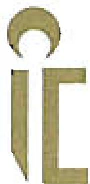

STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

JOE MANCHIN III
Governor

JANE L. CLINE
Insurance Commissioner

April 23, 2008

The Honorable Joe Manchin III, Governor
Office of the Governor
Charleston, WV 25305

The Honorable Earl Ray Tomblin
Senate President and Lieutenant Governor
Building 1, Rm 227M
Charleston, WV 25305

The Honorable Richard Thompson
Speaker of the House
Building 1, Room 234M
Charleston, WV 25303

Dear Governor Manchin, President Tomblin and Speaker Thompson:

On behalf of the Board of Directors of the West Virginia Health Insurance Plan ("AccessWV"), I am pleased to present the enclosed 2007 Annual Report, in accordance with §33-48-2(i) of Article 48 "Model Health Plan for Uninsurable Individuals Act". The Report provides a summary of enrollment, financial and performance data recorded during the past calendar year.

During 2007, the second full year of operation, the Plan continued to show a steady increase in enrollment. Membership grew from 302 policyholders in January to 436 in December, an increase of 44 percent. As a relatively new program, AccessWV is expected to continue to add new policyholders in the coming years.

Premium revenues during 2007 totaled $2,678,523. Incurred medical and pharmaceutical claims expenses during the year came to $2,295,742 and incurred administrative expenses were projected at $359,750. In addition to premium income, AccessWV received $1,899,164 from hospital assessments in 2007. AccessWV ended the year with a period surplus of $2,286,926 and carry-over funds of $8,318,976.

I hope this Report provides you with useful information regarding AccessWV's role in providing health insurance to medically vulnerable West Virginians, who would otherwise not have access to coverage. Should you have questions regarding this Report, please contact me at (304) 558-3354.

Sincerely,

Jane L. Cline
Insurance Commissioner and
Chair, AccessWV Board of Directors

enclosure

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West Virginia Health Insurance Plan

2007 Annual Report

April 2008

Jane L. Cline
Chair, Board of Directors

Alfreda Dempkowski
Executive Director

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I. Executive Summary

The West Virginia Health Insurance Plan ("AccessWV"), the state's high risk health insurance pool, continued to grow steadily during Calendar Year 2007, its second full year of operation. By December it was serving 436 policyholders, representing 497 members.

Persons joining the pool include those who are unable to obtain coverage in the private individual market because of pre-existing medical conditions as well as persons with guaranteed access to coverage through the Federal Health Insurance Accountability and Portability Act (HIPAA). Many of the latter, despite their right to coverage, are faced with excessively high rates because of their health status. AccessWV is also a state qualified plan for the Federal Health Coverage Tax Credit (HCTC) program and is open to dislocated workers who qualify for this credit.

The focus during 2007, the second full-year of operation, was on assuring smooth operations and exploring new approaches to program promotion. Highlights of Plan activities during the year included:

- Premiums and product design for Plan Year 2008, including new dis-incentives for use of out-of-state services
- Annual residency survey
- Open enrollment period for members
- Negotiation of Memo of Understanding with the Plan Administrator, including approval of additional subcontracted functions
- Updating of the Plan's Operational Protocols
- Outreach activities to promote AccessWV to the target population
- Mid Plan Year premium reductions (effective 1/1/08)
- Financial audit of Fiscal Year 2007

During Calendar Year 2007, projected premiums totaled $2,678,523 and covered 101 percent of projected expenses of $2,655,492, which include incurred medical and pharmacy claims of $2,295,742 and incurred administrative costs of $359,750. In addition to premium income, the program received $1,899,164 from hospital assessments in 2007. A period surplus of $2,286,926 was projected for the year with $8,318,976 available for carry-over to 2008.

Enrollment projections, based on the Plan's experience to date, provide for continued growth with membership reaching some 600 policyholders at the end of 2008 and some 845 policyholders by 2011. The projections have AccessWV experiencing a surplus in 2008 and ending that year with carry-over funds of approximately $10.6 million. Assuming the program continues to grow conservatively, AccessWV will continue to operate with a period surplus throughout the projection period. These projections assume that external financing will be provided at the level of the current hospital assessment and that premiums will increase five percent each year.

The Board of Directors submitted its third report to the Legislature on financing options for the pool in January 2008. The Board continues to support the hospital assessment as the financing

mechanism of choice, until financing from this source is no longer adequate to cover the Plan's operating needs. At that time, a permanent source of financing will be needed.

The Board is seeking additional actuarial advice and will consider whether the 2008 hospital assessment is needed at its March 2008 meeting, after updated financials are reviewed.

As AccessWV enters its third full-year of operation, the focus is on:

- Identifying new ways to reach out to the target population.
- Determining premiums and benefits for Plan Year 2008.
- Fine-tuning the premiums and product offerings to increase affordability and better reflect the Plan's own utilization experience.
- Monitoring potential funding opportunities.
- Providing an update to the Legislature in January 2009 on the financial status of the Plan with recommendations for continued financing.

II. Background and General Information

History and Purpose of the WV Health Insurance Plan

The West Virginia Health Insurance Plan ("AccessWV") was created by the West Virginia Legislature in 2004 to provide health insurance to eligible West Virginians who, because of their medical status, are unable to obtain coverage in the regular insurance market. The Plan serves as the State's high risk pool.

AccessWV also provides portability coverage to persons who are federally eligible through the Health Insurance Accountability and Portability Act (HIPAA). Many of these persons, despite their right to coverage, are faced with excessively high rates owing to their health status. AccessWV is also a state qualified plan for the Federal Health Coverage Tax Credit (HCTC) program and is open to dislocated workers who qualify for this credit.

The enabling legislation is the "Model Health Plan for Uninsurable Individuals Act", which is Article 48 of Chapter 33 of the State Code. AccessWV is a program of the State of West Virginia and is part of the Offices of the Insurance Commissioner. AccessWV participates in the National Association of State Comprehensive Health Insurance Plans (NASCHIP), an organization comprised of the high risk pools in 35 states.

AccessWV serves as an important option for West Virginians who have been denied health insurance coverage because of health conditions, who can afford the premiums, and who have no other alternative for coverage. While it is not a solution for every West Virginian in need of health insurance, it provides a critical service to a highly vulnerable population.

AccessWV began offering coverage in July 2005 and enrolled its first members effective August 2005. This Annual Report reflects activities during Calendar Year 2007, the second full-year of operation.

Governance and Administration

AccessWV is governed by a six member Board of Directors appointed by the Governor. The Insurance Commissioner is an *ex officio* member of the Board and the Chair. As required by statute, the Board of Directors includes two "individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan", two representatives of insurers and one hospital administrator. The majority of the Board is composed of individuals who are not representatives of insurers or health care providers. A list of the current Board of Directors appears as Attachment A. There were no changes to the Board of Directors in 2007.

The Board's activities are supported by an Executive Director, who provides policy direction and ongoing program development, oversees the day-to-day operations of the Plan, and works closely with the Plan Administrator, the Public Employees Insurance Agency (PEIA), and its subcontractors. PEIA provides administrative services including eligibility determination, premium billing, customer service and medical and pharmaceutical claims processing. Since the program's inception medical claims processing has been subcontracted to Wells Fargo Third Party Administrators (TPA) and pharmaceutical claims processing, to Express Scripts, Inc. As of November 2007, PEIA began subcontracting eligibility, premium billing and customer service to

Wells Fargo TPA. PEIA continues as the Plan Administrator, coordinating and overseeing the work of its subcontractors.

Legal Counsel is provided by attorneys from the WV Offices of the Insurance Commissioner. Financial, and public relations staff support is also provided by the Offices of the Insurance Commissioner. Actuarial services are provided by CCRC Actuaries, LLC. The 2007 financial audit was conducted by Suttle and Stalnaker, PLLC as part of the audit of the Offices of Insurance Commissioner.

The Board of Directors meets a minimum of four times a year at the Offices of the Insurance Commissioner in Charleston. A public notice of these meetings is provided. The Board also meets by teleconference as necessary. The Board has two active subcommittees—finance and outreach. These subcommittees meet as needed.

Eligibility for AccessWV

To qualify for AccessWV coverage, an applicant must document eligibility under one or more of the following criteria:

- Applicant has portability rights through the Federal Health Insurance Portability and Accountability Act (HIPAA); or
- Applicant is eligible for the Health Coverage Tax Credit (HCTC) program; or
- Applicant was rejected for health insurance during the last six months by a carrier selling health insurance in West Virginia; or
- Applicant was offered coverage during the last six months by a carrier doing business in West Virginia but the quoted rate was higher than AccessWV for substantially similar coverage or there was a restrictive waiver that excluded coverage for a medical condition; or
- Applicant has one or more of the presumptive health conditions identified by the Board of Directors as qualifying a person for coverage in the high risk plan, regardless of whether an application was made to another carrier.

An applicant must a legal resident of West Virginia for at least 30 days except in the case of HIPAA and HCTC eligibles for whom there are no minimum residency requirements. Dependents of persons eligible for AccessWV coverage are also eligible for inclusion on a family policy.

The following persons are not eligible for coverage through AccessWV:

- Those eligible to receive coverage under a group insurance plan offered either by their employer or a spouse's employer;
- Those eligible for medical coverage under a federal or state program including Medicare, Medicaid and the West Virginia Children's Health Insurance Program; and
- Residents of a public institution (i.e., federal or state correctional facility or a Veteran's home).

Waiting Period for Pre-Existing Conditions

AccessWV is required to impose a six month waiting period before it will cover pre-existing conditions. The waiting period applies to both medical and pharmaceutical services. Persons who are "federally defined eligible individuals" or "HIPAA eligible" are exempt from the waiting period. These are persons whose last coverage was through a group health plan, who

have exhausted COBRA or who do not have COBRA available, who have had at least 18 months of consecutive coverage and who do not have a break in coverage of more than 63 days at the time of their application to AccessWV. The waiting period is also waived for HCTC eligibles who have had at least 3 months of coverage and do not have a break of more than 63 days at the time of their application to AccessWV. The waiting period is also waived for persons who lose coverage involuntarily and make application to AccessWV within 63 days of the termination provided that they met a waiting period under the previous coverage. Their coverage with AccessWV must also begin the date the prior coverage was terminated.

Enrollment Procedures

Persons interested in enrolling in AccessWV may call 866-445-8491 toll free to request application materials. Materials may also be downloaded from the Plan's web-site at www.accesswv.org. Requests for information are fulfilled by the AccessWV program office. The completed application and first month's premium are returned to the Plan Administrator. The Plan Administrator determines eligibility and answers eligibility and benefit questions. Since mid-November (for persons with coverage effective January 1, 2008), the eligibility function has been turned over to the Plan Administrator's subcontractor, Wells Fargo TPA. Qualifying applications received by the 15th of the month that can result in coverage are effective the first of the following month.

Available Products

AccessWV offers a choice of three products—Plan A, B and C. The products differ in their deductibles and out-of-pocket maximums. All three products offer the same comprehensive coverage. Hospital, physician services, outpatient services, home care, prescription drugs, maternity, rehabilitation, outpatient therapies and other medical services are covered.

Annual medical deductibles range from $400 to $2,000 for individual coverage and $800 to $4,000 for family coverage for in-network services. The medical deductibles double for out-of-network services. A separate deductible, ranging from $200 to $1,000 for individual coverage and $400 to $2,000 for family coverage, applies to prescription drugs. The annual medical benefit maximum is $200,000 for all products, and the annual pharmacy benefit maximum is $25,000. A combined lifetime maximum of $1,000,000 for medical and pharmaceutical benefits applies to all products.

Per the enabling legislation, AccessWV is entitled to reimburse providers according to the PEIA schedule provided that the Plan Administrator is PEIA. All West Virginia providers who accept PEIA reimbursement are considered network providers and are prohibited from balance billing AccessWV members. To encourage care within West Virginia, cost-sharing is lowest when services are received from West Virginia providers. To further support the use of West Virginia providers, a prior authorization requirement was imposed for out-of-state services starting July 1, 2007. Benefits for out-of-state services that do not have prior authorization are paid subject to a penalty, which further increases the member's share of costs for out-of -state care.

In addition to the prior authorization requirement for out-of-state care, the benefit package incorporates cost containment measures including precertification of specified inpatient

admissions and outpatient services, medical case management, disease management, and pharmacy benefit management, including prior authorization, quantity limits and step therapy.

Premiums

By statute, AccessWV must set premiums between 125-150 percent of the standard risk rate, which is determined by the Plan in consultation with the Offices of the Insurance Commissioner.

Premiums for the 2007 Plan Year (July 1, 2006 through June 30, 2007) were set at 140 percent of the standard risk rate. To encourage enrollment in the Plan, the Board voted to set premiums at 130 percent of the standard risk rate for the 2008 Plan Year beginning July 1, 2007. This resulted in an across the board increase of 5 percent, an increase below that experienced in the regular market.

A recalculation of the premiums as percent of the standard risk rate in October 2007 showed that premiums were at 142 percent of the standard. The Board voted to decrease premiums in the middle of the Plan Year to bring them to 130 percent of the standard as of January 1, 2008.

Premiums are based on gender, age, region of residence, kind of coverage (single or family) and product (Plan A, B, or C).

III. Plan Enrollment During 2007[1]

Growth by Month

AccessWV began January 2007 with 302 policyholders and ended the year with 436, an increase of 44 percent. Total membership, including dependents of policyholders, went from 351 to 497. See below for monthly breakdown.

Monthly Enrollment during 2007

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
# Policies	302	318	336	349	363	372	391	405	409	434	426	436
# Members	*351*	*372*	*391*	*406*	*418*	*433*	*462*	*471*	*474*	*500*	*492*	*497*

Total Served During Year

While enrollment grew to 436 policyholders and almost 500 members at the end of 2007, the end-of-year membership understates the impact of the program, which experiences a constant flux as some members leave and others take their places. During 2007, AccessWV enrolled 276 new policyholders and provided insurance to a total of 587 different policyholders representing 692 members at some time during the course of the year.

Lapsed Coverages

During 2007, 155 policyholders ended their coverage in AccessWV. In the absence of systematic data on the reasons for cancellation, a special analysis was done of the 60 members whose coverage ended in the four month period starting July 2007.

The majority (43 percent) were cancelled for non-payment. The underlying reason for these cancellations is not known. Some policyholders let their coverage lapse because they are unable to afford the premiums, while others simply do not pay because they no longer need the coverage. Twenty percent began Medicare, and 12 percent reported they had secured other coverage. See table on next page for details. Going forward, the reasons for termination will be captured by the Plan Administrator and a more complete picture will be available.

AccessWV provides a "free look" period in which a new member may cancel coverage without a penalty. Twelve persons who applied for coverage during 2007 terminated their coverage without its ever being effective. This may happen if the applicant gets insurance elsewhere or is dissatisfied with the pre-existing condition requirement imposed upon acceptance.

[1] Enrollment data are as reported in the Monthly Enrollment Reports, which are based on the extracts from the membership file provided by the Plan Administrator during the particular month. Data for 2007 with the exception of "Lapsed Coverages" are based on December Enrollment Reports and are not adjusted for retroactive cancellations or reinstatements. The data for "Lapsed Coverages" are based on the extract provided in February 2008. These counts reflect retroactive cancellations.

Reasons for Termination: Cancelled Policies Jul 2007 – Oct 2007

Reason	# Policyholders	% of Total
Died	1	*2*
Left state	1	*2*
Medicare	12	*20*
Non-payment	26	*43*
Other insurance	7	*12*
Request by member no reason given	7	*12*
Too expensive	1	*2*
Data not available	5	*8*
All reasons	60	*100**

* rounding error

Enrollment by Product

AccessWV continues to offer the same three products (Plans A, B and C) that have been offered since its inception. The products differ in their deductible and out-of-pocket maximums. As of December, 46 percent of the policyholders were enrolled in Plan C, the option with the highest deductibles and the lowest premiums.

Product	Annual Med. Deduct. (Single/Family)	# Policies	*% of Total*
Plan A	$400/$800	131	*30*
Plan B	$800/$1,600	106	*24*
Plan C	$2,000/$4,000	199	*46*
Total		436	*100*

Enrollment by Region

Consistent with the commercial market, AccessWV uses four rating regions. Historically, premiums have been highest in the South region with the North region, second highest. The Central region has been third with the lowest premiums in the East region. This rating mirrored the differentials in the commercial market. (See below for a discussion of AccessWV's own experience by region.)

As of December 2007, the South, East and Central regions were similarly represented among Plan enrollees with each accounting for about 30 percent of the total. Enrollment was lightest in the North region, where there were 61 policies for 14 percent of the total.

Enrollment by Region

Region	# Policies	% of Total	Premium Rating Factor 1=Highest	Average Premium	# Unins. Adults Ages 19-64, 250%* FPL	Policies per 1,000 Unins. Adults 250%* FPL
North	61	*14*	2	$679	5,397	11.3
South	132	*30*	1	$654	10,892	12.1
East	125	*29*	4	$581	6,659	18.8
Central	118	*27*	3	$601	8,543	13.8
Total	**436**	***100***		**$622**	***31,491***	**13.8**

* From estimates presented in **Health Insurance in West Virginia: The Non-Elderly Adult Report**, WVU Institute for Health Policy Research., July 2002, reprinted May 2003. While the reliability is uncertain, better data are not available.

The average monthly premium for each region is also shown above. Actual premiums depend on the product selected and the demographic mix of the policyholders. Members in the East region are paying the lowest average monthly premium of $581 followed by the Central where the average is $601.

When enrollment in AccessWV is compared to the number of uninsured adults with incomes at or above 250 percent of the federal poverty level (FPL) in each region, the enrollment rate in the East outpaces the average for all regions by 36 percent. These data suggest that the relatively low premiums in the East region may encourage enrollment.

Enrollment by County

As of December 2007, membership was distributed through 52 of West Virginia's 55 counties. There were no policyholders in Clay, Gilmer and Roane counties. Kanawha County with 52 policyholders led in enrollment. Berkeley, Cabell, and Wood Counties each had 25+ policyholders. A breakdown of enrollment by county appears as Table 1 on page 31.

Enrollment by Gender

Females account for 56 percent of the total policyholders and males, 44 percent. Premiums for females are higher than the premiums for males through age group 50 to 54. Starting with age group 55 to 59, male premiums become higher. The average premium for females enrolled as of December 2007 at $673 is substantially higher than the average premium of $558 for males.

Gender	# Policyholders	*% of total*	Average Monthly Premiums 12/07
Females	244	*56*	$673
Males	192	*44*	$558
Both	**436**	***100***	**$622**

Enrollment by Age Band

Consistent with the commercial market, AccessWV age rates its premiums using nine bands. Despite higher premiums at older ages, more than half of the policyholders in AccessWV (55 percent) are age 50+. The average premiums paid by the policyholders in each group are shown below. The average for any age band depends on the all of the rating factors (gender, product selected, etc.)

Age	# Policies	% of total	Average Premium 12/07
Under 25	28	*6*	$264
25 to 29	30	*7*	$345
30 to 34	22	*5*	$381
35 to 39	26	*6*	$478
40 to 44	40	*9*	$470
45 to 49	46	*11*	$572
50 to 54	45	*10*	$643
55 to 59	80	*18*	$756
60+	119	*27*	$826
Total	**436**	***100****	**$622**

*rounding error

Persons ages 50 and over are much more likely to choose Plan C, which has the lowest premiums and the highest deductibles, than are persons under age 50. **Fifty-eight percent of the older policyholders are in Plan C compared to 30 percent of the younger members.** See below.

Plan Selection by Age Band

Age Band	Plan A	Plan B	Plan C	All Products
Under age 50				
Number of policyholders	84	51	57	192
% of total for age group	*44*	*27*	***30***	*100**
Age 50+				
Number of policyholders	47	55	142	244
% of total for age group	*19*	*23*	***58***	*100*

* rounding error

Enrollment by Tier

The overwhelming majority of policies (95 percent) are for individuals with 5 percent of policies for families. The 23 family policies represent a total of 84 members. Premiums for families are set at 240 percent of the premium for the policyholder regardless of the number of persons covered. The policyholders with family coverage are paying an average monthly premium of $1,003. Again, the premiums depend on the various rating factors that go into the premiums.

The average monthly premium per member covered on a family policy is $275. While this is lower than the $601 that is the average per member on a single policy, dependents on family policies do not necessarily have medical conditions that make them high risk.

Tier	# Policies	% of Total Policies	# Members	*% of Total Members*	Average Premium Per Policy	Average Premium Per Member
Family	23	*5*	84	*17*	$1,003	$275
Single	413	*95*	413	*83*	$601	$601
Total	**436**	***100***	**497**	***100***	**$622**	**$546**

Enrollment by Eligibility Category

Forty-five percent of the policyholders as of December joined as "federally defined eligible individuals" through HIPAA. Fifty-five percent were not able to purchase coverage in the regular market or affirmed they had a qualifying health condition. One policyholder is HCTC eligible.

Eligibility Category	# Policies	*% of total*
HIPAA	195	*45*
HCTC	1	*0*
Medically Uninsurable	240	*55*
Total	**436**	***100***

Policyholders with Waiting Periods for Pre-Existing Condition

During 2007, there was a marked decline in the proportion of members who ever had a waiting period for pre-existing conditions as well as in the proportion fulfilling a waiting period during a particular month. The proportion of policyholders who ever had a waiting period declined from 64 percent in December 2006 to 53 percent in December 2007. The proportion of policyholders still meeting a waiting period declined from 28 percent in December 2006 to 13 percent in December 2007. See below. As the proportion of policyholders not in a waiting period grows, the Plan's outlay for claims also grows.

Time Period	# Policy-holders	At Enrollment		In Current Month	
		No Wait Period	Wait Period *Required*	Wait Period *Met*	Wait Period *In Effect*
December 2007	436	207	229	173	56
% of total	*100*	*47%*	***53%***	**40%**	**13%**
December 2006	298	106	192	108	84
% of total	*100*	*36%*	***64%***	**36%**	**28%**

When a plan is relatively new, there are proportionally more members fulfilling a waiting period due to the short duration of membership. As the plan matures and members continue their coverage, more and more complete the waiting period requirement. As of December, 173 of the

policyholders had changed to a "no waiting period" status and were eligible for coverage of their pre-existing conditions.

Another factor contributing to the decline in the proportion of members fulfilling a waiting period is the increased representation of HIPAA eligibles in the Plan membership. The HIPAA membership increased from 36 percent in December 2006 to 45 percent in December 2007. In addition, a small group of medically eligible individuals (11 members in December) who lost insurance involuntarily due to an insurer pull-out from West Virginia were not required to meet a waiting period as stipulated in the risk pool legislation. While HCTC eligibles may also qualify for a waiver of the waiting period, there is little impact on the membership profile due to the low HCTC enrollment.

Discussion of Enrollment Experience

Affordability

Enrollment growth in AccessWV has been gradual but steady. Premiums are high relative to incomes in West Virginia and are viewed as the major deterrent to enrollment. Many persons in the target population are unable to afford AccessWV premiums, which are in excess of those charged in the regular market. While a high risk pool addresses the availability of coverage when this is not provided by the market, it does not address the issue of affordability.

From July through December 2007, premiums for individual coverage ranged from $155-$417 monthly at the youngest ages (under 25) to $625-$1,346 monthly for persons ages 60+. As of December, policyholders were paying an average monthly premium of $622, the equivalent of an annual premium of $7,464. Twenty-four percent of policyholders were paying $800 or more monthly. Twenty-four policyholders were paying $1,000 or more; 14 of these had single coverage and 10, family coverage. The distribution of policies by premium level is shown below by tier (single or family coverage).

Policies by Premium Level and Tier

Premium	**Total Policies**	***% of Total***	***# Single***	***# Family***
Under $200	5	*1*	5	0
$200 - $399	95	*22*	95	0
$400 - $599	93	*21*	90	3
$600 - $799	141	*32*	137	4
$800 - $999	78	*18*	72	6
$1,000+	24	*6*	14	10
All	**436**	***100***	**413**	**23**

As already noted, many medically eligible persons may find AccessWV premiums unaffordable. The average annual premium of almost $7,500 is more than 20 percent of an annual income of $34,340, which is 200 percent of the federal poverty level (FPL) for a family of three. Since most uninsured adults in West Virginia (about 80 percent) have incomes at or below 200 percent

of the FPL, the program is unaffordable to all but a small segment of the medically eligible population.

Some states deal with the issue of affordability by providing premium subsidies to the risk pool members. This is done through state funds, federal funds or a combination. The federal High Risk Pool Funding Extension Act of 2005 authorizes bonus grants to risk pools, which may be used for premium subsidies. A pool that qualifies for an operational grant to cover pool losses may apply for a bonus grant. Funds were appropriated to support this legislation in FFY 2006 (for State FY 2005) but not for FFY 2007 (for State FY 2006). Funds were recently appropriated for FFY 08 (for State FY 2007). While bonus grants offer pools the opportunity to provide premium relief to some members of their target population, AccessWV enjoyed an operating surplus in 2007 and presumably will not qualify for a bonus grant during 2008.

Despite the limitation imposed by premiums it must charge, AccessWV does serve as a very important niche program providing insurance when the market does not. As such, it is a vital safety net for those individuals who can afford the premiums.

"Hidden" Population

The population served by AccessWV is a small and hidden subset of the State's total population. It is not easily reachable through mass media. The overall strategy has been to involve various stakeholder groups, who are in contact with the target population, in the outreach effort. From time to time, special marketing initiatives directed at the target population are also undertaken. Program staff continues to explore new ways and identify effective approaches to reaching potential members. A discussion of the major outreach activities is provided below.

IV. Financial Results

Audited Financial Results: Fiscal Year 2007

AccessWV was included as an enterprise fund in the financial audit of the Offices of the Insurance Commissioner for State Fiscal Year 2007 ending June 30, 2007. The Independent Auditor's Report and the Financial Statement for AccessWV are included as Attachment B. No issues were identified for AccessWV. The Plan ended FY 2007 with assets of $6.246 million. Net premium revenues of $2.104 million for the fiscal year exceeded operating expenses of $1.741 million. The audit was done by Suttle and Stalnaker, PLLC of Charleston.

Financial Plan for Calendar Years 2007 – 2011

A detailed Financial Plan for Calendar Years 2007-2011 was prepared by CCRC Actuaries, Inc. at the beginning of 2008, using information from the pool's 29 months of experience as well as national and other West Virginia data. The Plan appears as Attachment C. The Financial Plan will continue to be revised regularly to incorporate additional experience and changing assumptions.

Financial Results: Calendar Year 2007

The Financial Plan for Calendar Years 2007 – 2011 presents the unaudited financial results for AccessWV as of the end of 2007 as required by §33-48-2 (i). They are as follows:

Summary of Year: Net Gain (Loss)

AccessWV was projected to end 2007 with a period surplus of $2,286,926 and carry-over funds of $8,318,976. AccessWV ended the year with an operational gain (premiums minus expenses) of $23,000.

Accrued Revenue

Accrued revenues during 2007 are calculated at $4,942,418. These revenues came from hospital assessments, premiums and interest.

Hospital Assessments. The "Uninsurable Individuals Act" provides for hospital assessments as the interim source of financing for the high risk pool. This financing source was continued in 2007 and provided $1,899,164 to support the pool. The assessment was taken at 0.025 percent of hospital gross revenues, which is the maximum allowable level. AccessWV had received revenues from three previous assessments totaling $4,924,049. Previous assessments were also taken at the maximum allowable level.

Federal Funding. AccessWV did not receive any federal funding in 2007. Federal funding to date has been limited to start-up grants of $1 million awarded in 2004.

While federal legislation ("High Risk Pool Funding Extension Act of 2006") authorizes funding to risk pools through 2010, no funds were appropriated for distribution in 2007. Such funds, if appropriated, would have covered operating losses for high risk pools during state fiscal year

2006 as well as bonus grants to pools experiencing operating losses. While AccessWV did have an operating loss in fiscal year 2006 due to start-up costs, it was still spending down monies from the federal start-up grant.

Premiums. AccessWV received a projected $2,678,523 in premium income during 2007. This income covered 101 percent of expenses for claims and administration.

Investment Income. The Plan invests funds on hand with the Treasurer's Office "Cash Liquidity Pool". Interest earnings for 2007 were projected at $364,731.

Incurred Expenses

The Plan incurred an estimated $2,655,492 in expenses for medical claims, pharmacy claims and administration during 2007.

Medical Claims. Incurred medical claims for 2007 were projected at $1,742,877. Paid medical claims paid totaled $1,598,877. The end of year medical claims reserve was $320,000.

Pharmacy Claims. Incurred pharmacy claims for 2007 were projected at $552,865. Paid claims totaled $544,065. The end of year pharmacy claims reserve was $18,000.

Administrative Expenses. Administrative expenses incurred for 2007 were projected at $359,750.

Administrative Expense Ratio. The projected administrative expense ratio (administrative expenses divided by premiums) in 2007 was 13 percent. The expected administrative expense ratio for 2008 will continue to be 13 percent with a small decline thereafter to 11 percent as the fixed costs are spread over a larger enrollment base.

Period Surplus (Deficit)

AccessWV was projected to have a period surplus of $2,286,926 for 2007 with $4,942,418 in accrued revenues and $2,655,492 in incurred expenses.

Policy Loss Ratio

The projected policy loss ratio (incurred claims divided by premiums) for 2007 was 86 percent. The policy loss ratio is favorable largely due to the impact of the six month waiting period requirement for pre-existing conditions, which is imposed on all members except those with portability rights through HIPAA or HCTC status. Claims pay-out is greatly reduced when pre-existing conditions are not covered.

The proportion of policyholders who have ever had a waiting period declined from 64 percent in December 2006 to 53 percent in December 2007, reflecting a greater representation of "federally defined eligible individuals" among the membership. The proportion of members with a waiting period in any month has been declining steadily going from 28 percent in December 2006 to 13 percent in December. This decline in the proportion of the membership with a waiting period is

expected to result in an increased policy loss ratio of 98 percent in 2008 with the policy loss ratio gradually climbing to 119 percent by 2011.

Carry-over Funds
At the end of December 2007, the high risk pool account had a projected total of $8,318,976 in available funds.

Details of Plan Claims Expenses

Conditions Covered
Claims related to "Neoplasms" at 15.8 percent of the total continued to account for the largest proportion of medical claims dollars paid by the Plan during 2007. "Musculoskeletal and connective tissue disease" at 13.1 percent of total claims dollars accounted for the second highest level of spending during 2007. "Diseases of the circulatory system" which had previously been the second most prominent diagnostic category in terms of spending dollars dropped to fourth place after "Supplemental factors influencing health status." The breakdown of paid claims by diagnostic category appears as Table 2 on page 32.

Claims Payments to West Virginia Providers
During 2007, 68 percent of all medical claims dollars were paid to West Virginia providers with 32 percent of claims dollars going to out-of-state providers. During this time, WV hospitals received 64 percent of the claims dollars paid for inpatient and outpatient care provided to AccessWV members with 36 percent going to out-of-state facilities. Overall, West Virginia hospitals received 40 percent ($638,010) of the total medical claims dollars ($1,615,076) paid on behalf of AccessWV members.

Paid Medical Claims by Provider Location, 2007

Services	# Claims			Payments		
	Total	# In-State	# OOS	Total	In-State	OOS
All Services	**12,020**	**9,892**	**2,128**	**$1,615,076**	**$1,090,945**	**$524,131**
% of All Services	*100%*	*82%*	*18%*	*100%*	***68%***	***32%***
All Hospital Services	**1,737**	**1,603**	**134**	**$1,003,003**	**$638,010**	**$364,993**
% of All Hospital	*100%*	*92%*	*8%*	*100%*	***64%***	***36%***

Source: Compiled from Monthly Health Care Management Reports Provided by Wells Fargo Third Party Administrators for December 2006, June 2007 and December 2007.

To re-direct patient care revenues to in-state providers, a prior authorization requirement was placed on out-of-state care effective July 1, 2007. During the last six months of 2007, there appeared to be some shift of medical claims dollars toward West Virginia hospitals with 73 percent of the hospital claims paid for services in West Virginia compared to 34 percent in the last six months of 2006. However, it is too soon to tell if the utilization patterns have been significantly altered; and one costly out-of-state hospitalization could change the proportions dramatically. The situation is also complicated by the fact that out-of-state reimbursement rates are higher than in-state rates. See below.

Paid Hospital Claims by Provider Location: Last Six Months of 2006 and 2007

Time Period	7/2006 – 12/2006		7/2007 – 12/2007	
	Amount	**% of Total**	**Amount**	**% of Total**
Total Paid Hospital	$342,534	100%	$611,101	100%
In-State	$117,007	34%	$447,265	73%
Out-of-State	$225,527	66%	$163, 836	27%

Source: Compiled from Monthly Health Care Management Reports Provided by Wells Fargo Third Party Administrators for December 2006 and December 2007.

Plan Share of Drug Costs

Of total drug costs paid in 2007 AccessWV covered 68 percent with members paying 32 percent either for copayments or deductibles. This represents an increase in the Plan's share from 59 percent the previous year.

Year	Total Drug Cost	Plan Share	Member Share
2007	$800,925	$542,014	$258,911
	100%	*68%*	*32%*
2006	$330,582	$196,343	$134,239
	100%	*59%*	*41%*

Generics as Percent of Total Drugs

Sixty-six percent of all prescriptions filled in 2007 were for generic drugs. However, generics accounted for only 13 percent of Plan costs, owing to the substantial expenses incurred by the Plan for branded drugs. See below.

Kind of Drug	# Scripts*	*% Scripts*	Plan Costs*	*% Plan Costs*
Generic	7,183	*66%*	$70,872	*13%*
Single Source Brand	3,653	*33%*	$466,028	*86%*
Multi Source Brand	94	*1%*	$5114	*1%*
All Drugs	**10,930**	***100%***	**$542,014**	***100%***

* calculated from data provided by Express Scripts

Top Therapeutic Classes

The top 10 therapeutic classes accounted for 32 percent of the covered prescriptions and 18 percent of Plan costs in 2007. The most frequent therapeutic class for the Plan was "opioid combinations" accounting for 532 scripts or 4.9 percent of total scripts. The next most frequent therapeutic class was "HMG COA reductase inhibitors" accounting for 418 prescriptions. Details of drug utilization by therapeutic class are presented in Table 3 on page 33.

Ten Most Frequently Filled Prescriptions

The prescription most frequently filled for Plan members was *Plavix 75 mg tablet*, followed by *Omeprazole 20 mg capsule dr* and then by *Lantus 100 units/ml vial*. Together the 10 most frequently filled prescriptions accounted for 7 percent of all filled prescriptions. These 10 drugs accounted for 11 percent of Plan expenses. Table 4 on page 34 provides details on the most frequently filled prescriptions and the cost-sharing required for these drugs. The Plan payment amounts are affected by whether the members are still meeting deductibles, and final Plan costs may be reduced by rebates.

Discussion of Claims Expenses

Out-of-State Usage. The intent of the Directors, since the inception of the Plan, has been to encourage use of West Virginia providers, and the products were designed accordingly. Higher coinsurance and, in some cases, additional copays have always applied to out-of-state services.

The introduction of a prior authorization requirement for out-of-state of services, effective July 1, 2007, was expected to have the greatest impact on avoidable out-of-state use, where there was no compelling reason to go out-of-state for services. Prior authorization is granted when a service is not available in West Virginia or receiving the service in West Virginia would create a geographic hardship or disrupt a provider-patient relationship where continuity was of paramount importance.

Failure to obtain prior authorization for out-of-state services results in increased coinsurance, a penalty of $1,000 in the case of a hospital admission, and, in some cases, a change in the fee schedule used for payment, thus exposing the member to balance billing.

Additional benefit or product changes may be needed to further improve in-state utilization. The situation with regard to out-of-state use is actively monitored.

Pharmacy Claims. Plan expenses for pharmaceuticals are a function of high ingredient costs for many drugs as well as relatively low cost-sharing by members. Drugs accounted for 24 percent of AccessWV claims dollars in 2007. Pharmacy claims are monitored on an ongoing basis. One significant problem that has emerged is polypharmacy. In December, for example, 18 members (4 percent of the total) had ten or more claims. Their costs to the Plan ($13,227) constituted 24 percent of the Plan's pharmacy costs of $55,334 for the month. The potential for intervention through care management continues to be explored.

Cost Containment

Precertification and Care Management

AccessWV requires precertification for certain inpatient and outpatient services. When there is no precertification requirement, admissions to a WV hospital requires notification.

Since July 2007, AccessWV has required prior authorization for services received from out-of-state providers. This policy is intended to direct usage to the WV facilities that provide financial

support to the program through the legislatively mandated assessment. Use of WV facilities also lowers claims costs, since out-of-state claim costs tend to be higher.

During 2007, 85 hospital admissions and 79 outpatient services were approved for AccessWV members. One inpatient admission and 4 outpatient services were denied.

Since July, two out-of-state hospitalizations were granted prior authorization because the care could not be provided in WV and four were paid at a reduced benefit because prior authorization was not requested or the out-of-state use was not justified for emergency treatment.

AccessWV also offers care management and disease management services to members with renal disease and diabetes. These services continue to be monitored and improved to assure their effectiveness in a high risk environment.

Provider and Other Discounts

During the medical claims administration process, $2.74 million in total discounts was applied to charges billed by providers in 2007. During 2007, AccessWV received $34,624 in pharmaceutical rebates, an amount equivalent to 6 percent of Plan costs before the rebates.

V. Highlights of Plan Activities during Calendar Year 2007

Overview

During the second full-year of Plan operations, the focus was on fine-tuning the infrastructure to ensure smooth operations, financial soundness and legislative compliance and to support a growing membership. Highlights of Plan activities during the year include:

- Report to the Legislature on Financing Options, January 2007
- Follow-up to the Full Performance Evaluation by the Legislative Auditor
- Benefits and premiums for Plan Year 2008
- Grant management for the CMS seed money award
- Annual residency survey
- Open enrollment period for members
- Revision of Plan's Policy and other communication materials
- Negotiation of Memo of Understanding with the Plan Administrator for Plan Year 2008, including approval of additional subcontracted functions
- Mid Plan Year premium reductions (effective 1/1/08)
- Outreach activities to promote AccessWV to the target population
- Update of Plan's Operational Protocols
- Financial audit of fiscal year 2007
- Analysis of plan data and preparation of related reports

Report to the Legislature on Financing Options, January 2007

The Board of Directors submitted an updated report on "Financing Options for AccessWV" to the Legislature in January 2007. The Board recommended that the hospital assessment at the current level be continued as the interim source of financing for AccessWV and that a permanent source of financing be identified before AccessWV begins to operate at a deficit.

The Board pledged its support to an operating plan that keeps expenditures at the approved funding level, which includes limiting enrollment to the number of participants that can be supported and amending benefits as necessary. The Board indicated it would return to the Legislature with a determination of the amount of financing needed, based on the pool's additional experience, and with recommendations for a permanent source of this financing.

Follow-Up to the Full Performance Evaluation by the Legislative Auditor

The Legislative Auditor's Office conducted a Full Performance Evaluation of the Offices of the Insurance Commissioner in 2006 and presented their report to the Joint Committee on Government Organization during Legislative Interims in January 2007. AccessWV took the following actions to respond to the recommendations in the Report:

Recommendation #1:

For the purposes of long-term planning, the Legislature should consider capping enrollment in the AccessWV Program as an option since the Commission lacks long-term data that can reliably predict future growth in enrollment.

Action Taken: Did not require action by AccessWV. However, AccessWV does not believe there is currently a need to set a cap on enrollment. Although enrollment continues to increase, growth is slow and the overall enrollment is still well below that which might be expected for a state the size of West Virginia. To date, the pool's financials have been very favorable.

Recommendation #2:
The Offices of the Insurance Commissioner should return to the Legislature in 2007 with an updated financial plan that will reflect actual program experience and provide projections of future program costs as well as offer recommendations regarding funding mechanisms.
Action Taken: The Board of Directors filed a Report which included an updated financial plan with the Legislature in January 2007 and intends to so report to the Legislature annually.

Recommendation #3:
The Offices of the Insurance Commissioner should provide an informational brochure on the Medicaid Program to all AccessWV applicants that outlines Medicaid eligibility requirements.
Action Taken:
After consultation with the Department of Health Human Services, it was determined that an informational brochure outlining Medicaid eligibility requirements was not available. To comply with the Legislative Auditor's request, AccessWV staff prepared an informational sheet with contact phone numbers and web addresses, encouraging applicants to explore their potential eligibility for Medicaid and/or CHIP. This sheet now forms part of the AccessWV application kit.

Benefits and Premiums for Plan Year 2008 (Starting July 1, 2007)

Benefits
Benefits for Plan Year 2008 remained essentially unchanged with the exception of the addition of a prior authorization requirement for out-of-state services and a change to a prescription drug copayment.

Out-of State Services. Utilization data through the end of 2006 indicated that a considerable proportion of medical claims dollars were being paid to out-of-state providers with the West Virginia hospitals receiving 30 percent of the medical claim dollars paid from the program's inception in mid-2005 through the end of 2006. Given that WV hospitals provide direct financial support to AccessWV through the yearly assessment, it was deemed appropriate to re-design the AccessWV product offerings to further encourage use of West Virginia providers.

From the outset, AccessWV has tried to direct members to WV providers by imposing the lowest coinsurance (20 percent) when services are received in the State. Services received from out-of-state providers carry a 30 percent coinsurance, if the provider is part of an affiliated network or a 40 percent coinsurance when the provider is out-of-network. These same coinsurance levels still apply, however, since July 2007 services from out-of-state providers require prior authorization. Failure to secure the authorization results in a benefit reduction.

While there are not yet enough data to conclusively assess the impact of the prior authorization requirement, there is some evidence that the situation with respect to out-of-state usage may be

improving. Out-of-state use continues to be tracked in order to determine if further benefit changes are indicated.

Pharmacy Benefit. The copay on brand non-formulary drugs was increased from $30 to $50 starting July 1. The change was applied to all AccessWV products (Plans A, B and C.)

The "Summary of Benefits" effective July 1, 2007 appears as Attachment D.

Other Product Considerations. The potential for introducing a high deductible health plan (HDHP) was explored and tabled for possible reconsideration in the future. An HDHP offers tax benefits to the insured, which might serve as an offset to premium expense, and thus make coverage in AccessWV more affordable. A number of high risk pools are successfully offering these products. To qualify as an HDHP, the coverage must meet federally imposed requirements with regard to deductibles and out of pocket maximums. Reasons for not proceeding with an HDHP at this time included:

- Given the modest size of the current enrollment and the unknown future membership size, the numbers that would enroll in an HDHP are likely to be small at least over the next five years.
- Administering a combined medical and drug deductible and a combined out-of-pocket maximum per the federal requirements cannot be easily accomplished in the current environment, which involves two separate claims administrators.
- An HDHP would introduce a product that was structurally quite different from the current product line, which was designed to mirror PEIA's benefit package in order to simplify administration and thereby hold down costs.

Premiums for Plan Year 2008 (Starting July 1, 2007)

AccessWV is required by statute to set premiums between 125 and 150 percent of the standard risk rate. The Board of Directors approved a premium increase of 5 percent as of July 1, 2007 with the proviso that the financial impact be reviewed regularly. The intent was to set premiums at 130 percent of the standard risk rate. The "Monthly Premiums" chart in effect as of July 1 appears as Attachment E.

Grant Management for the CMS Seed Money Award

The Final Performance Report for the seed grant was submitted to the Centers for Medicare and Medicaid Services (CMS) in March, 2007. The report reviewed the accomplishments during the grant period and provided a final financial report.

West Virginia received grant awards totaling $1 million dollars in 2004 to support the development of the high risk pool. Two "no cost" extensions were granted by CMS, which permitted AccessWV to use the remaining funds to offset initial administrative expenses. All funds from this grant were "spent down" prior to the end of 2006.

Annual Residency Survey

Legal residency in West Virginia is a requirement for eligibility in AccessWV. To monitor continued residency, the Board elected to require members to respond to an annual residency survey as part of the Operating Plan. A residency survey of the entire membership was

conducted by the Plan Administrator in April. No problems with residency were identified as a result of this survey, and no members needed to be terminated for failure to comply.

Open Enrollment Period for Members

AccessWV offers an annual open enrollment period, which gives policyholders the opportunity to change their coverage or add family members in the absence of a federally qualifying event. Requested changes are effective July 1, the start of the new Plan Year. Since premium increases have traditionally been effective July 1, the members have the opportunity to move to a product with a lower premium, if they wish.

The open enrollment offer was mailed to the membership in May. The mailing included the required notification regarding the July 1 premium increase. Eighteen policyholders opted to change their product. The majority (15) moved to a higher deductible product; three policyholders switched to a lower deductible product. No members added dependents.

Revision of Plan's Policy and Other Communication Materials

The Plan's **Policy** for coverage plans A, B and C was revised and approved by the Offices of the Insurance Commissioner effective July 1, 2007. Supporting materials, including the "Plan Overview" and the "Summary of Benefits", were also revised. A new informational piece "Tips for Getting the Most from Your AccessWV Coverage" was prepared for distribution to members. "Tips" encourages members to take advantage of the preventive care benefits, which are available regardless of pre-existing conditions status and are not subject to the deductible.

Negotiation of Memorandum of Understanding with the Plan Administrator

Plan Administrator and Subcontractors.

A Memorandum of Understanding to cover Plan Year 2008 was negotiated with PEIA, the Plan Administrator. PEIA continues to subcontract medical claims administration to Wells Fargo Third Party Administrators (TPA) and pharmacy claims administration to Express Scripts, Inc. While the obligations of the Plan Administrator remained essentially unchanged from the previous agreement, certain functions performed directly by PEIA are being subcontracted to Wells Fargo TPA as of November 2007. They include eligibility determination, billing, and customer service. PEIA retains a coordinating function and continues to provide oversight for all subcontracted functions. Per the high risk pool legislation, contracting with PEIA as Plan Administrator gives AccessWV access to the provider discounts in effect for PEIA.

Administrative PMPM's

Fees paid to the Plan Administrator through October 31, 2007 remained unchanged from the previous agreement. These included a "per member per month" (PMPM) rate of $16 for eligibility, billing and customer service and $35 for new enrollments.

As of November, 2007, AccessWV is paying $15.85 PMPM to Wells Fargo TPA for the newly subcontracted services including eligibility, billing, and customer service. PEIA receives $.50 PMPM for its services as Plan Administrator. As a result of these changes, the composite

PMPM for administrative services ($16.35) represents an increase of $.35 or 2 percent over the previous administrative PMPM. The latter had been the rate since the program's inception in 2005. The rate for new applications processed by Wells Fargo continues to be $35.

The fee for medical claims administration at $16.91 PMPM remains unchanged. As of July 1, the PMPM for pharmacy claims administration increased to $1.75 PMPM. This represents a 15 percent increase over the previous pharmacy PMPM of $1.525, which had been in effect since AccessWV began.

Related Issues

During 2007, the Plan Administrator and its pharmacy claims subcontractor, Express Scripts, Inc. requested that AccessWV be set up as a separate division owing to eligibility issues and difficulties calculating rebates when AccessWV is handled as part of the PEIA account. The Board of Directors approved payment of the set-up fees which were billed at $9,500.

The Plan Administrator issued an RFP for pharmaceutical claims processing during 2007 and announced that ExpressScripts, Inc. would continue as the vendor for the new contract period beginning January 1, 2008.

The AccessWV Board authorized AccessWV's participation in a Pharmacy Claims Repricing contract between PEIA and HDM Pharmacy Services. HDM will reprice 100% of AccessWV's pharmacy claims at a cost of $.115 per readjudicated claim. They will also retain 10 percent of recouped funds. Because of the increasing complexity of pharmacy benefit designs, it has become commonplace among payers to contract for claims repricing in the hope of uncovering errors and recouping inappropriate payments as a strategy for reining in drug costs.

Mid Plan Year Premium Reductions (Effective 1/1/08)

Sufficient credible data became available in 2007 to give more weight to AccessWV's own experience by various rating categories. The analysis found the East region to have the highest loss ratio followed by the North region. Both the Central and South regions had low loss ratios. At this time, the East region had the lowest premiums followed by the Central region. Premiums were highest in the South region and second highest in the North. These data suggested the need for an adjustment of the regional rates to better reflect costs.

Rating Region	Loss Ratio	Premium Rank (1=Highest)
North	71%	2
South	57%	1
East	94%	4
Central	51%	3
All Regions	**67%**	

When loss ratios were examined by product, Plan C had the most favorable loss ratio.

Plan	Loss Ratio
Plan A	95%
Plan B	67%
Plan C	44%
All Plans	**67%**

At the same time, the Actuary re-examined the methodology for calculating the percentage of the standard risk rate and informed the Board that it was possible to reduce premiums and still maintain AccessWV at 130 percent of the standard risk rate. The Board of Directors, at the October meeting, approved a selective premium reduction effective January 1, 2008. The premium reduction was to take into consideration AccessWV's actual experience by the various rating factors as well as the current premium levels with the stipulation that no premiums would be increased. As a result, the premium reductions shown below were taken January 1, 2008.

Factor	Approximate Premium Decrease
North	2%
South	8%
East	None
Central	8%
Plan C	9%

Outreach Activities to Promote AccessWV to the Target Population

During 2007, AccessWV continued to rely heavily on its strategy of working through stakeholders to reach the target population. Stakeholders include insurance agents, carriers, providers, disease organizations and other service entities that have contact with potential members. Public appearances by the Executive Director, the Insurance Commissioner and staff from the Offices of the Insurance Commissioner also contributed to the outreach effort.

Special mail campaigns were directed at a number of stakeholder groups including state legislators, Social Security district offices, county health departments, constituent offices of the WV congressional delegation, family practice physicians and Charleston health insurance agents.

Formal presentations on AccessWV were made at the Spring Meeting of the West Virginia Chapter of the National Association of Social Workers, the Osteopathic Medicine Annual Spring Conference, the WVU Summer Institute on Aging, and the National Association for Welfare Research & Statistics (NAWRS).

The Consumer Services Division of the Offices of the Insurance Commissioner offered information on AccessWV at numerous fairs throughout the State. A "floating banner" for AccessWV was created to attract traffic to the display booth. The display was also offered at the Governor's Summit on Aging.

AccessWV continued to provide promotional materials to numerous stakeholders for distribution and/or display at their locations. Included among these stakeholder partners were Valley Health Systems (OUCH), the American Diabetes Association, the WV Hospital Association, Workforce West Virginia, and DHHR Client Services. Materials were also provided to many other entities. As in the past, AccessWV was an active participant in "Cover the Uninsured Week" and furnished outreach materials for distribution throughout the State.

While many agents inform their clients about AccessWV on a good will basis, the Board of Directors believes that actively involving agents in the application process will boost AccessWV's enrollment of the target population. The Board thus voted to offer health insurance agents a one-time referral fee of $50 for assisting with the completion and submission of an application, if the applicant is accepted for coverage. The Referral Fee Program will be implemented in early 2008. Payment of a referral fee is standard practice among other high risk pools with $50 being the most frequent level of payment. At the request of AccessWV, a question on the high risk pool has been incorporated on the agent licensing exam.

Almost 600 persons affected by an insurer pull-out from West Virginia were notified by mail of their right to enroll in AccessWV without a pre-existing requirement, if they were otherwise eligible. Forty-two persons called in response to the mailing, and 13 joined AccessWV.

The Outreach subcommittee of the Board met as needed to discuss program promotion, and outreach strategies were frequently discussed at full Board meetings. Outreach Reports, detailing promotional efforts, were provided to the Board at regular intervals.

Fulfillment of Requests for Application Kits

AccessWV maintains a toll-free number (1-866-445-8491) as well as a local number (304-558-8264) to receive calls from prospective applicants. During 2007 AccessWV fulfilled 500 requests for application kits. About 80 additional callers declined information, most of them because they considered the premiums unaffordable. In such situations, AccessWV staff attempted to refer the caller to "safety net" providers or other organizations that might be of assistance.

Mountain State Blue Cross Blue Shield continued as the most prominent source of referrals to the phone line accounting for 41 percent of all callers who are sent application kits. Blue Cross provides an AccessWV brochure and contact information to all persons who are denied coverage for medical reasons or who receive medically underwritten quotes for portability coverage.

Agents were the second most important source of referrals, accounting for 19 percent of these callers. Thirteen percent of those receiving kits reported they learned about AccessWV through the Internet. The remaining 27 percent learned of the program through targeted mailings, flyers in stakeholder offices, various state governmental agencies including Workforce West Virginia, and miscellaneous sources.

Toward the end of 2007, the majority of applicants were downloading the materials directly from the program web-site and are not reflected in these data.

Update of Plan's Operational Protocols

AccessWV's policies and procedures continue to be modified and expanded as needed on an ongoing basis. An official update of the Plan's **Operational Protocols** was issued in November. The Executive Director is authorized to approve the protocols. Protocols that involve Plan Administrator functions are reviewed by the Plan Administrator. An official update of the Operational Protocols is undertaken annually.

Financial Audit of Fiscal Year 2007

A financial audit of AccessWV for FY 2007 was conducted as part of the audit of the Offices of the Insurance Commissioner, which considered AccessWV as an enterprise fund. Suttle and Stalnaker of Charleston performed the audit. The Auditor's Report did not identify any issues for AccessWV. AccessWV completed FY 2007 with an operating surplus.

The audit also included oversight of various functions performed by the Plan Administrator including eligibility determination, premium billing and claims administration. This component of the audit, although limited in scope, was deemed to preclude the need for a more extensive administrative audit at this time.

Analysis of Plan Data and Preparation of Related Reports

An Enrollment Report is prepared each month and distributed to the Board of Directors and other interested parties. An Outreach Report is prepared bimonthly and distributed to the Board. This serves a permanent record of the outreach activities as well as a stimulus for generating other ideas for this effort.

As the Plan added enrollment during the year and the proportion of members without a waiting period for pre-existing conditions increased, medical and pharmacy utilization also increased and began to yield data for meaningful analysis. Utilization is monitored continuously, and issues requiring follow-up are identified.

Financial reports, reflecting revenues and expenditures, are updated monthly for Board review. The Financial Plan, which reflects accrued as well as actual expenditures, is updated periodically.

VI. Going Forward

As AccessWV enters its third full-year of operation focus is on:

- ***Identifying new ways to reach out to the target population***

The Plan continued to see steady but slow growth during most of 2007 with the enrollment reaching somewhat of a plateau in the last few months of the year. Overall, the net monthly gain in enrollment for 2007 was 11-12 policyholders compared to 17-18 policyholders monthly during 2006.

AccessWV premiums are quite high for most West Virginians and have been a significant deterrent to enrollment. To increase affordability, the Board took the opportunity to selective lower premiums effective January 1, 2008, while still maintaining premiums at 130 percent of the standard risk rate. The potential for further lowering premiums by offering an additional product design will be explored in 2008.

At its December meeting, the Board voted to introduce an agent referral fee in the hope that formally involving agents in the application process will increase the numbers served by the Plan. The Referral Fee Program is scheduled for implementation in April 2008. Once implemented, the impact of the agent referral fee will be assessed and additional strategies for outreach will be undertaken as needed.

- ***Determining premiums and benefits for Plan Year 2009 (starting July 2008)***

Several "health and wellness" benefits offered by the Plan Administrator to its beneficiaries will be explored for potential inclusion in the AccessWV benefit package. They include smoking cessation, a weight reduction program and gym discounts. Participation in the Plan Administrator's contract for sleep management services will also be considered. The contract offers precertification and provider discounts for services related to sleep disorders.

A "prior authorization" requirement was imposed on all out-of-state services as of July 1, 2007. Data on out-of-state utilization will be reviewed to determine whether additional interventions are needed to keep utilization within West Virginia.

Premiums have previously been reviewed annually in March in anticipation of the new Plan Year on July 1. However, because of the recent premium review in October, the Board may choose to postpone its next review beyond the start of the 2009 Plan Year.

- ***Fine-tuning the premiums and product offerings to increase affordability and fairness and better reflect the Plan's own utilization experience.***

Possible New Product. Premiums continue to be a major deterrent to plan enrollment. Forty-six percent of policyholders elect Plan C, the product with the highest deductible and lowest premium. The potential appeal of a product with an even higher deductible and/or other cost-saving features will be explored.

Out-of-State Usage. Out-of-state usage will continue to be monitored closely. The relationship between out-of-state use and regional location will be examined with particular attention to the East region, which appears to be the greatest source of out-of-state use and which also has the

highest loss ratios. If appropriate, the potential for a "West Virginia only" product will be explored.

Regional Rating Methodology. As AccessWV matures, it is developing a body of credible experience which can be sued to examine its rating assumptions. Initially, AccessWV adopted the rating methodology used by Mountain Blue Cross and Blue Shield for the individual market. AccessWV began to move away from the Mountain State methodology when it revised its premiums for January 2008, taking into account the Plan's own loss ratios by region. The Board views regional rating as an open issue, which it will continue to revisit.

Family Premiums. Currently, family premiums are set at 240 percent of the individual premium. A family may elect the adult with the more favorable premium as the policyholder, provided that she or he is independently eligible for the risk pool. A preliminary analysis shows that some families may be paying premiums well below the market, while others are charged excessive rates. At the same time, the loss ratios for family policies are much more favorable than the loss ratios for individual coverage. The methodology for setting family premiums will be reviewed during 2008 and action taken as appropriate.

- ***Monitoring potential funding opportunities.***
  In late 2007, $50 M of the $75 M authorized by the High Risk Pool Funding Extension Act of 2006 was appropriated to fund risk pools for operational losses for fiscal year 2007. Bonus grants were also available to pools qualifying for operational grants. AccessWV did not have an operational loss in fiscal year 2007 and thus presumably will not be eligible for any federal funding. The Executive Director will continue to monitor the grant situation.

  The Insurance Commissioner, who is also chair of the AccessWV Board, contacted WV's Congressional delegation to encourage their support for the risk pool funding appropriations, which had been in jeopardy. AccessWV will continue to lobby in support of risk pool funding as appropriate. It is the expectation that in future years AccessWV will stand to benefit from any available federal funding.

- ***Providing an update to the Legislature in January 2009 on the financial status of the Plan with recommendations for continued financing.***
  In its most recent report to the Legislature in January 2008, the Board continued to support the hospital assessment as the financing mechanism of choice until funding from this source is no longer adequate to cover the Plan's operating needs. The Board noted that, despite the favorable projections to date, there is no guarantee that AccessWV's favorable financial results will continue. The situation could change dramatically if members start to present with catastrophic expenses. The Board is committed to return to the Legislature with recommendations for a permanent source of this financing once a period deficit is projected for the Plan.

  The financial situation of AccessWV will remain under the constant scrutiny of the Board of Directors, with the long-term Financial Plan updated regularly to reflect the Plan's latest experience. The Board will report to the Legislature in January 2009 on the financial status of the plan and will offer recommendations for continued financing depending upon the 2008 financial results.

VII. Appendix

Tables

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Table 1

Enrollment by County: December 2007

Region	County	# Policies
East	Barbour	3
	Berkeley	28
	Grant	5
	Hampshire	8
	Hardy	6
	Jefferson	16
	Lewis	5
	Mineral	8
	Morgan	13
	Pendleton	1
	Pocahontas	6
	Preston	9
	Randolph	9
	Tucker	2
	Upshur	4
	Webster	2
	Region total	***125***
Central	Braxton	2
	Cabell	33
	Calhoun	1
	Doddridge	4
	Gilmer	0
	Harrison	13
	Jackson	5
	Mason	5
	Pleasants	1
	Putnam	13
	Ritchie	3
	Roane	0
	Wayne	7
	Wirt	1
	Wood	30
	Region total	***118***
North	Brooke	5
	Hancock	6
	Marion	7
	Marshall	2
	Monongalia	24
	Ohio	12
	Taylor	1
	Tyler	1
	Wetzel	3
	Region total	***61***
South	Boone	3
	Clay	0
	Fayette	6
	Greenbrier	13
	Kanawha	52
	Lincoln	2
	Logan	5
	McDowell	3
	Mercer	13
	Mingo	7
	Monroe	2
	Nicholas	6
	Raleigh	14
	Summers	3
	Wyoming	3
	Region total	***132***

Total All Regions: 436

Table 2

Medical Claims by Diagnostic Category: Paid January 2007 through December 2007

ICD 9 Code	Diagnostic Category	Paid Claims	# of Claims	% of Claims Dollars
140-239	Neoplasms	$254,789	532	15.8%
710-739	Musculoskeletal and connective tissue disease	$212,298	800	13.1%
V00-V82	Supplemental factors influencing health status	$176,669	970	10.9%
390-459	Diseases of circulatory system	$159,491	578	9.9%
320-389	Diseases of nervous system and sense organs	$159,240	368	9.9%
780-799	Systems signs and ill-defined conditions	$145,636	1,089	9.0%
240-279	Endocrine, nutritional and metabolic diseases	$85,309	734	5.3%
800-999	Injury and poisoning	$84,149	368	5.2%
460-519	Diseases of respiratory system	$80,078	458	5.0%
580-629	Diseases of genitourinary system	$78,409	362	4.9%
520-579	Diseases of digestive system	$56,389	262	3.5%
290-319	Mental disorders	$30,895	448	1.9%
630-679	Complications of pregnancy and childbirth	$30,353	61	1.9%
680-709	Diseases of skin and subcutaneous tissue	$19,654	201	1.2%
280-289	Diseases of blood and blood forming organs	$18,137	93	1.1%
760-779	Conditions originating in perinatal period	$11,333	33	0.7%
000-139	Infectious and parasitic diseases	$6,858	95	0.4%
740-759	Congenital anomalies	$5,446	24	0.3%
	Other	-$56	1	0.0%
All		**$1,615,076**	**7,477**	**100.0%**

Source: Compiled from AccessWV Monthly Health Care Management Reports for December 2006, June 2007 and December 2007 presented by Wells Fargo Third Party Administrators. Column may not total due to rounding error.

Table 3

Drug Claims: Top 10 Therapeutic Classes by # of Scripts, 2007

Therapeutic Class Description	Rx Count Rank	Rx Count	% of Rx	Total Plan Cost*	% of Plan Costs*
Opioid combinations	1	532	4.9%	$4,718	.9%
HMG COA reductase inhibitors	2	418	3.8%	$16,253	3.0%
Proton pump inhibitors	3	406	3.7%	$22,920	4.2%
Selective serontonin reuptake inhibitors (SSRIS)	4	382	3.5%	$5,773	1.1%
ACE inhibitors	5	338	3.1%	$1,853	.3%
Beta blockers cardio-selective	6	330	3.0%	$3,479	.6%
Benzodiazepines	7	329	3.0%	$3,942	.7%
Thyroid hormones	8	315	2.9%	$993	.2%
Biguanides	9	229	2.1%	$2,253	.4%
Insulin	10	222	2.0%	$34,428	6.4%
Total 10 most frequent therapeutic classes		**3501**	**32.0%**	**$96,612**	**17.8%**
Total all classes		**10,930**	**100%**	**$542,014**	**100%**

Source: Compiled from reports provided by Express Scripts, Inc.

Note: Columns may not total due to rounding error.

Table 4

Individual Drugs—Top 10 by Prescription Count, 2007

Drug Name/ Drug NDC	Rank	Rx Count	Total Plan Cost*	Member Cost-Share Per Script**
Plavix 75 mg tablet/ 636531171	1	134	$12,819	$15
Omeprazole 20 mg capsule dr/ 003786150	2	93	$1,102	$5
Lantus 100 units/ml vial/ 000882220	3	85	$9,773	$15
Crestor 10 mg tablet/ 003100751	4	82	$4,972	$15
Nexium 40 mg tablet/ 001865040	5	70	$6,208	$50 (as of 7/1/07)
Tricor 145 mg tablet/ 000746123	6	64	$5,990	$15
Ascensia contour strips/ 001937090	7	60	$10,286	$15
Prevacid 30 mg capsule dr / 003003046	8	59	$7,169	$50 (as of 7/1/07)
Hydrocodone-APAP-5-500 tablet 004060357	9	55	$75	$5 or less
Furosemide 40 mg tablet 003780216	10	52	$30	$5 or less
Total for top ten drugs		*754*	*$58,424*	
Total for all drugs* **		**10,017**	**$540,163**	
Top ten as % of total		*7.5%*	*10.8%*	

Source: Compiled from data supplied by Express Scripts, Inc.

* Final cost to the Plan may be lower after rebates.
**Generic: $5 copay or less
Brand Formulary: $15 copay
Brand Non-Formulary: $50 copay (as of 7/1/07)
Specialty Medication: $50 copay
***Does not correspond to other totals due to listing differences.

Attachment A

Board of Directors and Administration

Board Members

Jane Cline, Chairperson
Charleston, WV
Insurance Commissioner

Fred Early II
Parkersburg, WV
Insurance Representative

David E. Haden
Charleston, WV
Insurance Representative

Laura Phillips
Charleston, WV
Consumer Representative

Christopher Plein, Ph.D.
Morgantown,WV
"Community at Large" Representative

Paul Prunty
Fairmont, WV
Consumer Representative

David Ramsey
Charleston, WV
Hospital Representative

AccessWV Staff

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Alfreda Dempkowski, Executive Director
E-mail: alfreda.dempkowski@wvinsurance.gov

Plan Administrator

Public Employees Insurance Agency
State Capitol Complex, Building 5, Room 1001
1900 Kanawha Boulevard East
Charleston, WV 25303-0710
1-888-680-7342

WEST VIRGINIA
OFFICES OF THE INSURANCE COMMISSIONER

Financial Statements, Required Supplementary Information
and Other Financial Information

Year ended June 30, 2007
and
Independent Auditors' Report

INDEPENDENT AUDITORS' REPORT

West Virginia Offices of the Insurance Commissioner
Charleston, West Virginia

We have audited the accompanying financial statements of the governmental activities, the business-type activities, and each major fund of the West Virginia Offices of the Insurance Commissioner as of and for the year ended June 30, 2007, which collectively comprise the basic financial statements of the West Virginia Offices of the Insurance Commissioner, as listed in the table of contents. These financial statements are the responsibility of the West Virginia Offices of the Insurance Commissioner's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the West Virginia Offices of the Insurance Commissioner's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statements of the West Virginia Offices of the Insurance Commissioner are intended to present the financial position, and the changes in financial position and cash flows, where applicable, of only that portion of the governmental activities business-type activities, and each major fund of the State of West Virginia that is attributable to the transactions of the West Virginia Offices of the Insurance Commissioner. They do not purport to, and do not, present fairly the financial position of the State of West Virginia as of June 30, 2007, and the changes in its financial position and its cash flows, where applicable, for the year then ended in conformity with accounting principles generally accepted in the United States of America.

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A Professional Limited Liability Company

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the business-type activities and each major fund of the West Virginia Offices of the Insurance Commissioner at June 30, 2007, and the respective changes in financial position and cash flows, where applicable, for the year then ended in conformity with accounting principles generally accepted in the United States of America.

The management's discussion and analysis on pages 5 through 11, the unaudited supplemental claims information on pages 48 through 53 and the budgetary comparison schedule on page 54 are not a required part of the basic financial statements but are supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit the information and express no opinion on it.

Suttle & Stalnaker, PLLC

Charleston, West Virginia
November 20, 2007

WEST VIRGINIA
OFFICES OF THE INSURANCE COMMISSIONER
STATEMENT OF NET ASSETS
PROPRIETARY FUNDS
June 30, 2007
(In Thousands)

	Workers' Compensation	AccessWV	Total
Assets:			
Current Assets:			
Cash and Cash Equivalents	$ 975,123	$ 6,588	$ 981,711
Receivables, Net:			
Taxes and Fees	9,347	-	9,347
Assessments	129	-	129
Premiums	4,938	-	4,938
Other	-	30	30
Total Current Assets	989,537	6,618	996,155
Noncurrent Assets:			
Surplus Note	185,000	-	185,000
Total Noncurrent Assets	185,000	-	185,000
Total Assets	1,174,537	6,618	1,181,155
Liabilities:			
Current Liabilities:			
Estimated Liability for Unpaid Claims and Claim Adjustment Expense	272,400	280	272,680
Excess Deposits	94	-	94
Accrued Expenses and Other Liabilities	3,361	92	3,453
Total Current Liabilities	275,855	372	276,227
Noncurrent Liabilities:			
Estimated Liability for Unpaid Claims and Claim Adjustment Expense	2,709,000	-	2,709,000
Total Noncurrent Liabilities	2,709,000	-	2,709,000
Total Liabilities	2,984,855	372	2,985,227
Net Assets:			
Restricted for:			
Coal Workers' Pneumoconiosis	137,627	-	137,627
Uninsured Fund	4,607	-	4,607
Self-Insured Funds	2,704	-	2,704
Private Carrier Guaranty Fund	1,993	-	1,993
AccessWV	-	6,246	6,246
Unrestricted (Deficit)	(1,957,249)	-	(1,957,249)
Total Net Assets (Deficit)	$ (1,810,318)	$ 6,246	$ (1,804,072)

See accompanying notes to financial statements.

WEST VIRGINIA
OFFICES OF THE INSURANCE COMMISSIONER
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN FUND NET ASSETS
PROPRIETARY FUNDS
For the Year Ended June 30, 2007
(In Thousands)

	Workers' Compensation	AccessWV	Total
Operating Revenues:			
Statutory Allocations	$ 41,000	$ 1,764	$ 42,764
Fees	136,796	-	136,796
Assessments	77,789	-	77,789
Net Premium Revenue	6,079	2,104	8,183
Other Operating Revenue	552	207	759
Total Operating Revenue	262,216	4,075	266,291
Operating Expenses:			
Claims and Claim Adjustment Expenses (See Note 5)	50,566	1,469	52,035
General and Administration	23,500	272	23,772
Total Operating Expenses	74,066	1,741	75,807
Operating Income	188,150	2,334	190,484
Nonoperating Revenues (Expenses):			
Investment Earnings	20,433	280	20,713
Net Increase (Decrease) in Fair Value of Investments	88,604	-	88,604
Total Nonoperating Revenues (Expenses)	109,037	280	109,317
Change in Net Assets Before BrickStreet Transactions and Transfers	297,187	2,614	299,801
BrickStreet Transactions, Net	(7,484)	-	(7,484)
Change in Net Assets Before Transfers	289,703	2,614	292,317
Other Transfers In (Out)	1,736	48	1,784
Change in Net Assets (Deficit)	291,439	2,662	294,101
Total Net Assets - Beginning of Year	(2,101,757)	3,584	(2,098,173)
Total Net Assets (Deficit) - End of Year	$ (1,810,318)	$ 6,246	$ (1,804,072)

See accompanying notes to financial statements.

WEST VIRGINIA
OFFICES OF THE INSURANCE COMMISSIONER
STATEMENTS OF CASH FLOWS-PROPRIETARY FUNDS
Year Ended June 30, 2007
(In Thousands)

	Workers' Compensation	AccessWV	Totals
Cash Flows from Operating Activities:			
Receipts from Statutory Allocations, Fees and Assessments	$ 272,583	$ 2,127	$ 274,710
Receipts from Policyholders	(3,915)	2,105	(1,810)
Payments to Claimants and Providers	(327,024)	-	(327,024)
Payments to Employees	(1,902)	(59)	(1,961)
Payments to Suppliers	(21,433)	(1,759)	(23,192)
Net Cash Provided (Used) by Operating Activities	(81,691)	2,414	(79,277)
Cash flows from Financing Activities:			
BrickStreet Transactions, Net	(7,484)	-	(7,484)
Other Transfers	1,736	48	1,784
Net Cash Provided by Financing Activities	(5,748)	48	(5,700)
Cash flows from Investing Activities:			
BrickStreet Note Receivable Principle and Interest payments	19,392	-	19,392
Investment Earnings	77,683	250	77,933
Net Increase (Decrease) in the Fair Value of Investments	26,962	-	26,962
Net Cash Provided (Used) by Investing Activities	124,037	250	124,287
Net increase in Cash and Cash Equivalents	36,598	2,712	39,310
Cash and Cash Equivalents - Beginning of Year	938,525	3,876	942,401
Cash and Cash Equivalents - End of Year	$ 975,123	$ 6,588	$ 981,711
Reconciliation of operating income (loss) to net cash provided (used) by operating activities:			
Operating income (loss)	$ 188,150	$ 2,334	$ 190,484
Adjustments to reconcile operating income (loss) to net cash provided (used) by operating activities:			
Net change in assets and liabilities:			
Receivables, net	54,658	-	54,658
Premium Advanced Deposits	(33,206)	157	(33,049)
Note Receivable	(15,000)	-	(15,000)
Estimated liability for claims and claim adjustment expenses	(277,700)	(140)	(277,840)
Compensated Absences	(1,518)	70	(1,448)
Accrued expenses and other liabilities	2,925	(7)	2,918
Net cash provided (used) by operating activities	$ (81,691)	$ 2,414	$ (79,277)

See accompanying notes to financial statements.

AccessWV

Baseline Scenario - Gross Monthly Growth Rate of 30 Policies
Premiums Effective January 1, 2008 and Subsequent 5% Annual Increase
Trend Assumptions of 10% Medical and 14% Pharmacy

Accrued Income Statement and Funds Available					
	2007	2008	2009	2010	2011
Accrued Revenue					
Federal Grant/Assessments	$ 1,899,164	$ 1,975,000	$ 2,054,000	$ 2,136,000	$ 2,221,000
Premiums	$ 2,678,523	$ 3,638,413	$ 4,791,716	$ 5,730,256	$ 6,516,560
Interest	$ 364,731	$ 658,246	$ 779,056	$ 884,066	$ 969,330
Revenue Total	$ 4,942,418	$ 6,271,659	$ 7,624,772	$ 8,750,322	$ 9,706,890
Incurred Expenses					
Medical Claims	$ 1,742,877	$ 2,672,543	$ 3,739,128	$ 4,719,554	$ 5,647,026
Pharmacy Claims	$ 552,865	$ 881,809	$ 1,279,513	$ 1,675,687	$ 2,079,220
Administrative Expenses	$ 359,750	$ 468,677	$ 549,247	$ 617,325	$ 676,949
Expense Total	$ 2,655,492	$ 4,023,029	$ 5,567,887	$ 7,012,566	$ 8,403,195
Period Surplus/(Deficit)	$ 2,286,926	$ 2,248,630	$ 2,056,884	$ 1,737,756	$ 1,303,695
Beginning Funds Available	$ 6,032,050	$ 8,318,976	$ 10,567,606	$ 12,624,490	$ 14,362,247
Period Surplus/(Deficit)	$ 2,286,926	$ 2,248,630	$ 2,056,884	$ 1,737,756	$ 1,303,695
Ending Funds Available	$ 8,318,976	$ 10,567,606	$ 12,624,490	$ 14,362,247	$ 15,665,942

AccessWV

Baseline Scenario - Gross Monthly Growth Rate of 30 Policies
Premiums Effective January 1, 2008 and Subsequent 5% Annual Increase
Trend Assumptions of 10% Medical and 14% Pharmacy

Policy Loss Ratio and Administrative Expense Ratio					
	2007	2008	2009	2010	2011
Policy Loss Ratio	86%	98%	105%	112%	119%
Administrative Expense Ratio	13%	13%	11%	11%	10%
AccessWV Cash Position					
	2007	2008	2009	2010	2011
Beginning Cash Balance	$ 6,177,743	$ 8,777,469	$ 11,112,113	$ 13,322,814	$ 15,204,137
Cash Flow	2,599,726	2,334,644	2,210,701	1,881,324	1,442,385
Ending Balance	$ 8,777,469	$ 11,112,113	$ 13,322,814	$ 15,204,137	$ 16,646,522
AccessWV Federal Grant					
	2007	2008	2009	2010	2011
Beginning Cash Balance	$ -	$ -	$ -	$ -	$ -
Expenditures	-	-	-	-	-
Ending Balance	$ -	$ -	$ -	$ -	$ -
Total Funds Available	$ 8,777,469	$ 11,112,113	$ 13,322,814	$ 15,204,137	$ 16,646,522
Enrollment Information					
	2007	2008	2009	2010	2011
HCTC	-	-	-	-	-
HIPAA	192	265	315	349	372
High Risk	244	337	400	444	473
Ending Enrollment	436	602	715	792	845
New Coverages	276	360	360	360	360
Lapsed Coverages	138	194	247	283	307
Claim Reserve and Payable Information					
	2007	2008	2009	2010	2011
Medical					
Beginning Reserve	$ 176,000	$ 320,000	$ 423,714	$ 565,219	$ 696,099
Paid Claims	1,598,877	2,248,829	3,597,623	4,170,092	5,521,569
Ending Reserve	$ 320,000	$ 423,714	$ 565,219	$ 696,099	$ 821,556
Prescription Drugs					
Beginning Reserve	$ 9,200	$ 18,000	$ 13,300	$ 18,262	$ 23,231
Paid Claims	544,065	868,509	1,274,551	1,516,265	2,074,090
Ending Reserve	$ 18,000	$ 13,300	$ 18,262	$ 23,231	$ 28,361
Administrative Expense Payable	$ 160,000	$ 147,000	$ 154,350	$ 162,068	$ 170,171
Ending Plan Liability	$ 498,000	$ 584,014	$ 737,831	$ 881,398	$ 1,020,088

Effective 7/1/07

SUMMARY OF BENEFITS

Offering individual health insurance coverage to West Virginians who have pre-existing, severe or chronic medical conditions.

P.O. Box 50540, Charleston, WV 25305-0540
1-866-445-8491 • www.AccessWV.org

AccessWV0003; 0407

Medical Benefits		Plan A	Plan B	Plan C
Annual Deductible:	Individual, In-Network	$400	$800	$2,000
	Family, In-Network	$800	$1,600	$4,000
	Individual, Out-of-Network	$800	$1,600	$4,000
	Family, Out-of-Network	$1,600	$3,200	$8,000
Annual Out-of-Pocket Maximum:	Individual, In-Network	$2,000	$2,500	$3,000
	Family, In-Network	$4,000	$5,000	$6,000
	Individual, Out-of-Network	$4,000	$5,000	$6,000
	Family, Out-of-Network	$8,000	$10,000	$12,000
Annual Benefit Maximum Per Member		$200,000	$200,000	$200,000

Prescription Drug Benefits		Plan A	Plan B	Plan C
Annual Deductible:	Individual	$200	$400	$1,000
	Family	$400	$800	$2,000
Annual Out-of-Pocket Maximum:	Individual	$2,000	$2,000	$2,000
	Family	$4,000	$4,000	$4,000
Annual Benefit Maximum Per Member		$25,000	$25,000	$25,000

Lifetime Benefit Maximum Per Member – All Benefits	Plan A	Plan B	Plan C
	$1,000,000	$1,000,000	$1,000,000

Note: Some enrollees will be subject to a 6-month waiting period for pre-existing conditions before claims for services related to their health condition will be paid by the plan.

Annual deductibles and maximums are based on a Plan Year, which begins July 1 and ends June 30 of the following year.

This is a summary of benefits provided by AccessWV and other limitations of coverage apply. Full coverage details are provided in AccessWV's Policy with members.

AccessWV Summary of Benefits – Partial Listing of Covered Services

Cost to Member

Physician Services	In-Network, WV	In-Network, Non-WV**	Out-of-Network**
Adult routine physical exams (including prostate & gyn exam with pap smear)	$10 copay (for office visit, other services additional)	30% coinsurance*	40% coinsurance*
Diagnostic x-ray, lab and testing	20% coinsurance*	30% coinsurance*	40% coinsurance*
Screening Mammogram	$0, Covered in full	30% coinsurance*	40% coinsurance*
Physician inpatient visits	20% coinsurance*	30% coinsurance*	40% coinsurance*
Physician office visits – primary care	$15 copay	30% coinsurance*	40% coinsurance*
Physician office visits – specialty care	$15 copay	30% coinsurance*	40% coinsurance*
Prenatal care (Routine care only)	$0, Covered in full	30% coinsurance*	40% coinsurance*
Second surgical opinion	$15 copay (no copay if required by AccessWV)	30% coinsurance*	40% coinsurance*
Well child exams and immunizations	$0, Covered in full	$0, Covered in full	$0, Covered in full

Inpatient Services	In-Network, WV	In-Network, Non-WV**	Out-of-Network**
Semiprivate room; ancillaries; therapy services, x-ray, lab, surgery related, and general nursing care	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Maternity care (delivery)	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Rehabilitation Facility (150 day limit per member per plan year)	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Skilled Nursing Facility (100 day limit per member per plan year)	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*

Hospital Outpatient Services	In-Network, WV	In-Network, Non-WV**	Out-of-Network**
Ambulatory/outpatient surgery	$50 copay + 20% coinsurance*	$75 copay + 30% coinsurance*	$100 copay + 40% coinsurance*
Preadmission testing	20% coinsurance*	30% coinsurance*	40% coinsurance*

Mental Health & Chemical Dependency Benefits	In-Network, WV	In-Network, Non-WV**	Out-of-Network**
Outpatient chemical dependency & mental health (20 visit limit per member per plan year)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Inpatient mental health and chemical dependency (30 day limit per member per plan year)	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*
Inpatient detoxification	20% coinsurance*	30% coinsurance*	$500 copay + 40% coinsurance*

Other Services	In-Network, WV	In-Network, Non WV**	Out-of-Network**
Allergy testing and treatment	20% coinsurance*	30% coinsurance*	40% coinsurance*
Cardiac and pulmonary rehabilitation (36 session limit per member per plan year)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Dental Services – accident related	20% coinsurance*	30% coinsurance*	40% coinsurance*
Diabetic supplies	Covered under prescription drug plan	Covered under prescription drug plan	Covered under prescription drug plan
Durable Medical Equipment (DME)	20% coinsurance*	30% coinsurance*	40% coinsurance*

*Medical deductible applies, if not already met

** **Prior Authorization Requirement for Out-of-State Services:** To qualify for the coverage shown, services received from "In-Network, Non-WV providers" or "Out-of-Network" providers must receive prior authorization from AccessWV. Without prior authorization, a penalty will apply. This requirement does not apply to Emergency Care.

AccessWV Summary of Benefits – Partial Listing of Covered Services

Cost to Member

Other Services	In-Network, WV	In-Network, Non WV**	Out-of-Network**
Home health services & supplies	20% coinsurance*	30% coinsurance*	40% coinsurance*
Hospice	20% coinsurance*	30% coinsurance*	40% coinsurance*
Medical supplies	20% coinsurance*	30% coinsurance*	40% coinsurance*
Outpatient Therapies (20 visits combined limit per member per plan year)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Prosthetics	20% coinsurance*	30% coinsurance*	40% coinsurance*
Radiation and chemotherapy	20% coinsurance*	30% coinsurance*	40% coinsurance*

Emergency Care	In-Network, WV	In-Network, Non WV	Out-of-Network
Emergency ambulance (Medically necessary)	20% coinsurance*	30% coinsurance*	40% coinsurance*
Emergency services (Certified as an emergency)	$25 copay + 20% coinsurance*	$25 copay + 20% coinsurance*	$25 copay + 20% coinsurance*
Emergency room treatment (Non-emergency)	$50 copay + 20% coinsurance*	$50 copay + 30% coinsurance*	$50 copay + 40% coinsurance*
Urgent Care	20% coinsurance*	30% coinsurance*	40% coinsurance*

Special Benefit	In-Network, WV & In-Network, Non-WV *(not available in WV)*	In-Network, Non WV *(if available in WV)***	Out-of-Network**
Transplants	20% coinsurance*	$7,500 additional deductible + 30% coinsurance*	$10,000 additional deductible + 40% coinsurance*
Transplant related transportation and lodging	$0 up to $5,000* then member pays all	Member pays all expenses	Member pays all expenses

*Medical deductible applies, if not already met.

** **Prior Authorization Requirement for Out-of-State Services:** To qualify for the coverage shown, services received from "In-Network, Non-WV providers" or "Out-of-Network" providers must receive prior authorization from AccessWV. Without prior authorization, a penalty will apply. This requirement does not apply to Emergency Care.

Prescription Drugs (Preferred Drug List with Mandatory Generics)

Cost to Member (After Pharmacy Deductible)

	In-Network	Out-of-Network
Generic	$ 5	$5 + $3 Out-of-Network copay
Formulary brand necessary	$15	$15 + $3 Out-of-Network copay
Brand requested by patient	$5 + full cost difference from generic	$5 + $3 Out-of-Network copay+ full cost difference from generic
Non-Formulary	$50	$50 + $3 Out-of-Network copay
Maintenance medication discount	90-day supply for 2 months copay in mail order program or Retail Maintenance Network. (Some restrictions may apply)	No discount available

P.O. Box 50540,
Charleston, WV 25305-0540
1-866-445-8491
www.AccessWV.org

MONTHLY PREMIUMS

Effective July 1, 2007
Premiums are based on region, age and gender.

EAST REGION

Counties: Barbour, Berkeley, Grant, Hampshire, Hardy, Jefferson, Lewis, Mineral, Morgan, Pendleton, Pocahontas, Preston, Randolph, Tucker, Upshur, Webster

SINGLE						AGE BAND	FAMILY					
PLAN A $400 Deductible		PLAN B $800 Deductible		PLAN C $2,000 Deductible			PLAN A $800 Deductible		PLAN B $1,600 Deductible		PLAN C $4,000 Deductible	
Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
$215	$338	$188	$295	$155	$245	Under 25	$517	$705	$452	$614	$373	$509
$229	$419	$201	$368	$166	$303	25 TO 29	$549	$872	$481	$764	$398	$631
$253	$439	$221	$382	$183	$317	30 TO 34	$607	$946	$529	$823	$439	$684
$294	$467	$256	$407	$212	$338	35 TO 39	$706	$1,041	$615	$907	$509	$753
$349	$485	$305	$425	$253	$352	40 TO 44	$837	$1,138	$731	$998	$607	$825
$463	$557	$404	$486	$336	$403	45 TO 49	$1,111	$1,325	$970	$1,158	$806	$961
$643	$665	$561	$582	$465	$482	50 TO 54	$1,542	$1,595	$1,346	$1,397	$1,116	$1,157
$831	$784	$726	$686	$601	$568	55 TO 59	$1,993	$1,883	$1,741	$1,645	$1,442	$1,363
$1,036	$862	$905	$754	$751	$625	60+	$2,487	$2,069	$2,172	$1,809	$1,802	$1,499

CENTRAL REGION

Counties: Braxton, Cabell, Calhoun, Doddridge, Gilmer, Harrison, Jackson, Mason, Pleasants, Putnam, Ritchie, Roane, Wayne, Wirt, Wood

SINGLE						AGE BAND	FAMILY					
PLAN A $400 Deductible		PLAN B $800 Deductible		PLAN C $2,000 Deductible			PLAN A $800 Deductible		PLAN B $1,600 Deductible		PLAN C $4,000 Deductible	
Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
$240	$369	$210	$322	$174	$267	Under 25	$578	$777	$504	$679	$418	$562
$256	$458	$224	$400	$186	$332	25 TO 29	$615	$965	$537	$842	$446	$699
$281	$482	$247	$421	$205	$349	30 TO 34	$675	$1,049	$592	$917	$491	$759
$328	$515	$287	$450	$238	$373	35 TO 39	$786	$1,154	$688	$1,010	$572	$836
$390	$541	$340	$473	$281	$392	40 TO 44	$935	$1,272	$817	$1,111	$675	$921
$518	$623	$453	$543	$375	$450	45 TO 49	$1,242	$1,484	$1,086	$1,294	$900	$1,074
$717	$743	$628	$649	$520	$539	50 TO 54	$1,721	$1,784	$1,507	$1,557	$1,247	$1,293
$928	$877	$811	$765	$672	$635	55 TO 59	$2,228	$2,104	$1,946	$1,838	$1,613	$1,525
$1,159	$964	$1,012	$842	$839	$698	60+	$2,783	$2,313	$2,430	$2,021	$2,014	$1,676

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MONTHLY PREMIUMS

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NORTH REGION

Counties: Brooke, Hancock, Marion, Marshall, Monongalia, Ohio, Taylor, Tyler, Wetzel

SINGLE PLAN A $400 Deductible		SINGLE PLAN B $800 Deductible		SINGLE PLAN C $2,000 Deductible		AGE BAND	FAMILY PLAN A $800 Deductible		FAMILY PLAN B $1,600 Deductible		FAMILY PLAN C $4,000 Deductible	
Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
$260	$393	$227	$342	$188	$284	Under 25	$625	$835	$544	$728	$452	$603
$276	$487	$242	$426	$201	$354	25 TO 29	$663	$1,035	$580	$905	$481	$752
$305	$513	$266	$449	$221	$372	30 TO 34	$731	$1,125	$637	$985	$529	$814
$354	$551	$310	$482	$256	$399	35 TO 39	$849	$1,242	$743	$1,086	$615	$899
$420	$582	$368	$508	$305	$421	40 TO 44	$1,008	$1,369	$882	$1,196	$731	$991
$559	$671	$487	$585	$404	$485	45 TO 49	$1,341	$1,600	$1,170	$1,394	$970	$1,157
$774	$801	$676	$700	$561	$581	50 TO 54	$1,857	$1,923	$1,623	$1,681	$1,346	$1,393
$1,002	$946	$874	$826	$726	$686	55 TO 59	$2,405	$2,270	$2,097	$1,983	$1,741	$1,645
$1,250	$1,040	$1,091	$908	$905	$753	60+	$2,999	$2,495	$2,619	$2,180	$2,172	$1,807

SOUTH REGION

Counties: Boone, Clay, Fayette, Greenbrier, Kanawha, Lincoln, Logan, McDowell, Mercer, Mingo, Monroe, Nicholas, Raleigh, Summers, Wyoming

SINGLE PLAN A $400 Deductible		SINGLE PLAN B $800 Deductible		SINGLE PLAN C $2,000 Deductible		AGE BAND	FAMILY PLAN A $800 Deductible		FAMILY PLAN B $1,600 Deductible		FAMILY PLAN C $4,000 Deductible	
Male	Female	Male	Female	Male	Female		Male	Female	Male	Female	Male	Female
$280	$417	$245	$364	$203	$302	Under 25	$673	$894	$587	$780	$486	$648
$297	$518	$260	$454	$215	$375	25 TO 29	$713	$1,109	$625	$971	$517	$802
$328	$548	$286	$479	$237	$397	30 TO 34	$786	$1,209	$686	$1,055	$569	$875
$381	$590	$333	$515	$276	$427	35 TO 39	$915	$1,336	$799	$1,164	$663	$967
$454	$626	$396	$546	$328	$454	40 TO 44	$1,089	$1,475	$950	$1,287	$786	$1,070
$602	$721	$526	$630	$436	$523	45 TO 49	$1,444	$1,721	$1,262	$1,504	$1,046	$1,247
$834	$863	$729	$755	$604	$626	50 TO 54	$2,001	$2,072	$1,749	$1,812	$1,449	$1,502
$1,078	$1,019	$942	$889	$781	$738	55 TO 59	$2,588	$2,444	$2,261	$2,135	$1,875	$1,771
$1,346	$1,119	$1,176	$978	$974	$812	60+	$3,231	$2,686	$2,822	$2,346	$2,338	$1,948