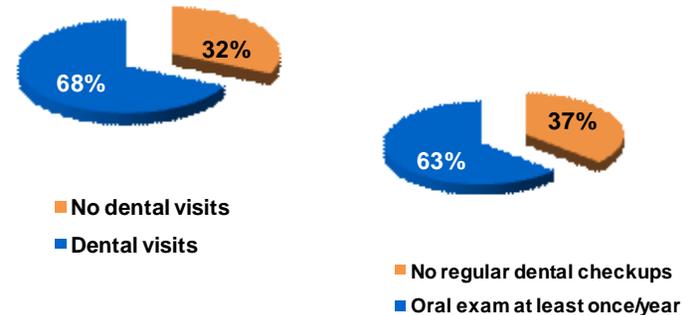
Dental claim costs were up 3 percent for the state program in 2012, due in part to higher claims paid per employee. Dental benefits continue to represent only 6 percent of total claims expense and are provided at a moderate cost to employees. About 366,000 dental claims were processed in 2012, up 1 percent from 363,000 the prior year. The plan pays 100 percent for preventive and diagnostic services, which accounted in 2012 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. The number who do not have regular dental check-ups declined 1 percent in 2012, to 37 percent. 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. Efforts continue to increase member engagement.

Annual Dental Cost Per Employee

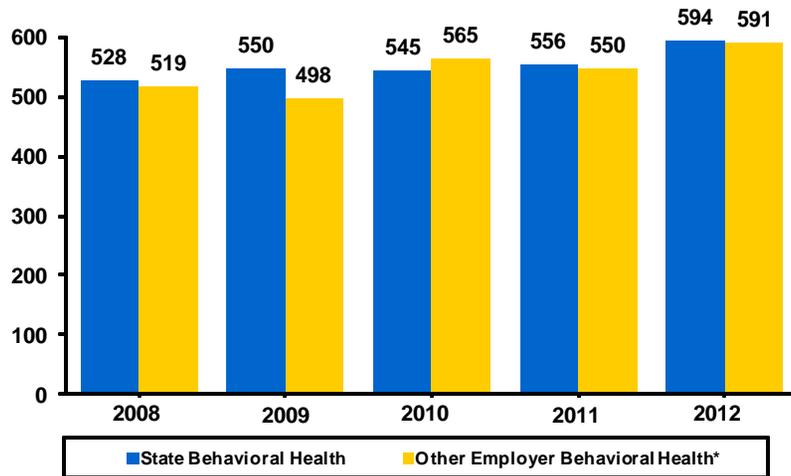


2012 Dental Care State Plan Members Dental Visits



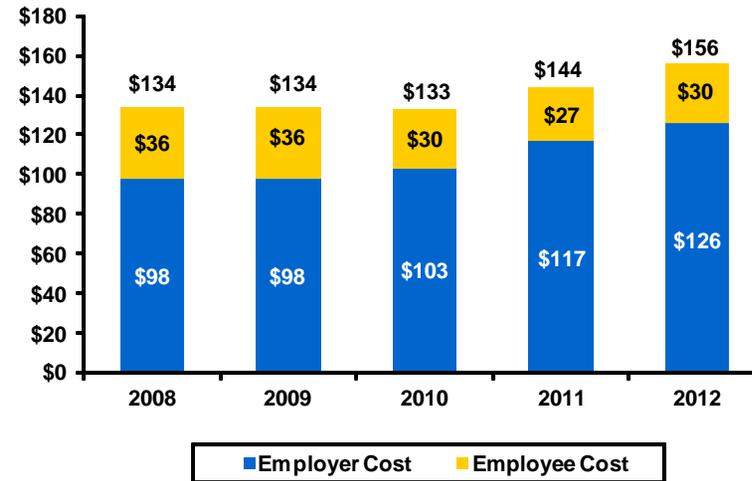
# Behavioral Health

Total Behavioral Health Outpatient Visits/1,000 Members

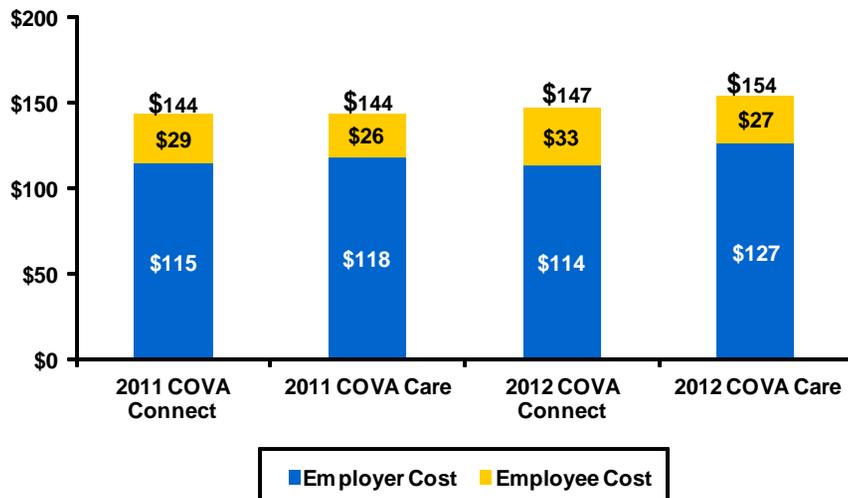


\*Other employers with ValueOptions and Optima Health behavioral health benefits

Total Annual Behavioral Health Expense Per Employee



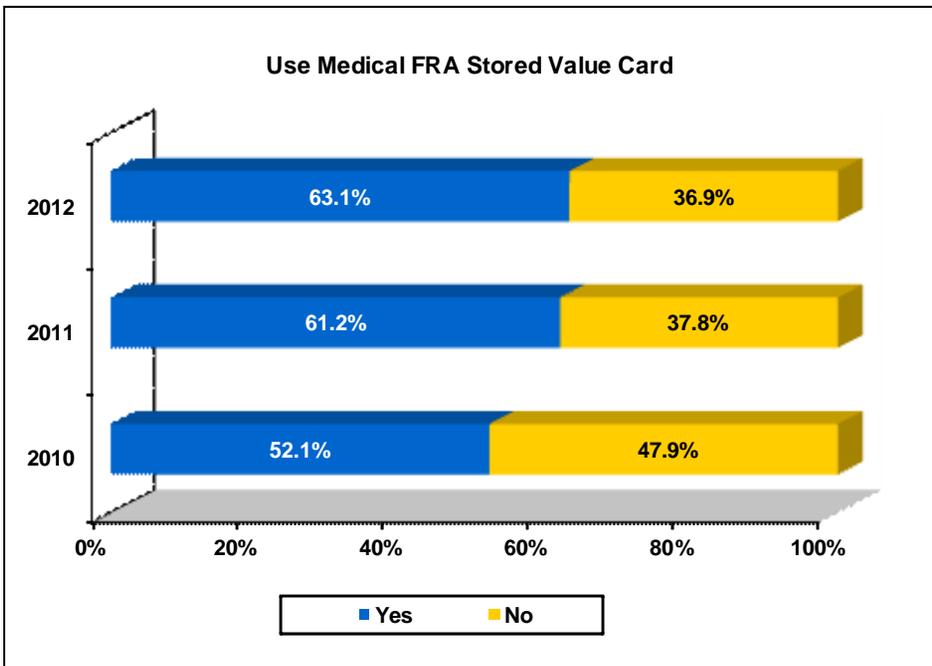
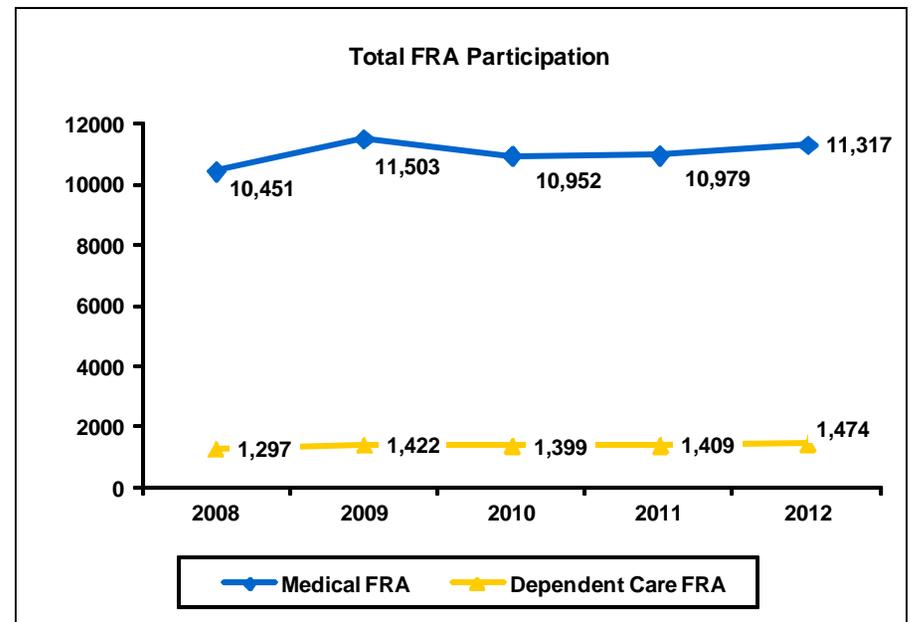
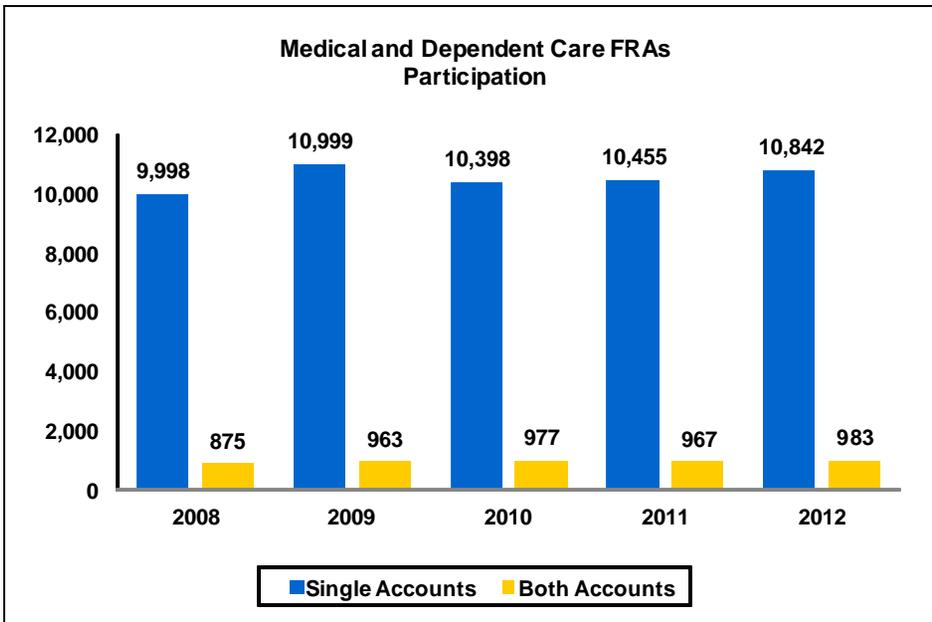
Behavioral Health Cost Per Employee Per Plan  
COVA Care and COVA Connect



About 7 percent of those enrolled in the health plan have used the behavioral health benefit in the past two years. Three quarters 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 7.5 percent to \$11.4 million in 2012 from \$10.6 million in 2011. Cost increases were seen across all levels of care. Higher cost members grew by 7 percent in 2012, and represented 15.4 percent of total claims paid in 2012 compared to 14 percent the year before. Fifty-five percent of claims expense was for outpatient services, 34 percent for inpatient treatment, and 10 percent for alternative levels of care. Employee cost for services has declined since 2010, when the copayment for non-medical specialists, such as psychologists, was reduced to \$25 from \$35.

The Employee Assistance Program (EAP) handled almost 4,500 total cases in 2012, up 2 percent from 4,400 cases in 2011. The annualized 5 percent utilization rate in 2012 remained above the 4.4 percent national utilization rate. Of members who used the EAP, 78 percent sought services for relationship and job concerns, and 22 percent for emotional issues such as depression, anxiety and drug abuse. Use of legal and financial services declined 22 percent to 435 cases from the previous high of 560 cases in 2011. The primary reasons for using legal and financial services were domestic relations at 36 percent, civil matters at 11.5 percent, and criminal and debt management at 6.5 percent.

# Flexible Reimbursement Accounts



A flexible reimbursement account (FRA) allows employees to set aside part of their income before taxes to pay for certain health or day care expenses not covered by the plan. 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 about 3 percent in 2012, after lackluster growth or a decline in prior years. Dependent care accounts increased almost 5 percent and are up nearly 14 percent compared to 2008. 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.

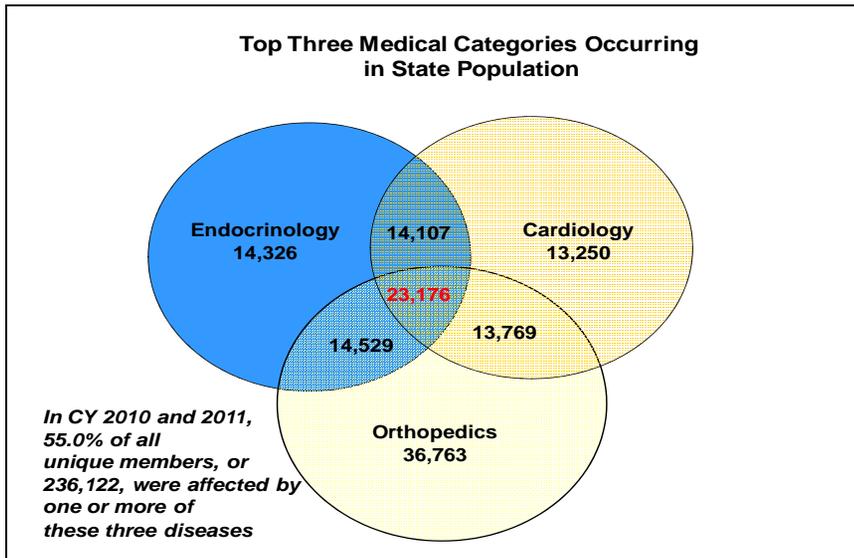
Since 2008, Medical FRA participants have had the option of using a stored value card, similar to a debit card, to pay for eligible expenses at the point of service. Use of the card has grown 21 percent since its introduction, and 81 percent of users enjoy its convenience. National health reform continues to have an impact on medical flexible benefits. In 2011, a provision of the ACA eliminated reimbursement of over-the-counter drugs using a Medical FRA. Next year the legislation limits to \$2,500 the total contribution allowed for Medical FRAs, reducing by half the state plan's current \$5,000 maximum.

# 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 state 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 \$533 million, or 59 percent, of state plan expenses during 2012 came from claims for the top ten medical procedures, chronic conditions and prescription drugs. Total expense in these areas declined 10.4 percent from the previous year, in part because of a number of brand name drugs that are now available as generics. 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.

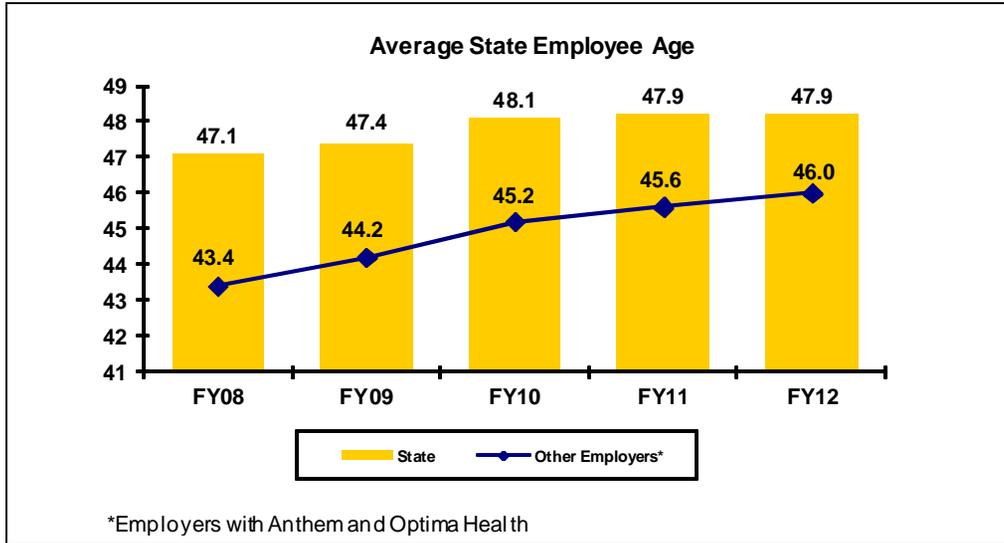
Three of the top four medical conditions occurring among state employees are related to lifestyle. Smoking and overeating contribute to diabetes, heart disease, arthritis and other musculoskeletal issues. The treatment categories for these four conditions are endocrinology, cardiology and orthopedics, which cost the state program more than \$162 million in 2012, up about 4 percent from \$156 million in 2011.



“Top Ten” Claims Expense		
Medical Procedures	Chronic Conditions	Prescription Drugs
1. Musculoskeletal	1. Coronary artery disease	1. <i>Nexium</i> (stomach acid)
2. Neoplasms (tumors)	2. Breast cancer	2. <i>Enbrel</i> (rheumatoid arthritis)
3. V-Codes (health services not classified as disease or injury)	3. Cerebrovascular disease	3. <i>Humira</i> (rheumatoid arthritis)
4. Circulatory	4. Diabetes	4. <i>Crestor</i> (high cholesterol)
5. Ill-defined symptoms (undetermined causes)	5. Hypertension	5. <i>Singulair</i> (asthma/allergy)
6. Digestive	6. Lung cancer	6. <i>Cymbalta</i> (depression)
7. Genitourinary	7. Skin cancer	7. <i>Copaxone</i> (multiple sclerosis)
8. Accidental injury	8. Obesity	8. <i>Atorvastatin Calcium</i> (high cholesterol)
9. Nervous system/sense organs	9. Oral cancer	9. <i>Lipitor</i> (high cholesterol)
10. Respiratory	10. Substance abuse	10. <i>Ambly</i> (depression)
<b>47.3% of All Claims Expense</b>	<b>6.7% of All Claims Expense</b>	<b>5.0% of All Claims Expense</b>

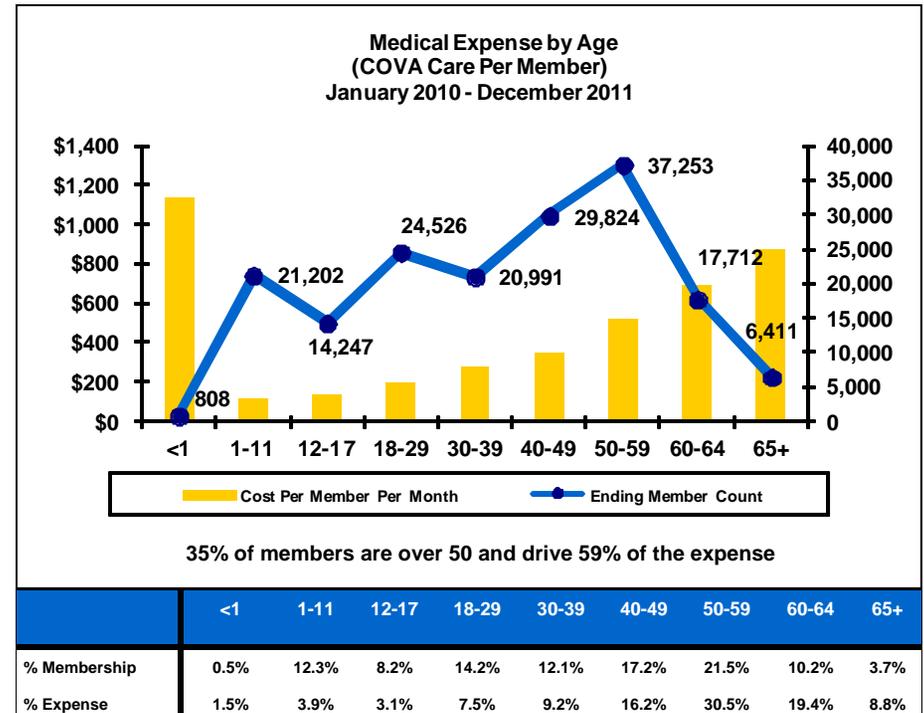
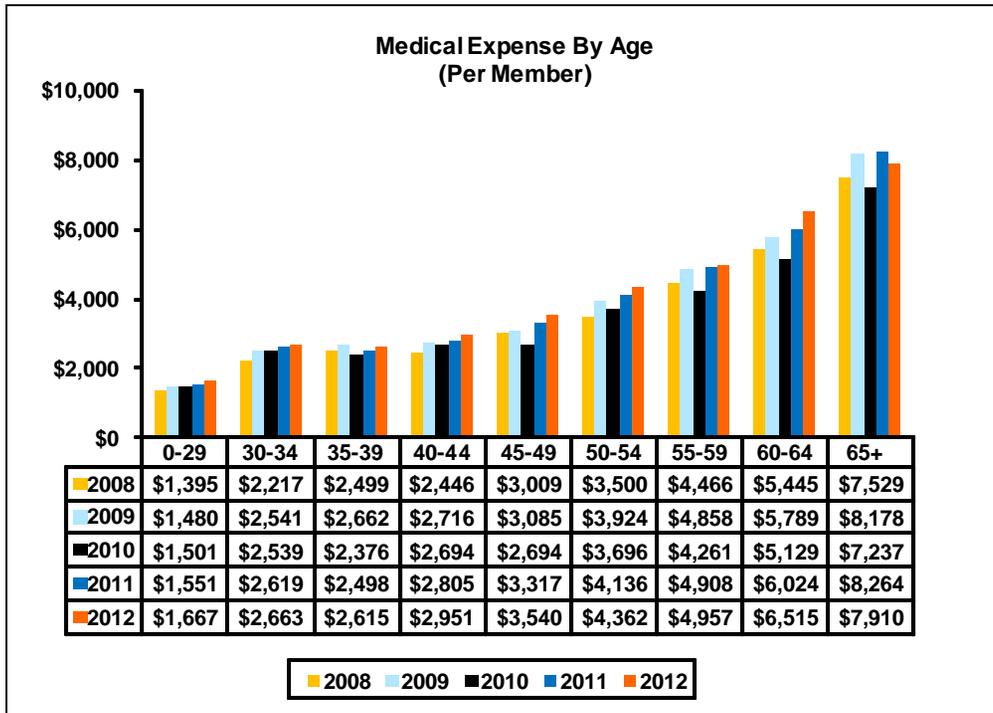
*Note: These areas may not be mutually exclusive*

# Cost Drivers: An Aging Population



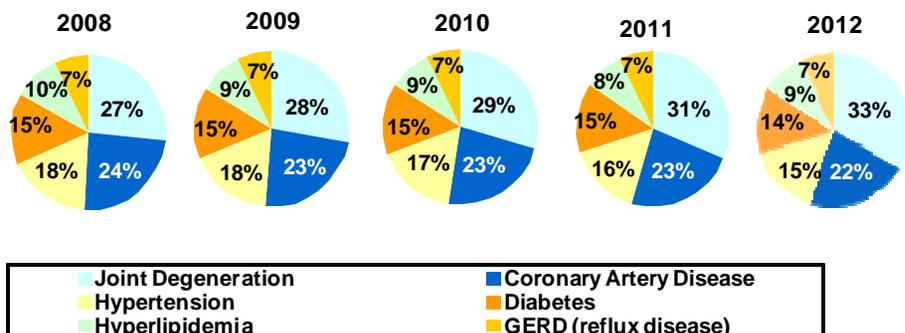
State employees on average are older than their counterparts in the private sector. According to the American Medical Association, many diseases correlate with an aging population. As people age, they are more likely to develop chronic conditions such as high cholesterol, high blood pressure, heart disease and diabetes.

An age gap continued in 2012 between the state workforce enrolled in the health benefits program, with an average age of 47.9, and employees at other employers, whose average age was 46.0. 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 COVA Care and 40 percent of COVA Connect health plan members in calendar year 2011. This age group was responsible for 59 percent of COVA Care and 61 percent of COVA Connect total plan medical expenses.



# Lifestyle Influences

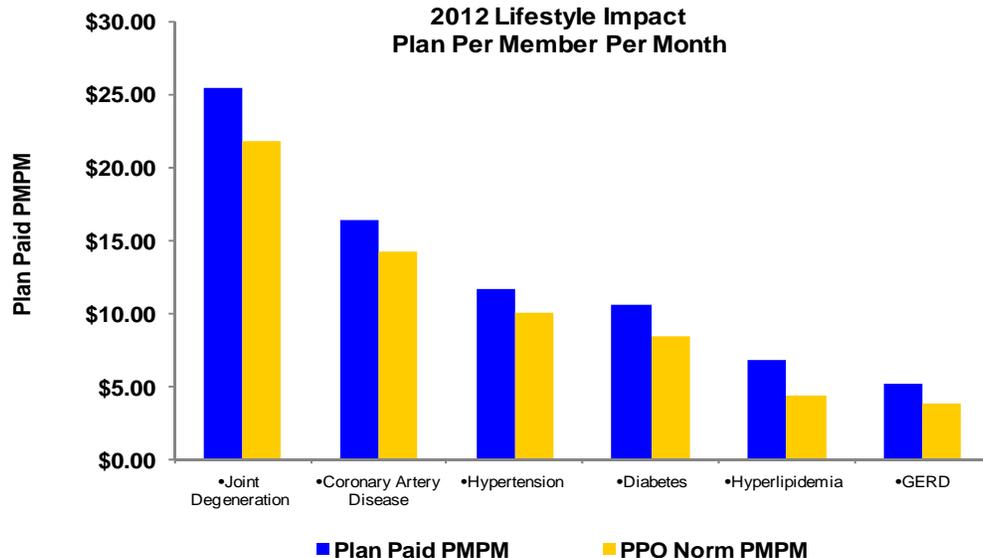
Lifestyle Related Claims



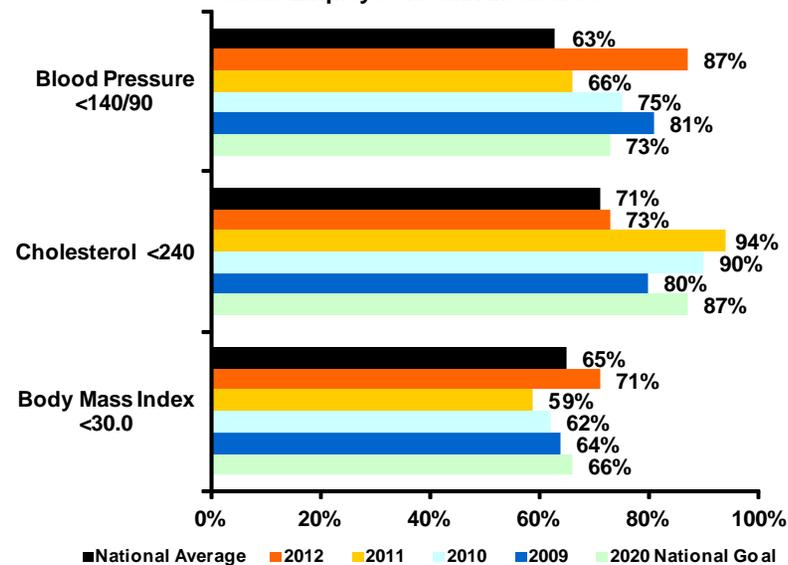
According to the National Institutes of Health, more than two-thirds of American adults and one in three children are overweight or obese. Six conditions that correlate with being overweight represented more than \$164 million, or 24.2 percent, of the state plans' total medical expense in 2012.

About 5,145 employees in 2011 and 6,234 in 2012 took part in health screenings through the CommonHealth wellness program. The group was better than the national average in normal cholesterol and blood pressure levels. It also showed that fewer employees in the 2012 group were seriously overweight or obese than in the 2011 group. Among the screened state population in 2012, 29 percent showed a body mass index of 30 or more compared to 41 percent the year before. This year's statistic is 6 percent lower than the national average of 35 percent.

2012 Lifestyle Impact  
Plan Per Member Per Month



State Employee Health Measures

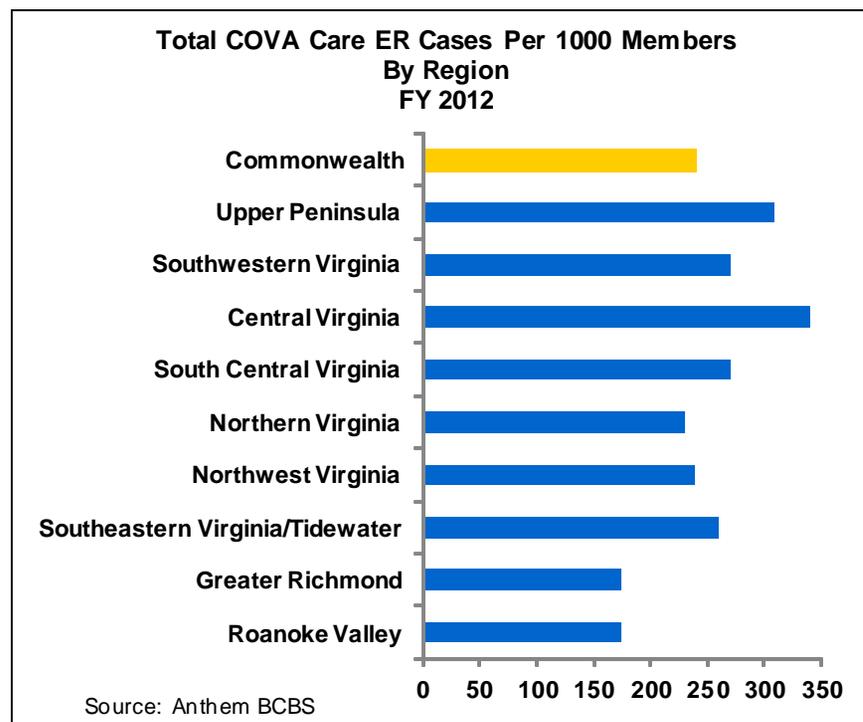
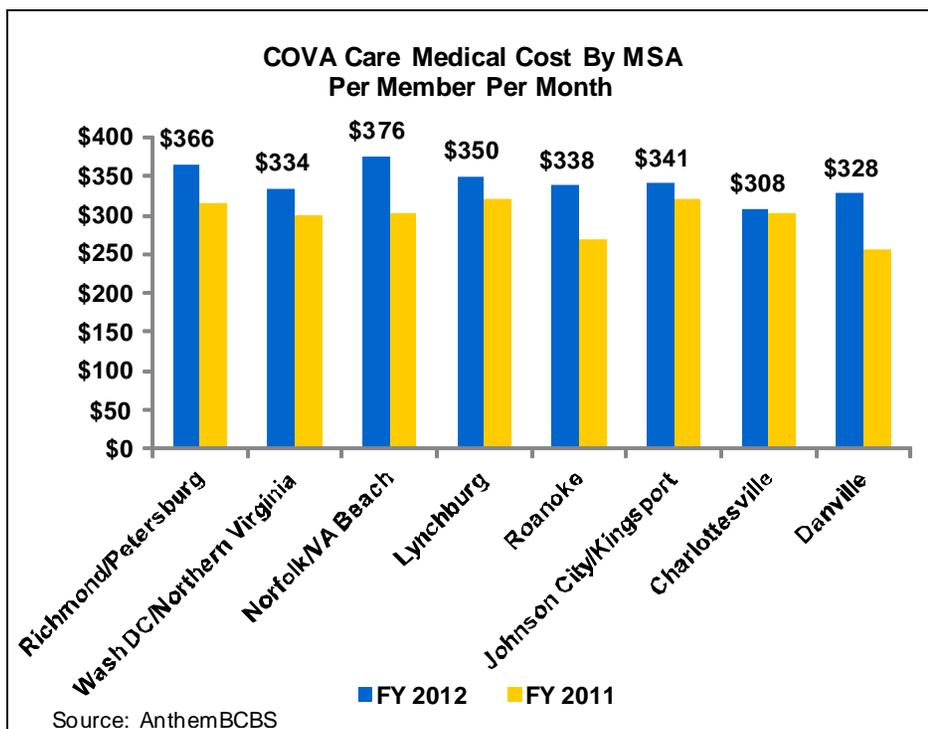


Sources: CommonHealth biennial health checks of select employee groups and Healthy People 2020

# Regional Differences

Another factor contributing to state health benefits program expense is variability in cost and services by regions of the state. The health benefits program is working to control future regional expenses by targeting employee programs and communications to areas with higher medical costs and use of services. For example, COVA Care medical expense per member per month (PMPM) in FY 2012 was 22 percent higher in the Norfolk/Virginia Beach metropolitan statistical area (MSA) than in Charlottesville. Costs may also vary significantly from year to year by region. Roanoke's medical cost PMPM for 2012 was 25 percent higher than the previous year, while Danville's expenses were about 29 percent more than for 2011.

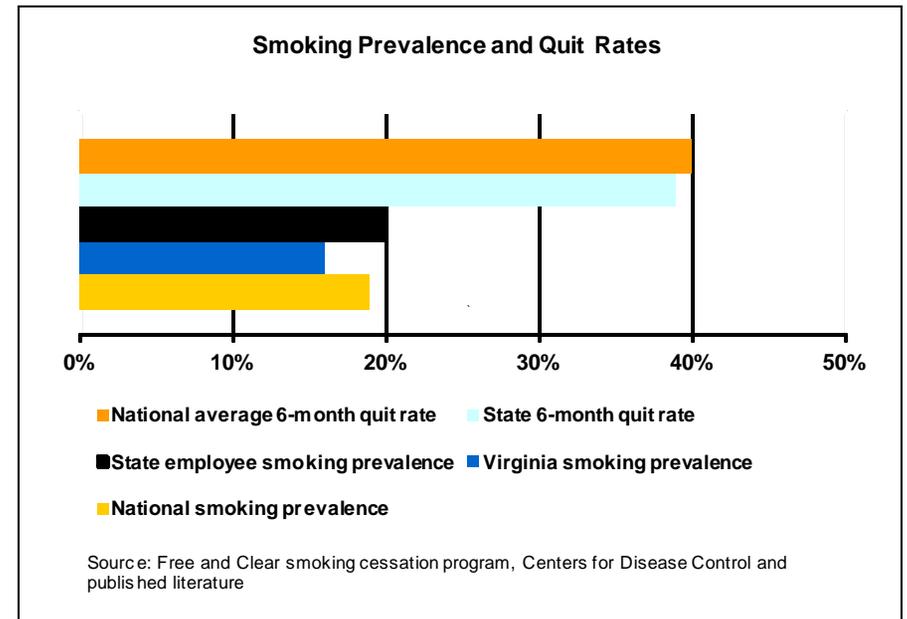
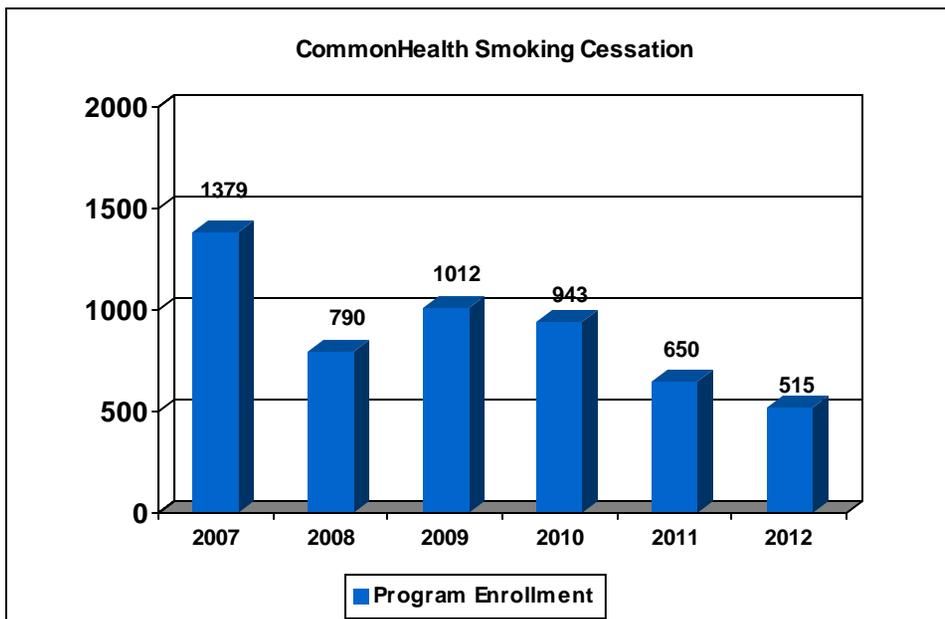
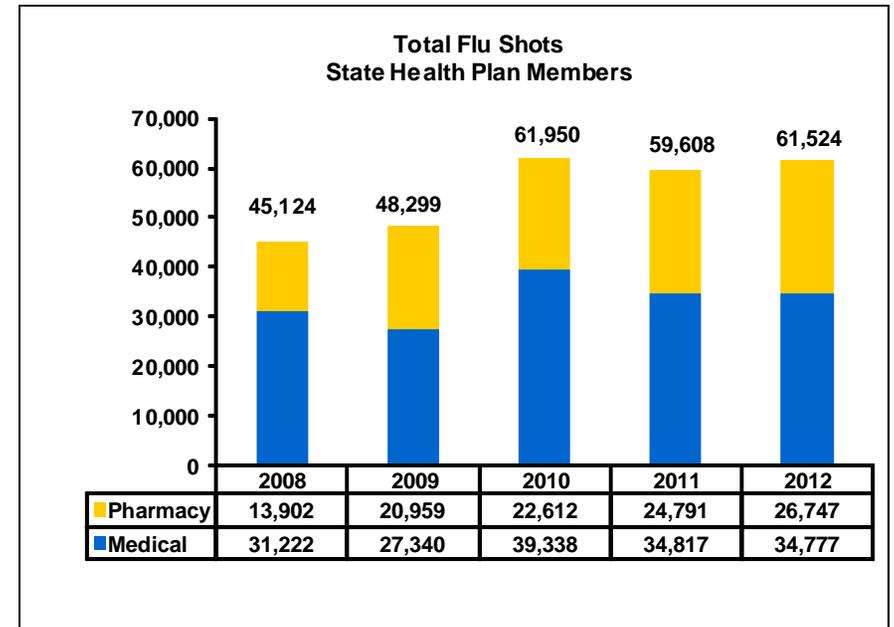
In terms of services, the health benefits program focuses on areas with higher expense trends across the Commonwealth. Use of the emergency room is one example. In 2012, COVA Care members as a whole had approximately 240 emergency room (ER) cases per thousand members. When the state is divided by regions, the differences in number of cases become apparent. For instance, Central Virginia had about 42 percent more emergency room cases than the state did as a whole. On the other hand, Greater Richmond and the Roanoke Valley had about 27 percent fewer emergency room cases than the Commonwealth overall. The program can communicate directly to Central Virginia members that using the emergency room will cost them more than visiting an urgent care center for non-emergency treatment.



# Employee Wellness

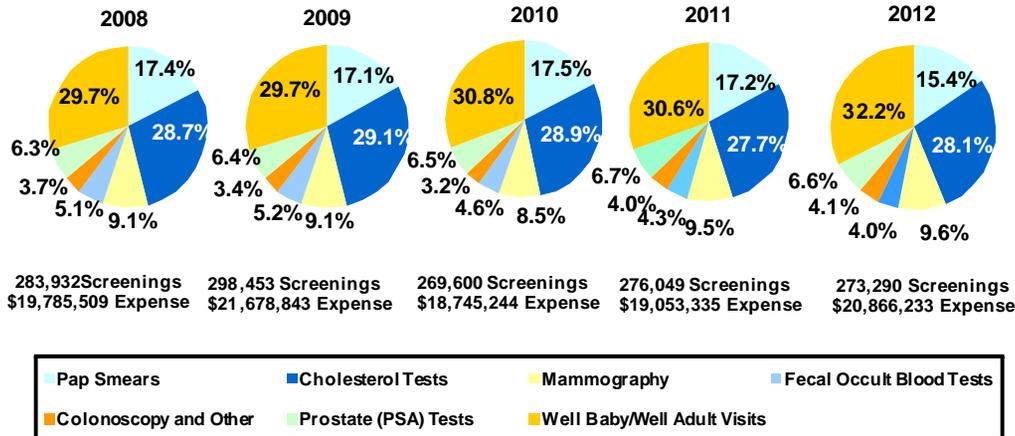
The *CommonHealth* employee wellness program emphasizes the Commonwealth's commitment to help its employees lead healthier lives. The program promotes healthy employee lifestyles and encourages integration of health and physical activity into the work culture. Administration of *CommonHealth* changed 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. Total participation in *CommonHealth* rose 3 percent in 2012 to 24 percent from 21 percent the prior year. The program focused during the year on fitness, nutrition and healthy eating, and ways to prevent distracted driving.

Getting a flu shot is one of the best ways to stay healthy, and the state program offers free flu shots each year. The number of flu shots in 2012 increased 3 percent over 2011, due in part to the option of bringing pharmacy representatives to the workplace to administer the shots. Enrollment in the "Quit for Life" smoking cessation program dropped in 2012 to a 0.37 percent rate from 0.49 percent the year before, yet is still within the national norm of 0.31 percent to 1.55 percent of the total eligible population. The state's quit rate in 2012 was 39 percent compared to 41 percent in 2011, within the national norm of 38 to 41 percent. In addition, more than 1,500 prescriptions for smoking cessation drugs were filled through the state health plan.

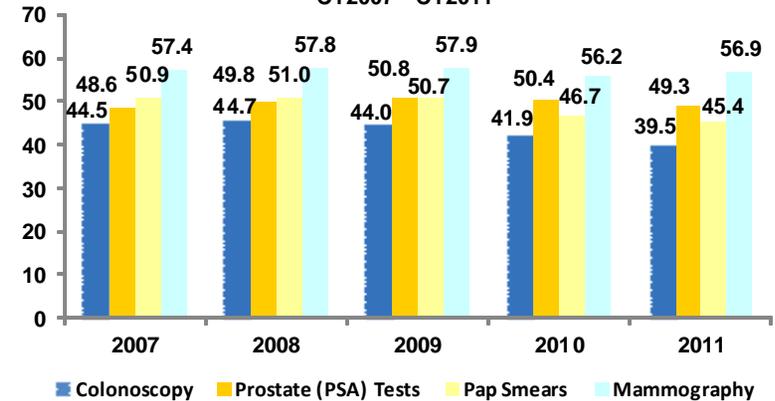


# Preventive Care

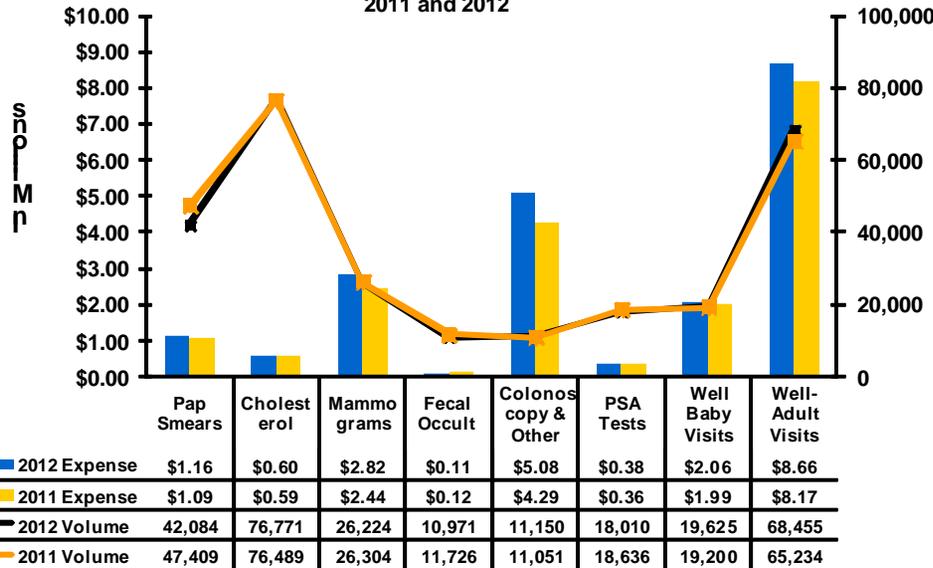
Preventive Screenings



Average Compliance Rates (Percentages) Selected Preventive Screenings CY2007 - CY2011



Preventive Screenings 2011 and 2012



In 2012, 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. The plan also paid 100 percent for additional preventive care measures required under ACA, such as immunizations and screenings for diabetes, aortic aneurysm and cholesterol.

Outpatient wellness visits and preventive screenings in 2012 were about 3 percent of total medical expenses, comparable to the previous year. Baby and adult wellness checkups and cholesterol tests represented 60 percent of total screening volume, compared to 58 percent in 2011. For both years, about one-third of preventive care screenings were pap smears, mammograms and PSA tests.

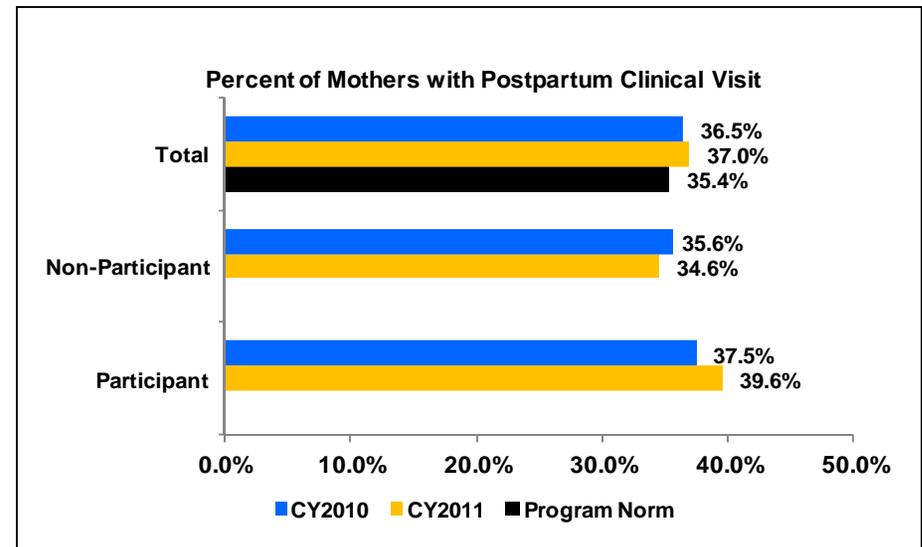
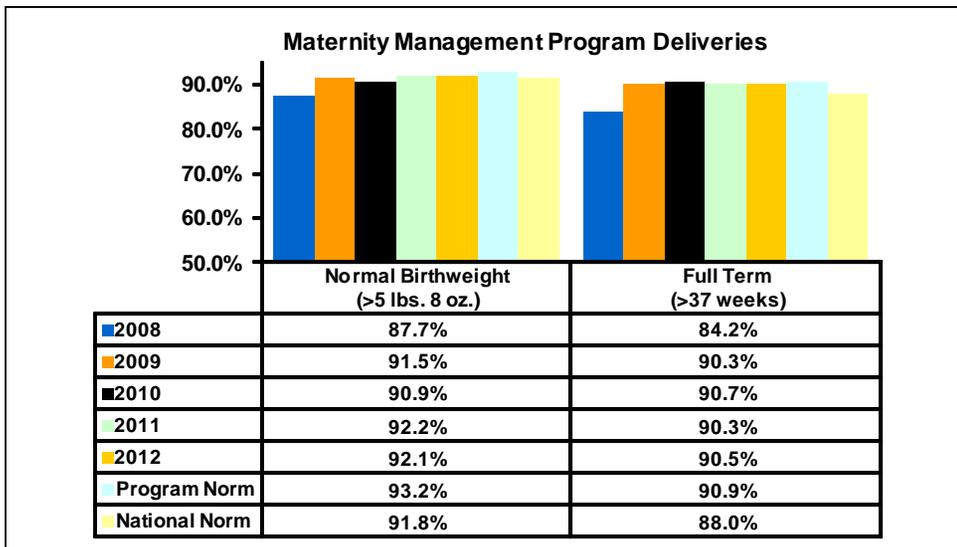
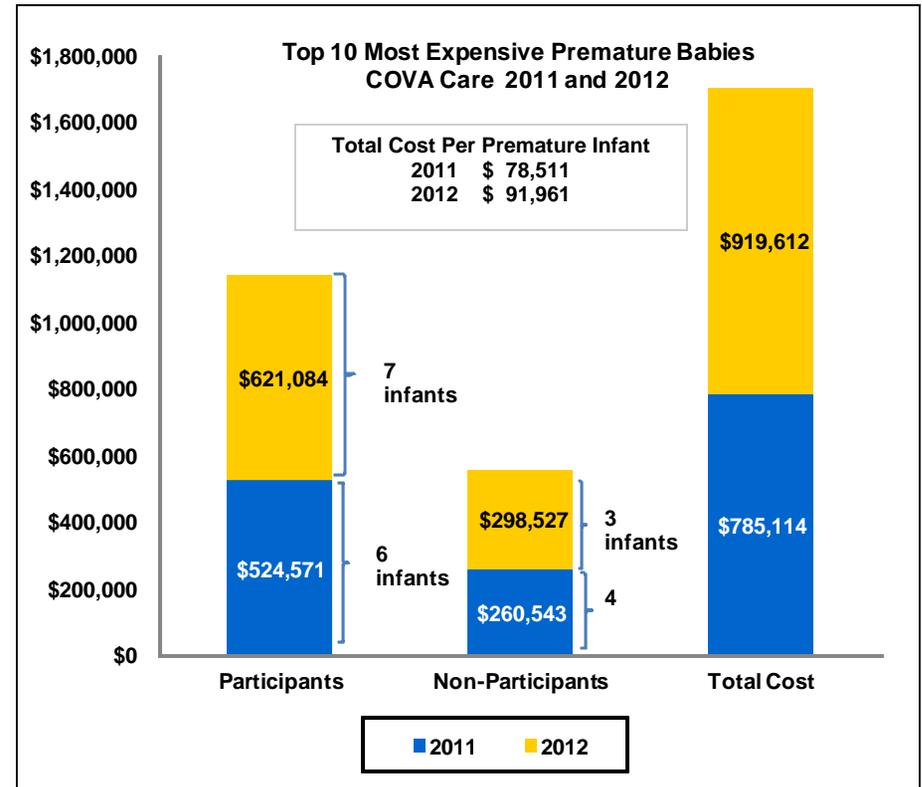
The average screening compliance rate over the past few years has been highest for mammography, at approximately 57 percent of women in the applicable population. The state health benefits program continues to evaluate screening compliance and consider ways to increase preventive screenings.

# Maternity Management

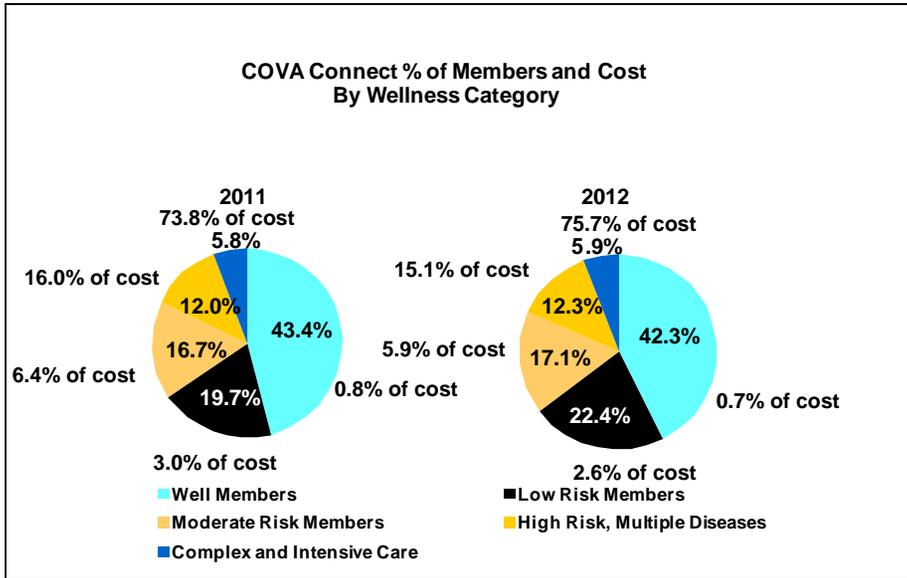
More than 1,600 state plan members delivered babies during 2012. Forty-nine percent of those women participated in the maternity management program, offered to members at no additional cost to help expectant mothers deliver healthy babies. Much of the participation in this program is attributed to an incentive that waives the maternity inpatient copayment for participants who complete the program requirements. More than 90 percent of participants reported full-term deliveries (>=37 weeks) and normal birth weight (>=2500 grams) infants. About 79 percent registered in the first trimester, compared to Anthem's book of business norm of 60 percent.

According to the March of Dimes, about one in every 12 babies in the United States, including Virginia, is born with low birth weight, which plays a major role in a child's overall lifetime health. Special prenatal care during pregnancy can prevent premature birth. Premature babies require expensive medical care at birth and over their lifetimes. There were 129 premature births among plan members in the 2012 fiscal year, up 14 percent from 113 in 2011, and costing over \$3 million in claims. About 60 percent were born to mothers enrolled in maternity management. The two most expensive premature infants had individual claims costs in excess of \$130,000 each.

About 38 percent of maternity management participants in FY 2012 were considered at high risk for pregnancy complications, with weight management the most common risk factor. Participants were much more likely to follow up on their health after pregnancy. In calendar year 2011, 37.5 percent of participants had a postpartum clinical visit compared to 35.6 percent of mothers not enrolled in maternity management.

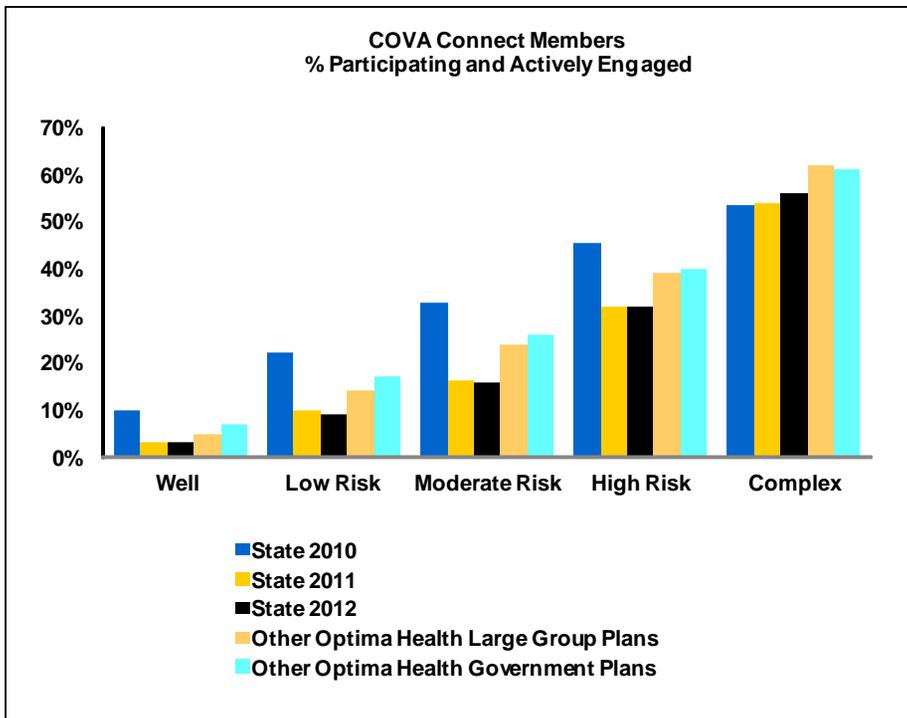


# Public Private Education Act (PPEA) Partnership



In 2012, the Department of Human Resource Management continued the COVA Connect pilot program under the Public Private Education Act (PPEA), passed by the General Assembly 10 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 2012, the well member group declined to 42 percent of the COVA Connect population, 1.5 percent lower than Optima Health's municipal employer plans. The members at the greatest risk for illness made up almost 76 percent of COVA Connect's costs, 2.5 percent higher than Optima's book of business. The predominant risks for the COVA Connect population continue to be cardiac illness, diabetes and respiratory disease. Ideally, the population should have better outcomes. The state program and Optima Health continue to work to address these results.



About 56 percent of the 5.9 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 engagement rate is defined as at least two successful contacts with the member. The state plan's result is lower 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 congestive heart failure at 53.4 percent, three times the rate in 2011. About 2,800 members were actively engaged in disease management during 2012, or 47 percent more than the 1,900 in 2011. The increase is due in part to an up to \$300 incentive paid to members for meeting disease management requirements. Of the 121 subscribers to the disease management incentive program, 104 or 86 percent received the full incentive amount.

Ninety-one members successfully completed an incentive pilot program to encourage better diabetes management and improve medication compliance. These members used the emergency room less often, their claims expense declined, and pharmacy costs rose due to better compliance with medications. In the long term, it is anticipated that these pharmacy cost increases will lead to better health outcomes and reduced medical costs.

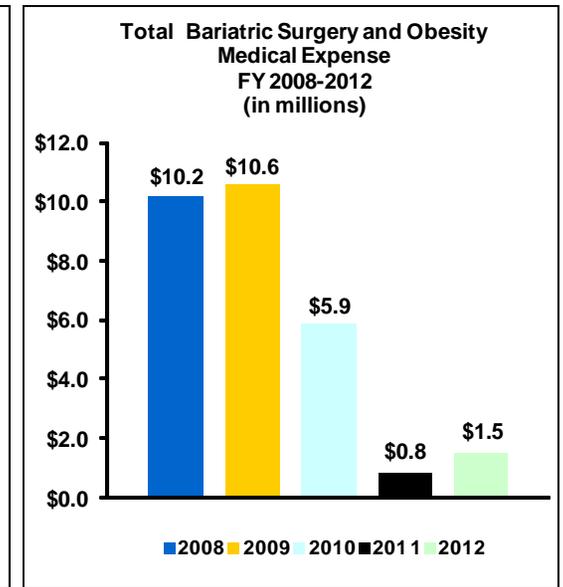
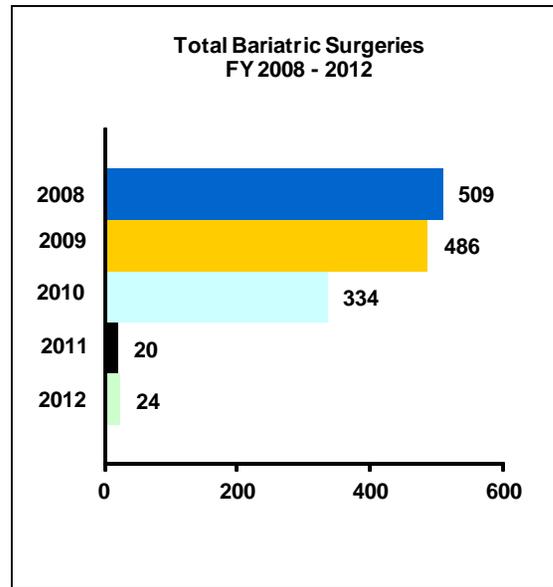
# Pre-Bariatric Surgery Pilot Program

The Commonwealth continues to attract national attention for its gastric bypass pre-surgery education program. A proposal was made during the 2009 legislative session as part of plan funding issues to eliminate coverage for gastric bypass surgery. As an alternative, the General Assembly agreed to a new progressive weight management program. A 12-month pre-surgery pilot program was launched in February 2010 and continued in fiscal year 2012. 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 surgery that may achieve only short-term weight reduction. 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, participants who have the surgery pay no inpatient or outpatient hospital copayment.

From FY2008 to FY2010, there were 1,389 bariatric surgery cases. By June 2010, 58 plan members were participating in the pilot program. A total of 291 members have participated on a rolling basis since inception. About 88 percent have lost weight, and many have experienced lifestyle changes and better health.

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, since FY 2008 the number of bariatric surgery cases has declined by 95.3 percent, from 509 in FY 2008 to 24 in FY 2012. Initiation of the pilot has reduced overall bariatric surgery claims and other claims cost by 86 percent since 2009, from \$10.6 million that year to \$1.5 million in 2012.

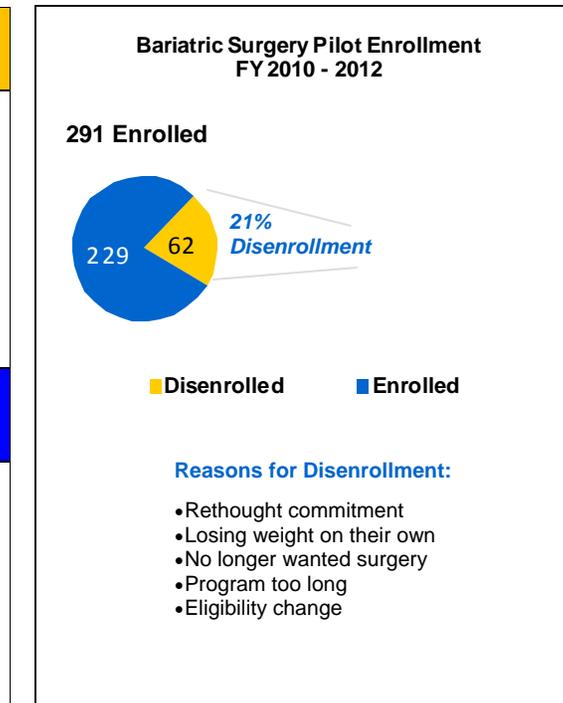


Lifestyle Changes	
• Improved nutrition	80%
• Smaller food portions	81%
• Better beverage choices	78%
• Increased activity/exercise	65%
• More positive coping skills	62%
• Increased confidence	59%
• More health care engagement	57%
• Stopped smoking	8%

Health Condition Improvements	
• Diabetes	50%
• Blood Pressure	46%
• High Cholesterol	15%

\*All results from post 12-month survey



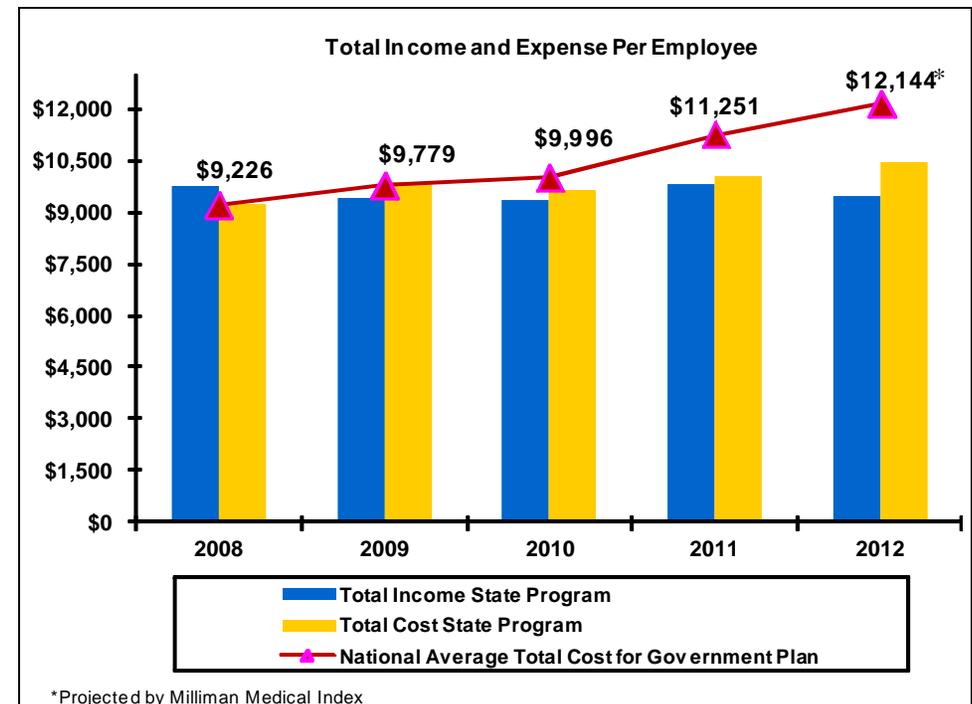
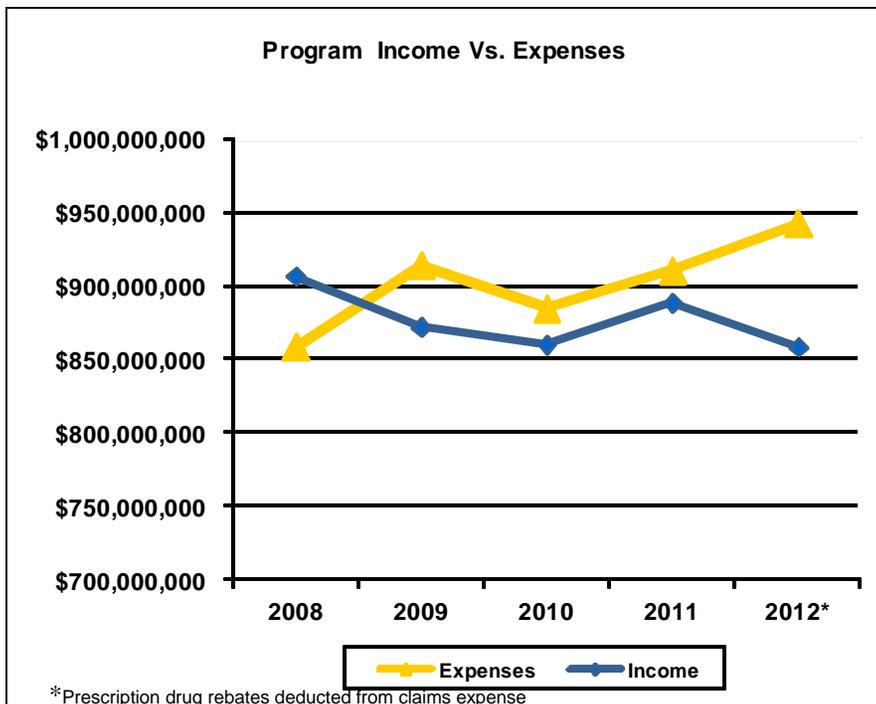
# Operating Statement

PROGRAM TOTAL	FISCAL YEAR 2008	FISCAL YEAR 2009	FISCAL YEAR 2010	FISCAL YEAR 2011	FISCAL YEAR 2012
<b>Annual Income</b> <i>(Premiums, Interest, Other)</i>	\$906,826,957	\$871,914,528	\$860,279,484	\$888,755,794	\$858,355,689
<b>Annual Expenses</b> <i>(Claims, Contract Administration, Other)</i>	\$858,812,728	\$914,296,899	\$885,109,068	\$910,706,267	\$942,600,413*
<b>Income Less Expenses</b>	\$48,014,229	(\$42,382,371)	(\$24,829,584)	(\$21,950,473)	(\$84,244,724)

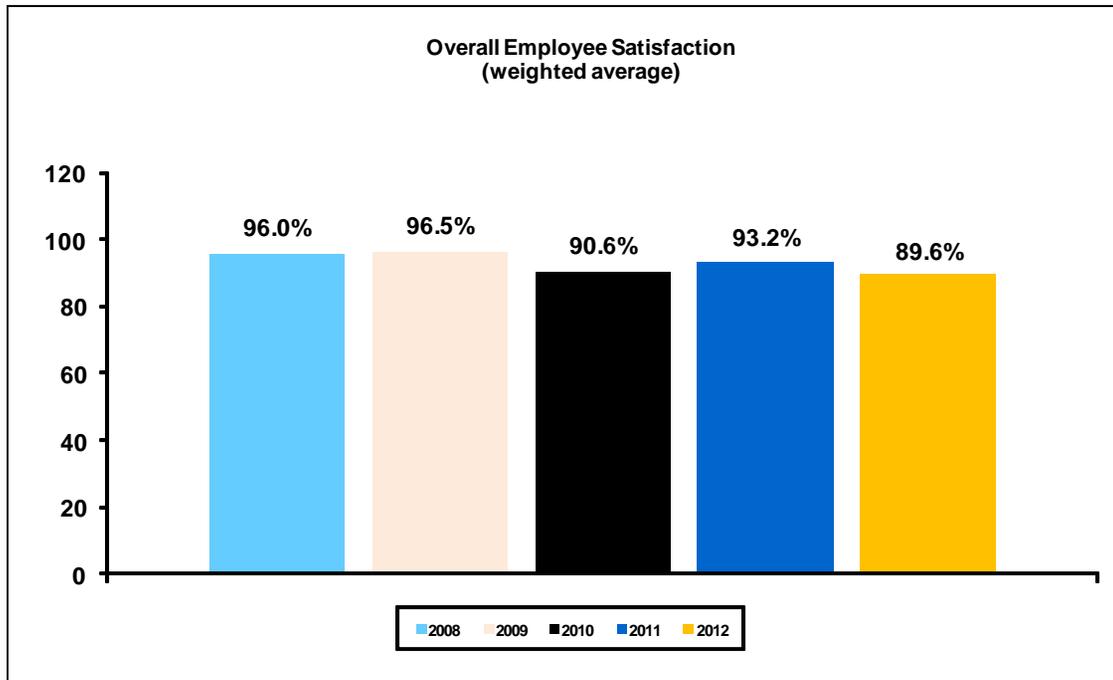
\*Prescription drug rebates deducted

Premiums provide 100 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, premiums have been artificially held low to maintain contribution levels, resulting in deficits. The program has used its reserves to fund employee and employer premium subsidies during tight budget years. Beginning in 2012, an accounting change deducts \$36.8 million in prescription drug rebates from claims expense rather than including those dollars as income.



# Employee Satisfaction



Input from employees is essential 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®) 2012 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. Since the surveys are random, results may vary depending on which members are surveyed and the experience respondents have with their benefits.

Overall satisfaction with the health plan in 2012 declined to 89.6 percent from 93.2 percent in 2011, primarily due to lower overall ratings for medical and dental benefits. COVA Care's prescription drug benefits had the highest rating in 2012, at 97 percent. After their initial dissatisfaction with the mandatory COVA Connect plan, employees are more accepting of the plan's medical and pharmacy benefits. COVA Connect satisfaction increased by 2 percent in 2012, from 56 to 58 percent.

