

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

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WELLCHOICE, INC. AND SUBSIDIARIES

*The following discussion and analysis presents a review of WellChoice, Inc. and its subsidiaries (collectively, the "Company") for the three-year period ended December 31, 2002. This review should be read in conjunction with the consolidated financial statements and other data presented herein.*

The statements contained in the Annual Report on Form 10-K, including those set forth in "Item 1—Business—Company Overview," "—Our Strategy," "—Customers," "—Information Systems and Telecommunications Infrastructure," "—Collaborations," "Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations" and contained in this report include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or the PSLRA. When used in this report, in the Annual Report on Form 10-K and in future filings by the Company with the Commission, in our press releases, presentations to securities analysts or investors and in oral statements made by or with the approval of one of our executive officers, the words or phrases "believes," "anticipates," "intends," "will likely result," "estimates," "projects" or similar expressions are intended to identify such forward-looking statements. Any of these forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

The discussion of risks described in "Item 1—Business" and "Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Annual Report on Form 10-K and the following discussion contain certain cautionary statements regarding our business that investors and others should consider. These discussions are intended to take advantage of the "safe harbor" provisions of the PSLRA. Except to the extent otherwise required by federal securities laws, in making these cautionary statements, we are not undertaking to address or update each factor in future filings or communications regarding our business or operating results, and are not undertaking to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected our past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this report and in any other public statements we make may turn out to be wrong. They can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining future results. Consequently, no forward-looking statement can be guaranteed. Actual future results may vary materially from those expressed in our communications.

### Overview

We are the largest health insurance company in the State of New York based on total preferred provider organization, or PPO, and health maintenance organization, or HMO, membership, which includes members under our insured and administrative services only, or ASO, plans. We offer managed care and traditional indemnity products to over 4.6 million members. We have licenses with the Blue Cross Blue Shield Association which entitle us to the exclusive use of the Blue Cross and Blue Shield names and marks in ten counties in the New York City metropolitan area and in six counties in upstate New York, the nonexclusive right to use the Blue Cross and Blue Shield names and marks in one upstate New York county, the exclusive right to only the Blue Cross name and mark in seven upstate New York counties and the nonexclusive right to only the Blue Cross name in four upstate New York counties. We market our products and services using these names and marks in our New York service areas. We also market our managed care products in 16 counties in New Jersey under the WellChoice brand.

We offer our products and services to a broad range of customers, including large groups of more than 500 employees; middle market groups, ranging from 51 to 500 employees; small groups, ranging from two to 50 employees and individuals. Over one million of our members are covered through our national accounts, which include Fortune 500 companies.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

Our revenue primarily consists of premiums earned and administrative service fees derived from the sale of managed care and traditional indemnity health benefits products to employer groups and individuals. Premiums are derived from insured contracts and administrative service fees are derived from self-funded contracts, under which we provide a range of customer services, including claims administration and billing and membership services. Revenue also includes administrative service fees earned under the BlueCard program for providing members covered by other Blue Cross and Blue Shield plans with access to our network providers, reimbursements under our government contracts with the Centers for Medicare and Medicaid Services, or CMS, to act as a fiscal intermediary for Medicare Part A program beneficiaries and a carrier for Medicare Part B program beneficiaries and investment income.

Our cost of benefits provided expense consists primarily of claims paid and claims in process and pending to physicians, hospitals and other healthcare providers and includes an estimate of amounts incurred but not yet reported. Administrative expenses consist primarily of compensation expenses, commission payments to brokers and other overhead business expenses.

We report our operating results as two business segments: commercial managed care and other insurance products and services. Our commercial managed care segment accounted for 82.6% of our membership as of December 31, 2002. Our commercial managed care segment includes group PPO, HMO (including Medicare+Choice), EPO, and other products (principally dental-only coverage), as well as our PPO business under our accounts with New York City and New York State. Our other insurance products and services segment consists of our indemnity and individual products. Our indemnity products include traditional indemnity products and government contracts with CMS to act as a fiscal intermediary and carrier. Our individual products include Medicare supplemental, state sponsored plans, government mandated individual plans and individual hospital-only. We allocate administrative expenses, investment income and other income, but not assets, to our segments. Except when otherwise specifically stated or where the context requires, all references in this document to our membership include both our insured and ASO membership. Our New York City and New York State account members are covered under insured plans.

Our future results of operations will depend in part on our ability to predict and control health care costs through underwriting criteria, utilization management, product design and negotiation of favorable provider and hospital contracts. Our ability to contain such costs may be adversely affected by changes in utilization rates, demographic characteristics, the regulatory environment, health care practices, inflation, new technologies, clusters of high-cost cases, continued consolidation of physician, hospital and other provider groups, acts of terrorism and bioterrorism or other catastrophes, including war, and numerous other factors. The inability to mitigate any or all of the above-listed or other factors may adversely affect our future profitability.

### Critical Accounting Policies and Estimates

The following is an explanation of our accounting policies considered most significant by management. These accounting policies require us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information is known. Actual results could differ materially from those estimates.

### Revenue Recognition

Our membership contracts generally have one year terms and are subject to cancellation upon 60 days written notice. Premiums are generally due monthly and are recognized as revenue during the period in which we are obligated to provide services to our members. We record premiums received prior to such periods as unearned premiums. We record premiums earned net of an allowance for doubtful accounts. Premiums recorded for groups with certain funding arrangements are based upon the actual and estimated claims experience of these groups. Future adjustments to the claims experience of these groups will result in changes in premium revenue. Our estimated claims experience is based on a number of factors, including prior claims experience. These estimates are continually reviewed and adjusted based on actual claims experience. Any changes in these estimates are included in current period results. Funds received from these groups in excess of premiums recorded are reflected as liabilities on our balance sheet.

We recognize administrative service fees during the period the related services are performed. Administrative service fees consist of revenues from the performance of administrative services for self-funded contracts, reimbursements from our contracts with CMS under which we serve as an intermediary for the Medicare Part A program and a carrier for the Medicare Part B program, and fees earned under the BlueCard program. The revenue earned under our contracts with CMS is recorded net of an allowance for an estimate of disallowed expenses.

### Cost of Benefits Provided

Cost of benefits provided includes claims paid, claims in process and pending, and an estimate for unreported claims for charges for healthcare services for enrolled members during the period. We are required to estimate the total amount of claims that have not been reported or that have been received, but not yet adjudicated, during any accounting period. These estimates, referred to as unpaid claims on our balance sheet, are recorded as liabilities.

We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. Factors we consider include medical cost trends, the mix of products and benefits sold, internal processing changes and the amount of time it took to pay all of the benefits for claims from prior periods. To the extent the actual amount of these claims is greater than the estimated amount based on our underlying assumptions, such differences would be recorded as additional cost of benefits provided in subsequent accounting periods and our future earnings would be adversely affected. To the extent the claims experience is less than estimated based on our underlying assumptions, such differences would be recorded as a reduction in cost of benefits provided in subsequent accounting periods.

### Taxes

We account for income taxes using the liability method. Accordingly, deferred tax assets and liabilities are recognized for the future tax consequences attributable to the difference between the financial reporting and tax basis of assets and liabilities. We record a valuation allowance to reduce our deferred tax asset to the amount we believe is more likely than not to be realized. This determination, which requires considerable judgment, is based on a number of assumptions including an estimate of future taxable income. If future taxable income or other factors are not consistent with our expectations, an adjustment to our deferred tax asset may be required in the future. Any such adjustment would be charged or credited to income in the period such determination was made.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

### The Conversion

The conversion has been accounted for as a reorganization using the historical carrying values of assets and liabilities of Empire HealthChoice, or HealthChoice, our parent company prior to its conversion and our initial public offering. Immediately following the conversion, HealthChoice's unassigned reserves were reclassified to par value of common stock and additional paid-capital. Concurrently, HealthChoice became a wholly owned subsidiary of WellChoice. The costs of the conversion were recognized as an expense when incurred. We started incurring conversion-related expenses in 1998 when HealthChoice first began paying fees and expenses of advisors to the New York State Superintendent of Insurance, or Superintendent, in connection with the New York State Department of Insurance's consideration of our original draft plan of conversion. From inception of the conversion process through the completion of our initial public offering in December 2002, we incurred conversion and offering expenses of \$23.9 million.

We have benefited from certain favorable tax attributes over the years. HealthChoice has reported its income for tax purposes using certain beneficial rules afforded Blue Cross and Blue Shield plans under Section 833 of the Internal Revenue Code, or the Code. Among other provisions of the Code, these plans were granted a special deduction, the 833(b) deduction, for regular tax calculation purposes. As a result of this deduction, HealthChoice has incurred no regular tax liability but, in profitable years, has paid taxes at the alternative minimum tax rate of 20%. The 833(b) deduction is calculated as the excess of 25% of the incurred claim and claim adjustment expenses for the tax year over adjusted surplus, as defined, but limited to taxable income. The amount of 833(b) deductions utilized in each tax year is accumulated in an adjusted surplus balance. Once the cumulative adjusted surplus balance exceeds the 833(b) deduction for the current taxable year, the deduction is eliminated. During the fourth quarter of 2002, we reevaluated our tax position for financial statement purposes related to HealthChoice's ability to utilize the Section 833(b) deduction and determined that when HealthChoice converted to a for-profit entity, its ability to utilize the Section 833(b) deduction was uncertain. No authority directly addresses whether a conversion transaction will render the 833(b) deduction unavailable. We are aware, however, that the IRS has taken the position related to other Blue Cross Blue Shield plans that a conversion could result in the inability of a Blue Cross Blue Shield plan to utilize the 833(b) deduction. In light of the absence of governing authority, while we intend to continue to take the deduction on its tax returns after the conversion, we will assume, for financial statement reporting purposes, that the deduction will be disallowed. Accordingly, our income tax provision for 2002 assumes the utilization of approximately \$145.0 million regular operating loss carryforwards for financial reporting purposes in excess of those utilized for tax purposes. Because the conversion occurred in the fourth quarter and the tax provisions for the first three quarters had assumed the availability of the section 833(b) deduction, we recorded additional tax expense of \$50.7 million in the fourth quarter representing the utilization of regular operating loss carryforwards rather than the 833(b) deduction.

We have substantial tax loss and credit carryovers. At December 31, 2002, our regular tax loss carryforwards were approximately \$310.0 million and our alternative minimum tax credit carryforward was approximately \$134.0 million. We recently received a ruling from the Internal Revenue Service that our conversion was not viewed as a change in control and therefore did not result in limitations in the use of our net regular tax operating loss carryforwards and alternative minimum tax credits. However, subsequent sales of shares of our common stock, including sales by the Fund and/or Foundation, could result in such a limitation, which would have an impact on our cash flow.

### Additional State and Local Taxes

As a result of the conversion, we became a for-profit entity and are subject to New York state and local taxes that we were not previously required to pay. These include premium taxes on most non-HMO insured business and sales and use taxes (which are recorded as administrative expenses), as well as state and local income taxes.

### Discontinued Operations

In February 2002, we discontinued the operations of NextHealth, Inc., a development stage subsidiary formed in March 2000 to develop Internet portal software to market to other health benefit companies. We discontinued these operations as part of our overall strategy to outsource certain technology functions.

### Capitated Provider Arrangements

Our cost of benefits provided under capitated arrangements is not significant. Payments under capitated arrangements totaled \$88.7 million for the year ended December 31, 2002, representing 2.3% of total cost of benefits provided for each period.

We currently maintain a single global capitation arrangement to provide hospital and medical benefits for approximately 1,000 members enrolled in our Medicare+Choice product. Payments made under this arrangement totaled \$7.5 million for the year ended December 31, 2002, respectively. The premiums earned in excess of costs of benefits provided under this arrangement was approximately \$1.3 million for the year ended December 31, 2002.

We also have capitated arrangements with service providers for certain disease management programs and utilization management services. At December 31, 2002, we had approximately 55,000 members under a capitated utilization management program for eye care services and 851,000 members under capitated disease management programs.

Other capitated arrangements are in place to manage and assume risk for certain benefits covered under specific products. The following sets forth the membership and respective benefits under these capitated arrangements at December 31, 2002:

Benefit	Membership
	<i>(in thousands)</i>
Mental health	1,550
Laboratory services	385
Vision	345
Hearing	133
Dental	100

Approximately 34.0% of our membership is provided one or more benefits under a capitated program.

**MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL  
CONDITION AND RESULTS OF OPERATIONS (CONTINUED)**

WELLCHOICE, INC. AND SUBSIDIARIES

**Selected Membership Data and Results of Operations**

The following table sets forth selected membership data as of the dates set forth below:

December 31	2002	2001	2000
	<i>(members in thousands)</i>		
Products and services:			
Commercial managed care:			
Group PPO, HMO, EPO and other <sup>(1)(2)</sup>	2,019	1,752	1,432
New York City and New York State PPO <sup>(3)</sup>	1,786	1,563	1,512
Total commercial managed care	3,805	3,315	2,944
Other insurance products and services:			
Indemnity	567	804	906
Individual	236	264	285
Total other insurance products and services	803	1,068	1,191
Overall total	4,608	4,383	4,135
Customers:			
Large group <sup>(3)</sup>	2,903	2,695	2,686
Small group and middle market	394	366	272
Individuals	290	323	326
National accounts	1,021	999	851
Overall total	4,608	4,383	4,135
Funding type:			
Commercial managed care:			
Insured <sup>(3)</sup>	2,597	2,441	2,312
Self-funded	1,208	874	632
Total commercial managed care	3,805	3,315	2,944
Other insurance products and services:			
Insured	463	691	838
Self-funded	340	377	353
Total other insurance products and services	803	1,068	1,191
Overall total	4,608	4,383	4,135

(1) Our HMO product includes Medicare+Choice. As of December 31, 2002, 2001 and 2000, we had approximately 55,000, 59,000 and 41,000 members, respectively, enrolled in Medicare+Choice.

(2) "Other" principally consists of our members enrolled in dental only coverage.

(3) Enrollment as of December 31, 2002 includes 175,000 New York State PPO account members who reside in New York State but outside of our service areas. Prior to January 1, 2002, these members were enrolled in the New York Blue Cross Blue Shield plan licensed in the area where the members resided and, accordingly, the membership was reported by these plans and not by us. Beginning January 1, 2002, in accordance with a change to the contract with New York State under which we administer the entire plan, we began including those members enrolled outside of our service area, and all members were therefore enrolled in, and reported by, WellChoice. New York State PPO account members who reside in New York State but outside of our service areas are excluded from enrollment totals for all other periods presented.

The following table sets forth results of operations for each of our segments for the periods set forth below:

Year ended December 31	2002	2001	2000
	(dollars in millions)		
<b>Commercial Managed Care:</b>			
Total revenue	\$4,000.6	\$3,448.3	\$2,948.8
Income from continuing operations before income tax expense	\$ 253.4	\$ 121.1	\$ 95.0
Medical loss ratio:			
Commercial managed care total	86.0%	88.6%	89.1%
Commercial managed care, excluding New York City and New York State PPO <sup>(1)</sup>	81.6%	85.8%	85.5%
Administrative expense ratio	13.9%	13.0%	12.6%
Administrative expense ratio—premium equivalent basis	9.7%	10.0%	10.4%
<b>Other Insurance Products and Services:</b>			
Total revenue	\$1,105.0	\$1,182.9	\$1,284.9
Income from continuing operations before income tax expense	\$ 56.3	\$ 26.5	\$ 25.5
Medical loss ratio	82.4%	86.2%	86.4%
Administrative expense ratio	27.8%	25.0%	24.6%
Administrative expense ratio—premium equivalent basis	17.4%	15.9%	16.4%

(1) We present commercial managed care medical loss ratio, excluding New York City and New York State PPO, because these accounts differ from our standard PPO product in that they are hospital-only accounts which have lower premiums relative to administrative expense and are retrospectively rated with a guaranteed administrative service fee. In addition, the size of these accounts distorts our performance when the total medical loss ratios are presented.

### Year Ended December 31, 2002 Compared to Year Ended December 31, 2001

As of December 31, 2002, total enrollment was 4.6 million members and commercial managed care enrollment was 3.8 million members (82.6% of total enrollment). If we add to the December 31, 2001 enrollment the 167,000 New York State PPO account members who reside in New York State but outside of our service areas, total enrollment and commercial managed care enrollment increased 1.3% and 9.3%, respectively, from December 31, 2001 to December 31, 2002. Enrollment in our group PPO, HMO, EPO and other products increased 15.2%, or 267,000 members. This growth was attributable to the migration of members enrolled in our indemnity products to our commercial managed care products, new large group and national accounts business in our PPO and EPO products and increased enrollment by small group and middle market customers in our Direct Connection HMO (our HMO product which allows members to seek care from in-network specialists without a referral) and EPO products. The enrollment growth in self-funded products of 23.7% was the result of both new membership and the migration from insured business, most noticeably in the large group PPO and national EPO membership. Enrollment in other insurance products and services declined 24.8% to approximately 0.8 million members due, in part, to the continued migration of members to commercial managed care products.

As of December 31, 2002, our New York State account covered approximately 985,000 members, or 21.4% of our total membership and 25.9% of our commercial managed care membership, and our New York City account covered approximately 801,000 members, or 17.4% of our total membership and 21.1% of our commercial managed care membership. The pricing of our products provided to New York State and New York City historically have been renegotiated annually. Effective January 1, 2003, we agreed to new pricing with New York State covering a three-year period through December 31, 2005, though both parties retain the right to terminate the contract on six months' notice. The New York City account is currently under renegotiation based upon a competitive bid process that is open to us and to third parties and involves renegotiation with respect to rates. The contract awarded to the winner of this competitive bid process is expected to commence July 1, 2003. We had rates in place through December 31, 2002 with respect to our PPO products with the New York City account. We are currently negotiating the pricing of our PPO products with New York City for the first six months of 2003. The loss of one or both of the New York City and New York State accounts would result in reduced membership and revenue and require us to reduce, reallocate or absorb administrative expenses associated with these accounts.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

Total revenue increased 10.2%, or \$474.4 million, to \$5,105.6 million for the year ended December 31, 2002, from \$4,631.2 million for the year ended December 31, 2001 primarily due to an increase in premium and administrative service fee revenue.

Premium revenue increased \$381.8 million, or 9.0%, to \$4,628.0 million for the year ended December 31, 2002, from \$4,246.2 million for the year ended December 31, 2001. The increase in premium revenue was primarily due to growth in our commercial managed care segment. Commercial managed care premium revenue was \$3,723.0 million for the year ended December 31, 2002, a 14.6% increase compared to the year ended December 31, 2001. The increase in commercial managed care premium revenue was attributable to enrollment growth and premium rate increases, particularly in our HMO and PPO products. Premium revenue growth was partially offset by the anticipated decline in our other insurance products and services enrollment, the cancellation of unprofitable EPO contracts and the migration of insured EPO national and large group indemnity contracts to self-funded contracts. On a per member per month, or PMPM basis, premium for the year ended December 31, 2002 increased 7.2%, to \$124.65, from \$116.29 for the year ended December 31, 2001. Commercial managed care PMPM premium increased to \$120.90 for the year ended December 31, 2002, from \$115.22 for the year ended December 30, 2001. Excluding the New York City and New York State PPO, commercial managed care PMPM premium increased to \$250.72 for the year ended December 31, 2002, compared to \$226.59 for the year ended December 31, 2001.

Administrative service fee revenue increased 23.0%, or \$74.2 million, to \$396.2 million for the year ended December 31, 2002, from \$322.0 million for the year ended December 31, 2001. The increase was primarily due to growth in self-funded group PPO, HMO, EPO and other membership, expanded volume of services provided under our CMS contract for Medicare Part A and Part B programs and increased BlueCard fees. Approximately \$52.7 million of the increase was driven by the migration of approximately 45,000 members from insured EPO national account contracts and approximately 137,000 insured large group indemnity contracts to self-funded contracts and approximately 69,000 members from new national and large group customers. Administrative service fee revenue from our CMS contracts increased 10.6%, or \$12.2 million, to \$127.3 million for the year ended December 31, 2002, from \$115.1 million for the year ended December 31, 2001. Total BlueCard fees increased 26.3%, or \$9.3 million, to \$44.6 million for the year ended December 31, 2002, from \$35.3 million for the year ended December 31, 2001 due to an increase in transaction volume.

Investment income, net of investment expenses, decreased 6.5%, or \$4.5 million, to \$64.8 million for the year ended December 31, 2002, from \$69.3 million for the year ended December 31, 2001 due to lower interest rates. Net realized gains of \$2.6 million for the year ended December 31, 2002 was primarily the result of net gains on government and corporate bond sales and the sale of a portion of our WebMD Corp. common stock. The net realized loss of \$12.4 million for the year ended December 31, 2001 was primarily due to a \$10.5 million impairment loss recorded on our holdings of WebMD Corp. common stock.

Other income, net of \$14.0 million for the year ended December 31, 2002 consisted primarily of a gain of \$8.0 million resulting from insurance settlements in excess of estimated recoveries recorded as of December 31, 2001 for property and equipment lost at our World Trade Center headquarters, \$5.4 million related to the recovery of amounts previously recorded against net income, interest received on outstanding hospital advances of \$1.9 million and late payment fee income of \$0.7 million. Other income, net of \$6.1 million for the year ended December 30, 2001 primarily consisted of a gain of \$6.8 million resulting from insurance recovery estimates in excess of book values for property and equipment lost at our World Trade Center headquarters, \$1.6 million from the demutualization of MetLife, Inc., the life insurance carrier for our employees, late payment fee income of \$0.6 million and interest income earned on advances to hospitals of \$1.2 million, offset in part by a charge of \$3.7 million due to the restructuring of an outstanding provider note receivable and other miscellaneous expenses of \$0.4 million.

Total cost of benefits provided increased 5.6%, or \$208.6 million, to \$3,947.4 million for the year ended December 31, 2002, from \$3,738.8 million for the year ended December 31, 2001, reflecting a 1.7% increase in member months and a 3.8% increase in PMPM benefit costs. The increase in benefit costs was due to increases in unit costs, offset in part by decreases in utilization. Cost of benefits provided for the year ended December 31, 2002 included a \$3.3 million premium deficiency reserve charge related to our New Jersey PPO business, offset in part by net litigation reserve related activity of \$13.7 million. Overall, benefit expense on a PMPM basis for the year ended December 31, 2002 increased to \$106.32, from \$102.39 for the year ended December 31, 2001.

The total medical loss ratio decreased to 85.3% for the year ended December 31, 2002, from 88.1% for the year ended December 31, 2001. This decrease was attributable to, in part, \$40.1 million of prior period reserve development on the at-risk book of business. Excluding prior period development and the litigation reserve release, the total medical loss ratio for the year ended December 31, 2002, was 86.3%. The medical loss ratio in our commercial managed care segment decreased to 86.0% for the year ended December 31, 2002, from 88.6% for the year ended December 31, 2001. Excluding New York City and New York State PPO, the medical loss ratio in our commercial managed care segment decreased to 81.6% for the year ended December 31, 2002, from 85.8% for the year ended December 31, 2001 due to better than anticipated claim experience. The medical loss ratio for other insurance products and services decreased to 82.4% for the year ended December 31, 2002, from 86.2% for the year ended December 31, 2001.

Administrative expenses increased 12.2%, or \$90.3 million, to \$833.1 million for the year ended December 31, 2002, from \$742.8 million for the year ended December 31, 2001. This increase was attributable to increased broker commissions of \$18.8 million due to premium revenue growth in small group and middle market customers, increased employee benefit expense of \$15.6 million, increased professional services related to our technology outsourcing strategy of \$23.1 million, increased premium taxes of \$6.2 million, employee-related transition costs of \$9.5 million incurred as part of our outsourcing agreement with IBM in June 2002, restructuring charges of \$13.7 million related to our plan to streamline operations and other miscellaneous expenses. This increase was offset in part by a gain of \$19.3 million resulting from the settlement of our business property protection and blanket earnings and extra expense insurance claim related to the loss of our headquarters located at the World Trade Center. Conversion and IPO expenses increased \$13.4 million to \$15.4 million for the year ended December 31, 2002, from \$2.0 million for the year ended December 31, 2001 due to the increased conversion and IPO related activities as we reached the effective date of the conversion and completed our initial public offering.

In 2003, we plan to transition from several leased properties, which temporarily replaced our World Trade Center office, to a long-term leased facility. During the transition period (June through December 2003), we will incur rent expense for both our temporary leased facilities and our long-term leased facility. As a result, we will incur approximately \$9.8 million in incremental rent costs in 2003. In addition, in 2003 we estimate that we will incur \$8.6 million in depreciation and start-up costs related to our long-term leased facility. We will continue to incur additional facility costs beyond 2003 due to the increased costs associated with our long-term leased facility when compared to the cost of our World Trade Center facility.

Income from continuing operations before income taxes increased 109.8%, or \$162.1 million, to \$309.7 million for the year ended December 31, 2002, from \$147.6 million for the year ended December 31, 2001. This improvement was primarily driven by increased commercial managed care membership and improved underwriting performance. The tax benefit of \$67.9 million increased income from continuing operations to \$377.6 million for the year ended December 31, 2002. The tax expense of \$0.1 million reduced income from continuing operations to \$147.5 million for the year ended December 31, 2001. Taking into account our loss from discontinued operations, our net income for the year ended December 31, 2002 was \$376.5 million and for year ended December 31, 2001 was \$131.0 million.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

### Year Ended December 31, 2001 Compared to Year Ended December 31, 2000

Total enrollment grew 6.0%, or 248,000 members, to 4.4 million members as of December 31, 2001, compared to 4.1 million members as of December 31, 2000. Commercial managed care enrollment increased 12.6%, or 371,000, to 3.3 million members, representing 75.6% of total enrollment. Enrollment in our group PPO, HMO, EPO and other products increased 22.3%, or 320,000 members. This growth was attributable to new large group and national accounts business in our PPO and EPO products, increased enrollment by small group and middle market customers in our commercial managed care HMO products and individuals enrolled in our Medicare+Choice product. Membership in New York City and New York State PPO increased 3.4%, or 51,000 members, with enrollment gains reported in both the New York City and New York State plans. Other insurance products and services enrollment decreased 10.3% for the year due to a continued shift to commercial managed care programs.

Premium revenue increased \$369.3 million, or 9.5%, to \$4,246.2 million for the year ended December 31, 2001, from \$3,876.9 million for the year ended December 31, 2000 as a result of enrollment growth in commercial managed care products, partially offset by anticipated enrollment declines in other insurance products and services. Premium revenue for New York City and New York State PPO increased as a result of enrollment growth. Group PPO, HMO, EPO and other premium revenue increased 26.8% due to enrollment growth in all products. PMPM premiums in 2001 increased 10.2%, or \$10.81, to \$116.29, from \$105.48 in 2000. The PMPM premium increase was primarily due to an increase in premium revenue from higher premium products as a percentage of total premium revenue.

Administrative service fee revenue increased 21.6%, or \$57.1 million, to \$322.0 million for the year ended December 31, 2001, from \$264.9 million for the year ended December 31, 2000 due to new national accounts business and BlueCard fees. Approximately \$51.4 million of the increase was driven by the enrollment of approximately 148,000 new self-funded PPO members. BlueCard fees increased 19.3%, or \$5.7 million, to \$35.3 million for the year ended December 31, 2001, from \$29.6 million for the year ended December 31, 2000.

Investment income, net of investment expenses, increased 5.8%, or \$3.8 million, to \$69.3 million for the year ended December 31, 2001, from \$65.5 million for the year ended December 31, 2000. The increase was due to higher average invested balances offset by lower interest rates. The net realized loss of \$12.4 million for the year ended December 31, 2001 is primarily due to a \$10.5 million impairment loss recorded on our holdings of WebMD Corp. common stock. The net realized gain of \$22.1 million for the year ended December 31, 2000 is primarily due to a series of transactions related to our investment interest in The Health Information Network, LLC, or THINC. In January 2000, CareInsite, Inc. purchased our investment interest in THINC for warrants in CareInsite common stock. We exercised our warrants and recognized a gain of \$13.2 million. In February 2000, CareInsite was acquired by WebMD and we received WebMD common stock in exchange for our investment in CareInsite. As a result of this transaction, we recognized an additional gain of \$7.8 million.

Other income increased 41.9%, or \$1.8 million, to \$6.1 million for the year ended December 31, 2001, from \$4.3 million for the year ended December 31, 2000. Other income in 2001 primarily consisted of a gain of \$6.8 million resulting from insurance recovery estimates in excess of book values for property and equipment lost at our World Trade Center headquarters, late payment fee income of \$0.6 million and interest income earned on advances to hospitals of \$1.2 million, offset in part by a charge of \$3.7 million due to the restructuring of an outstanding provider note receivable. Other income in 2000 primarily consisted of real estate rental income.

Total revenue increased 9.4%, or \$397.5 million, to \$4,631.2 million for the year ended December 31, 2001, from \$4,233.7 million for the year ended December 31, 2000 primarily due to an increase in premium revenue.

Total cost of benefits provided increased 9.1%, or \$312.4 million, to \$3,738.8 million for the year ended December 31, 2001, from \$3,426.4 million for the year ended December 31, 2000 primarily due to increased utilization of physician, outpatient services and prescription drugs and higher unit costs, partially offset by a decrease in utilization of inpatient hospital services. Overall PMPM benefit expense for the year ended December 31, 2001 increased 9.5%, to \$102.39, from \$93.48 for the year ended December 31, 2000 due to higher costs for healthcare services.

The total medical loss ratio decreased to 88.1% for the year ended December 31, 2001, from 88.4% for the year ended December 31, 2000. The medical loss ratio in our commercial managed care segment decreased to 88.6% for the year ended December 31, 2001, from 89.1% for the year ended December 31, 2000. Excluding New York City and New York State PPO, the medical loss ratio in our commercial managed care segment increased to 85.8% in 2001, from 85.5% in 2000 due to healthcare cost increases in excess of premium rate increases. The higher healthcare costs were driven by increased utilization, primarily in outpatient and physician services, as well as higher inpatient and drug unit costs.

The medical loss ratio for other insurance products and services decreased to 86.2% for the year ended December 31, 2001, from 86.4% for the year ended December 31, 2000, due to an improvement in the small and large group indemnity products and Medicare supplemental plans, partially offset by higher claims cost as a percentage of premium with respect to the New York State-mandated direct pay products.

Administrative and conversion expenses increased 8.4%, or \$58.0 million, to \$744.8 million for the year ended December 31, 2001, from \$686.8 million for the year ended December 31, 2000. This increase was attributable to increased broker commissions of \$10.1 million incurred to support continued growth in our small group and middle market customers and higher general administrative expenses of \$47.9 million to service increased commercial managed care enrollment.

Income from continuing operations before income taxes increased \$27.1 million, or 22.5%, to \$147.6 million for the year ended December 31, 2001, from \$120.5 million for the year ended December 31, 2000. Income tax expense was \$0.1 million for the year ended December 31, 2001 compared to income tax benefit of \$74.5 million for the year ended December 31, 2000. The 2000 benefit is the result of management's conclusion that based on continued, current and projected positive taxable income and the expected timing of the reversal of other tax deductible temporary differences, our deferred tax valuation allowance could be significantly reduced by \$71.9 million. Income from continuing operations decreased 24.4%, or \$47.5 million, to \$147.5 million for the year ended December 31, 2001, from \$195.0 million for the year ended December 31, 2000. Taking into account our loss from discontinued operations, our net income for the year ended December 31, 2001 was \$131.0 million and for the year ended December 31, 2000 was \$190.4 million.

### **Liquidity and Capital Resources**

WellChoice is a holding company and depends on its subsidiaries for cash and working capital to pay expenses. WellChoice receives cash from its subsidiaries from administrative and management service fees, as well as tax sharing payments and dividends. On November 7, 2002, the Superintendent approved the payment of a dividend to WellChoice from its subsidiary, Empire HealthChoice Assurance, or Empire, in the amount of \$225.0 million, which was paid on November 8, 2002. This dividend has been accounted for as an equity transfer from a subsidiary to the parent of a consolidated group. On November 20, 2002, we received net proceeds of approximately \$28.0 million, after deducting the underwriting discount, from the exercise of the underwriters' over-allotment option in our initial public offering. We used these proceeds from the exercise of the over-allotment option to pay offering and conversion expenses and for general corporate purposes.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

Our subsidiaries' primary source of cash is from premiums and fees received and investment income. The primary uses of cash include healthcare benefit expenses, brokers' and agents' commissions and administrative expenses. We generally receive premium revenues in advance of anticipated claims for related healthcare services.

Our investment policies are designed to provide liquidity to meet anticipated payment obligations and to preserve principal. We believe the composition of our marketable investment portfolio is conservative, consisting primarily of high-rated, fixed income securities with the objective of producing a consistently growing income stream and maximizing risk-adjusted total return. The fixed income portfolio is comprised of U.S. government securities, corporate bonds, asset-backed bonds and mortgage-related securities. The average credit rating of our fixed income portfolio as of December 31, 2002 was "AA." A portion of the fixed income portfolio is designated as short-term and is intended to cover near-term cash flow needs. Our marketable equity portfolio as of December 31, 2002 consisted of an investment in a mutual fund indexed to the S&P 500, our common stock investment in WebMD and our investment in nonredeemable preferred stock of several companies. As of December 31, 2002, our marketable equity portfolio was 3.5% of the total marketable investment portfolio, compared to 2.0% as of December 31, 2001.

On October 17, 2002, we entered into a credit and guaranty agreement, effective as of November 7, 2002, with The Bank of New York, as Issuing Bank and Administrative Agent, and several other financial institutions as agents and lenders, which will provide us with a credit facility. We are able to borrow under the credit facility for general working capital purposes. The total outstanding amounts (including the amount of the letter of credit) under the credit facility cannot exceed \$100.0 million. The facility has a term of 364 days, subject to extension for additional periods of 364 days with the consent of the lenders. Borrowings under the facility will bear interest, at our option, at The Bank of New York's prime commercial rate (or, if greater, 0.50% plus the federal funds rate) as in effect from time to time plus a margin of between zero and 1.0%, or LIBOR plus a margin of between 1.125% and 2.250%, with the applicable margin to be determined based on our financial strength rating. As of December 31, 2002, there were no funds drawn against this line of credit.

The credit facility contains covenants that limit our ability to issue any equity interest which is not issued on a perpetual basis or in respect of which we shall become liable to purchase, redeem, retire or otherwise acquire any such interest, including any class of redeemable preferred stock. However, the credit facility does not restrict us from paying dividends on our common stock or repurchasing or redeeming shares of our common stock. Covenants under the credit facility also impose limitations on the incurrence of secured debt, creation of liens, mergers, asset sales, transactions with affiliates and material amendments of material agreements, as defined in the credit facility without the consent of the lenders. In addition, the credit facility contains certain financial covenants. Failure to comply with any of these covenants will result in an event of default, which could result in the termination of the credit facility.

We believe that cash flow from our operations and our cash and investment balances, including the proceeds of the dividend mentioned above, will be sufficient to fund continuing operations and capital expenditures for at least the next twelve months.

### Year Ended December 31, 2002 Compared to Year Ended December 31, 2001

Cash from operating activities decreased \$31.6 million to \$182.7 million as of December 31, 2002, from \$214.3 million as of December 31, 2001. The decrease in cash from operating activities is principally due to a \$75.8 million return of advanced premium held related to our New York State account compared to an increase of premium held of approximately \$24.4 million in 2001 and an increase of \$74.0 million in taxes paid. This decrease was partially offset by \$46.5 million in World Trade Center insurance proceeds, net of recovery expense and positive operating results net of noncash items. Some of the noncash items impacting net income include the net deferred income tax benefit of \$151.4 million, litigation reserve releases of \$15.4 related to the settlement of a large case and prior year "at risk" claim reserve adjustments, offset in part by depreciation and amortization expense of \$34.5 million and accrued restructuring expenses of \$20.9 million.

Net cash used in investing activities of \$129.5 million for the year ended December 31, 2002, was consistent with cash used in investing activities of \$129.3 million for the year ended December 31, 2001.

Net cash provided by financing activities of \$25.6 million includes net proceeds from the sale of common stock in the initial public offering of \$28.0 million and payments made on capital lease obligations of \$2.4 million for the year ended December 31, 2002. Cash used in financing activities of \$1.9 million for the year ended December 31, 2001 reflects payments for capital lease obligations.

#### Year Ended December 31, 2001 Compared to Year Ended December 31, 2000

Cash from operating activities increased \$98.3 million to \$214.3 million for the year ended December 31, 2001, from \$116.0 million for the year ended December 31, 2000. The increase in cash from operating activities is principally due to premium collection increases in excess of increases in paid claims and a decrease in disbursements related to the settlement of outstanding group and contract liabilities.

Net cash used in investing activities decreased \$8.6 million to \$129.3 million in 2001, from \$137.9 million in 2000. Cash used in investing activities in 2001 was impacted by a strategic decision to maintain cash flow generated by operations in cash and cash equivalents to cover business needs related to the recovery of our World Trade Center operations.

#### Contractual Obligations

We are contractually obligated to make future minimum payments as follows:

	2003	2004	2005	2006	2007	Thereafter
	<i>(in millions)</i>					
Lease Commitments:						
Operating Leases	\$49.9	\$43.8	\$39.9	\$33.4	\$31.1	\$357.6
Capital Leases	11.1	11.4	11.7	12.0	12.2	36.0

Operating lease terms generally range from one to 27 years with certain early termination or renewal provisions. We anticipate that we will incur leasehold improvement costs and related capital expenditures of approximately \$55.4 million at our Brooklyn, New York facility in 2003. These expenditures will be funded using internal cash. The schedule above includes rent commitments for our Staten Island facility. However, as part of the information technology outsourcing agreement with IBM, we entered into a sublease agreement with IBM for this property. The Company expects to receive net sublease income of approximately \$1.0 million per year for the next ten years.

#### Contractual Commitments to IBM

In June 2002, we entered into a ten-year agreement with IBM to modernize our systems applications and operate our data center and technical help desk. Our payments to IBM for operating our data center and technical help desk will be based upon actual utilization of services billed at the rates established in the agreement. We estimate that our payments to IBM for operating our data center and technical help desk will total approximately \$681.0 million over the remaining term of the agreement, which we anticipate to be less than the costs we would have otherwise incurred had we continued to operate the data center and technical help desk ourselves. Under the terms of the contract, we will work jointly with IBM to modernize our systems applications, centered around a new claims payment system being developed by deNovis, Inc., a privately held startup company, in coordination with IBM and which will be licensed to us in perpetuity. The system is expected to be ready for acceptance by us in accordance with its specifications no earlier than 2005. Subject to the successful completion and acceptance of the claims payment system, we will pay \$50.0 million for a perpetual license granted by IBM, which includes custom development fees. Under the agreement with IBM, we are scheduled to pay \$25.0 million of this fee in four equal installments upon the achievement of specified milestones, the last of which is our acceptance of the claims payment system. The remaining \$25.0 million will be paid one year following the date we accept the claims payment system. Following the expiration of the one year warranty period which begins upon the payment of the final installment, we will pay IBM an annual fee of \$10.0 million for maintenance and support services.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

The agreement also provides for IBM to assist us in modernizing our other systems. In connection with these services, we have agreed to purchase up to \$65.0 million in modernization services from IBM for a four year period beginning in 2002, with a target purchase rate of \$7.3 million, \$28.3 million, \$19.0 million, \$7.2 million and \$3.2 million during 2002, 2003, 2004, 2005 and 2006, respectively. We may defer the purchase of services beyond the target date, provided that to the extent we delay purchases more than one year beyond the target year, we shall pay a premium to IBM of 10% per annum of the contract price. The amount that we will actually spend for these integration and modernization services could be less or greater than the annual target purchase rate, though over the term we anticipate that the amount we will actually spend for these services could be significantly greater than those contractual minimums. We will own all software developed by IBM under the agreement, other than the claims payment system. Actual expenses incurred related to these purchases were \$4.2 million for the year ended December 31, 2002.

We intend to fund the modernization expenses incurred in connection with this collaboration with IBM in part through the cost savings we expect to realize as a result of the outsourcing of our applications development functions, data center and help desk to IBM. Any substantial increase in these expenses or inability to achieve our anticipated cost savings could have an adverse effect on our profitability, financial condition and results of operations. We do not expect to realize significant cost savings from this contract in the early years of the project.

Our outsourcing agreement with IBM contains standard indemnification clauses which reduce the risks associated with a variety of claims and actions, including certain failures of IBM to perform under the agreement. We have the right to terminate certain services if IBM fails to meet our quality and performance benchmarks and we may terminate our relationship with IBM in its entirety upon the occurrence of material breaches under the agreement, IBM's entrance into the health insurance business, changes of control and certain other events which are damaging to us. We can terminate the outsourcing agreement without cause after June 1, 2004, or at any time within twelve months following a change of control of WellChoice, provided that we pay IBM a termination fee. The termination fee includes a lump sum payment which decreases over the life of the agreement. For any WellChoice termination without cause, the lump sum decreases from \$25.0 million beginning in June 2004 to \$0.9 million in January 2012. We have the right to pay only a portion of this lump sum payment if we choose not to terminate the entire agreement but only certain discrete portions of IBM's services. Any termination following a change of control of WellChoice requires a similar lump sum payment which decreases over the life of the agreement and which is approximately 80% of the payment described in the previous sentence, although we do not have the similar right to terminate only portions of IBM's services, as allowed with a termination without cause. In addition, upon termination we must reimburse certain of IBM's costs, subject to reduction to the extent we purchase equipment, assume licenses and leases and hire employees used by IBM to provide the services. We also have the right to terminate the agreement at no cost within six months following a change of control of IBM.

### Regulatory and Other Developments

Empire is subject to capital and surplus requirements under the New York insurance laws and the capital and surplus licensure requirements established by the Blue Cross Blue Shield Association. Each of these standards is based on the NAIC's RBC Model Act, which provides for four different levels of regulatory attention depending on the ratio of a company's total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The capital and surplus level required to meet the minimum requirements under the New York insurance laws and Blue Cross Blue Shield Association licensure requirements applicable to Empire is 200% of Risk-Based Capital Authorized Control Level. Empire exceeds the New York minimum capital and surplus requirements and the Blue Cross Blue Shield Association capital and surplus licensure requirements.

Capital and surplus requirements for Empire HealthChoice HMO, Inc., our HMO subsidiary which is directly owned by Empire, are regulated under a different method set forth in the New York Department of Health's HMO regulations. The regulations require that Empire HealthChoice HMO currently maintain reserves of five percent of its annual premium income. Empire HealthChoice HMO, with respect to its operations in New York, meets the financial reserve standards of the New York Department of Health. The Department of Health is currently redrafting its regulations and proposes to increase the required reserves gradually over the next six years to twelve and one half percent of annual premium income. If that requirement changes it will affect all HMOs and we expect we will meet those revised standards. In November 2002, Empire HealthChoice HMO received a \$50.0 million capital contribution from Empire, which was made in connection with the transfer of our New York HMO business from HealthChoice to Empire HealthChoice HMO during 2002 in order to ensure compliance with New York capital and surplus requirements. Empire HealthChoice HMO is also licensed in New Jersey and there are minimum net worth standards established under New Jersey laws and regulations. Empire HealthChoice HMO, with respect to its operations in New Jersey, meets the minimum net worth standards established under New Jersey law. Empire HealthChoice HMO is also subject to the Blue Cross Blue Shield Association capital and surplus licensure requirement which is applicable to Empire and satisfies that requirement.

Our New Jersey operations are not subject to the Blue Cross Blue Shield Association capital and surplus licensure requirement. At December 31, 2002, WellChoice Insurance of New Jersey met the minimum capital and surplus requirements of the New Jersey Department of Banking and Insurance.

Regulation of financial reserves for insurers and HMOs is a frequent topic of legislative and regulatory scrutiny and proposals for change. It is possible that the method of measuring the adequacy of our financial reserves could change and that could affect our financial condition. However, any such change is likely to affect all companies in the state.

The ability of our insurance and HMO subsidiaries to pay dividends to us is subject to regulatory requirements, including state insurance laws and health department regulations and regulatory surplus or admitted asset requirements, respectively. These laws and regulations require the approval of the applicable state insurance department or health regulators in order to pay any proposed dividend over a certain amount. For example, any proposed dividend to WellChoice from Empire, which, together with other dividends paid within the preceding twelve month period, exceeds the lesser of 10% of its surplus to policyholders or 100% of adjusted net investment income will be subject to approval by the New York Department of Insurance. The provisions of our Blue Cross and Blue Shield licenses also may limit our ability to obtain dividends or other cash payments from our subsidiaries as they require our licensed subsidiaries to retain certain levels of minimum surplus and liquidity.

### **Recent Accounting Pronouncements**

In July 2002, the Financial Accounting Standards Board issued SFAS 146, *Accounting for Costs Associated with Exit or Disposal Activities*, which supersedes Emerging Issues Task Force (EITF) Issue 94-3, *Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (including Certain Costs Incurred in a Restructuring)*. SFAS 146 requires that a liability for costs associated with exit or disposal activities first be recognized when the liability is irrevocably incurred rather than at the date of management's commitment to an exit or disposal plan. The provisions of the new standard are effective prospectively for exit or disposal activities initiated after December 31, 2002. We do not anticipate that the adoption of SFAS 146 will materially affect our financial statements.

## MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (CONTINUED)

WELLCHOICE, INC. AND SUBSIDIARIES

### Investments

We classify all of our fixed maturity and marketable equity investments as available for sale and, accordingly, they are carried at fair value. The fair value of investments in fixed maturities and marketable equity securities are based on quoted market prices. Unrealized gains and losses are reported as a separate component of other comprehensive income, net of deferred income taxes. The amortized cost of fixed maturities, including certain trust preferred securities, is adjusted for amortization of premiums and accretion of discounts to maturity, which is included in investment income. Amortization of premiums and discounts on collateralized mortgage obligations are adjusted for prepayment patterns using the retrospective method. Investment income is shown net of investment expenses. The cost of securities sold is based on the specific identification method. When the fair value of an investment is lower than its cost and such a decline is determined to be other than temporary, the cost of the investment is written down to fair value and the amount of the write down is charged to net income as a realized loss.

Short-term investments are carried at fair value, and consist principally of U.S. treasury bills, commercial paper and money market investments. We consider securities with maturities greater than three months and less than one year at the date of purchase as short-term investments. The fair value of short-term investments is based on quoted market prices.

Other long-term equity investments include joint ventures and warrants. Joint ventures are accounted for under the equity method. Our warrants are considered derivatives and are carried at fair value. Our warrants are not classified as hedging instruments. Fair values of warrants are determined using the Black-Scholes Options Valuation Model. Changes in the fair values of warrants are recorded as realized gains or losses.

We are subject to state laws and regulations that require diversification of our investment portfolios and limit the amount our insurance company subsidiaries may invest in certain investment categories, such as below-investment-grade fixed income securities, mortgage loans, real estate and equity investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital and, in some instances, require the sale of those investments.

### Quantitative and Qualitative Disclosures About Market Risk

Our fixed maturity and marketable equity securities are subject to the risk of potential losses from adverse market conditions. To manage the potential for economic losses, we regularly evaluate certain risks, as well as the appropriateness of the investments, to ensure the portfolio is managed within its risk guidelines. The result is a portfolio that is well diversified. Our primary risk exposures are changes in market interest rates, credit quality and changes in equity prices. The market value of our investments varies from time to time depending on economic and market conditions. Our investment portfolio is not significantly concentrated in any particular industry or geographic region.

### Interest Rate Risk

Interest rate risk is defined as the potential for economic losses on fixed-rate securities due to an adverse change in market interest rates. Our fixed maturity portfolio consists exclusively of U.S. dollar-denominated assets, invested primarily in U.S. government securities, corporate bonds, asset-backed bonds and mortgage-related securities, all of which represent an exposure to changes in the level of market interest rates. We manage interest rate risk by maintaining a duration commensurate with our insurance liabilities and policyholders' surplus. Further, we do not engage in the use of derivatives to manage interest rate risk. A hypothetical increase in interest rates of 100 basis points would result in an estimated decrease in the fair value of the fixed income portfolio at December 31, 2002 of approximately \$44.3 million.

### Credit Quality Risk

Credit quality risk is defined as the risk of a credit downgrade to an individual fixed income security and the potential loss attributable to that downgrade. We manage this risk through our investment policy, which establishes credit quality limitations on the overall portfolio as well as dollar limits for individual issuers. The result is a well-diversified portfolio of fixed income securities, with an average credit rating of approximately "AA."

### Fixed Maturity Securities Quality Distribution

The following chart shows the quality distribution of our fixed maturity securities portfolio as of December 31, 2002 and December 31, 2001 (at fair value):

	December 31, 2002	Percent of Total	December 31, 2001	Percent of Total
<i>(dollars in millions)</i>				
Total fixed maturity				
Aaa	\$ 892.3	72.9%	\$ 793.4	69.3%
Aa	70.7	5.8	85.5	7.5
A	251.3	20.6	262.6	22.9
Baa	8.5	0.7	3.6	0.3
Total fixed maturity	\$1,222.8	100.0%	\$1,145.1	100.0%
Total fixed maturity corporate securities:				
Industrial	\$ 37.2	10.1%	\$ 52.7	12.2%
Finance	251.3	68.2	254.9	59.2
Utility	20.4	5.5	47.7	11.1
Asset-backed securities	30.0	8.2	35.8	8.3
Other	29.5	8.0	39.7	9.2
Total fixed maturity corporate securities	\$ 368.4	100.0%	\$ 430.8	100.0%
Total mortgage-related securities:				
Mortgage pass through certificates	\$ 12.0	6.9%	\$ 15.7	8.6%
Collateralized mortgage obligations	162.6	93.1	167.1	91.4
Total mortgage-related securities	\$ 174.6	100.0%	\$ 182.8	100.0%

### Equity Price Risk

Equity price risk for stocks is defined as the potential for economic losses due to an adverse change in equity prices. Equity risk exposure is managed through our investment in an indexed mutual fund. Specifically, we are invested in the ML S&P 500 Index LLC, which is an S&P 500 index mutual fund, resulting in a well-diversified and liquid portfolio that replicates the risk and performance of the broad U.S. stock market. We also hold a direct common stock investment in WebMD and investments in nonredeemable preferred stock of several companies. Our investment in nonredeemable preferred stock is managed in conjunction with our fixed maturity portfolio. We estimate our equity price risk from a hypothetical 10% decline in the S&P 500 and the relative effect of that decline in the value of our marketable equity portfolio at December 31, 2002 to be a decrease in fair value of \$2.9 million.

### Fixed Income Securities

Our fixed income strategy is to construct and manage a high quality, diversified portfolio of securities. Additionally, our investment policy establishes minimum quality and diversification requirements resulting in an average credit rating of approximately "AA." The average duration of our portfolio as of December 31, 2002 was 1.6 years.