discussion

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis presents a review of WellChoice, Inc. and its subsidiaries (collectively, "we" or the "Company") for the three-year period ended December 31, 2003. This review should be read in conjunction with the consolidated financial statements and other data presented herein.

The statements contained in this Annual Report include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or the PSLRA. When used in this Annual Report, 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 following discussion and the discussion in "Item 1—Business" of our 2003 Annual Report on Form 10-K contain certain cautionary statements regarding our business that investors and others should consider. This discussion is 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.

& Analysis

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 approximately 4.8 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 non-exclusive 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 non-exclusive 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, generally large, multi-state companies, including many Fortune 500 companies.

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 86.4% of our membership as of December 31, 2003. Our commercial managed care segment includes group PPO, HMO (including Medicare+Choice), EPO, and other products (principally dental-only coverage as well as POS) 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.

Based upon the higher level of payments we expect to receive from CMS as a result of the recently enacted Medicare Prescription Improvement and Modernization Act, subject to CMS approval, we will eliminate the additional premiums required by members of our Medicare+Choice program in Rockland and Westchester counties, reduce the additional premium required by members in Nassau and Suffolk counties and increase benefits available to New York City members. This increase in payments from CMS will not have a material impact on operations, as they will either be utilized to provide additional benefits or as a reduction in premiums required by members.

Our future results of operations will depend in part on our ability to predict and control healthcare 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, healthcare 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. Our inability to mitigate any or all of the above-listed or other factors may adversely affect our future profitability.

The Conversion

The conversion has been accounted for as a reorganization using the historical carrying values of HealthChoice's assets and liabilities. 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 2002, we incurred conversion and offering expenses of $24.0 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 incurred no regular tax liability but, in profitable years, 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 Internal Revenue Service 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 our tax returns for periods after the conversion, we will assume, for financial statement reporting purposes, that the deduction will be disallowed. Accordingly, we have utilized $77.0 million of regular operating loss carryforwards for financial statement purposes in excess of those utilized for tax purposes.

We have substantial tax loss and credit carryovers. At December 31, 2003, for income tax purposes, our regular tax loss carryforwards, which expire between 2004 and 2023, were approximately $259.0 million and our alternative minimum tax credit carryforwards, which have no expiration, was approximately $191.0 million. In early 2003, we 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.

As a result of the New York State Budget Legislation enacted in May 2003, which eliminated the net income portion of the New York State franchise tax applicable to our New York accident and health insurance subsidiary, we expect to incur federal, state and local income taxes at the rate of approximately 39% of pre-tax net income.

Discontinued Operations

In February 2002, we discontinued the operations of NexxtHealth, 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 $102.5 million for the year ended December 31, 2003, representing 2.5% of total cost of benefits provided.

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 $8.4 million for the year ended December 31, 2003. The premiums earned in excess of costs of benefits provided under this arrangement was approximately $0.8 million for the year ended December 31, 2003.

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, 2003:

Benefit	Membership
	(in thousands)
Mental health	1,601
Laboratory services	425
Vision	349
Hearing	119
Dental	84

We also have capitated arrangements with service providers for certain disease management programs. At December 31, 2003, we had approximately 79,000 members under capitated disease management programs.

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

Selected Membership Data and Results of Operations

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

December 31	**2003**	2002	2001
		(members in thousands)	
Products and services:			
Commercial managed care:			
Group PPO, HMO, EPO and other[1][2]	**2,301**	2,019	1,752
New York City and New York State PPO[3]	**1,805**	1,786	1,563
Total commercial managed care	**4,106**	3,805	3,315
Other insurance products and services:			
Indemnity	**428**	567	804
Individual	**220**	236	264
Total other insurance products and services	**648**	803	1,068
Overall total	**4,754**	4,608	4,383
Customers:			
Large group[3]	**2,931**	2,903	2,695
Small group and middle market	**444**	394	366
Individuals	**269**	290	323
National accounts	**1,110**	1,021	999
Overall total	**4,754**	4,608	4,383
Funding type:			
Commercial managed care:			
Insured[3]	**2,620**	2,597	2,441
Self-funded	**1,486**	1,208	874
Total commercial managed care	**4,106**	3,805	3,315
Other insurance products and services:			
Insured	**398**	463	691
Self-funded	**250**	340	377
Total other insurance products and services	**648**	803	1,068
Overall total	**4,754**	4,608	4,383

(1) Our HMO product includes Medicare+Choice. As of December 31, 2003, 2002 and 2001, we had approximately 50,000, 55,000 and 59,000 members, respectively, enrolled in Medicare+Choice.

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

(3) Enrollment as of December 31, 2003 and 2002 includes 177,000 and 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, us. 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	**2003**	2002	2001
		($ in millions)	
Commercial Managed Care:			
Total revenue	**$4,425.0**	$4,000.6	$3,448.3
Income from continuing operations before income tax expense	**$ 292.6**	$ 253.4	$ 121.1
Medical loss ratio:			
Commercial managed care total	**85.9%**	86.0%	88.6%
Commercial managed care, excluding New York City and New York State PPO[1]	**82.1%**	81.6%	85.8%
Administrative expense ratio[2]	**14.0%**	13.9%	13.0%
Other Insurance Products and Services:			
Total revenue	**$ 957.5**	$1,105.0	$1,182.9
Income from continuing operations before income tax expense	**$ 51.0**	$ 56.3	$ 26.5
Medical loss ratio	**82.7%**	82.4%	86.2%
Administrative expense ratio[2]	**28.0%**	27.8%	25.0%

(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 than accounts with full medical and hospital coverage and are retrospectively rated with a guaranteed administrative service fee. The lower premiums and the size of these accounts distort our performance when the total medical loss ratios are presented.

(2) As presented, our administrative expense ratio does not take into account a significant portion of our activity generated by self-funded, or ASO, business, which represents approximately 36.2% and 38.6% of our managed care and other insurance products and services members, respectively. Therefore, in the following table, we provide the information needed to calculate the administrative expense ratio on a "premium equivalent" basis because that ratio measures administrative expenses relative to the entire volume of insured and self-funded business serviced by us and is commonly used in the health insurance industry to compare operating efficiency among companies. Administrative expense ratio on a premium equivalent basis is calculated by dividing administrative and conversion and IPO expenses by "premium equivalents" for the relevant periods. Premium equivalents is the sum of premium earned, administrative service fees and the amount of paid claims attributable to our self-funded business pursuant to which we provide a range of customer services, including claims administration and billing and membership services. Claims paid for our self-funded health business is not our revenue. The premium equivalents for the years indicated were as follows:

Year ended December 31	**2003**	2002	2001
		($ in millions)	
Commercial Managed Care:			
Premiums earned	**$4,099.5**	$3,723.0	$3,247.8
Administrative service fees	**274.1**	212.2	154.1
Claims paid for our self-funded health business	**2,408.0**	1,696.8	1,102.5
Premium Equivalent	**$6,781.6**	$5,632.0	$4,504.4
Other Insurance Products and Services:			
Premiums earned	**$ 775.9**	$ 905.0	$ 998.4
Administrative service fees	**171.7**	184.0	167.9
Claims paid for our self-funded health business	**547.3**	651.1	689.4
Premium Equivalent	**$1,494.9**	$1,740.1	$1,855.7

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

As of December 31, 2003, total enrollment was 4.8 million members, a 3.2% increase from December 31, 2002 to December 31, 2003. The increase in enrollment was driven by a 7.9% increase in commercial managed care enrollment. Our commercial managed care enrollment at December 31, 2003 was 4.1 million and represents 86.4% of our total enrollment. The increase in commercial managed care enrollment was the result of the following:

- Enrollment growth of 13.6%, or 240,000 members, in group PPO, EPO and other due primarily to a combination of new national account customers in our PPO and EPO products and the migration of members enrolled in our indemnity products to our commercial managed care products; and
- Enrollment growth of 16.7%, or 42,000 members, in group HMO primarily related to new small group and middle market customers.

The increase in commercial managed care enrollment was offset by a 19.3% decline in other insurance product and services enrollment. This decrease of approximately 155,000 members was due, in part, to the continued migration of members to commercial managed care products discussed above.

Our self-funded enrollment increased 12.1% in 2003 and at December 31, 2003 represented approximately 36.5% of our total enrollment; 36.2% of commercial managed care enrollment; and 38.6% of other insurance product and services enrollment. The migration of fully-insured business to self-funded arrangements as well as new self-funded enrollment resulted in the increase in self-funded enrollment. The migration to self-funded enrollment was most noticeable in insured large group PPO and indemnity products. New self-funded national account enrollment accounted for 149,000 new members. We expect self-funded enrollment to continue to increase in 2004 through the continued migration of fully-insured business to self-funded arrangements and new self-funded accounts. Although the trend to self-funded business will reduce our insured premium and claim volume, we do not expect the trend to materially impact net income.

As of December 31, 2003, our New York State account covered approximately 989,000 members, or 20.8% of our total membership and 24.1% of our commercial managed care membership, and our New York City account covered approximately 816,000 members, or 17.2% of our total membership and 19.9% of our commercial managed care membership. We provide hospital-only coverage under both of these accounts. The pricing of our products provided to New York State and New York City has historically been renegotiated annually. With respect to the New York State account, effective January 1, 2003, we agreed to new pricing covering a three-year period through December 31, 2005, though both parties retain the right to terminate the contract on six months' notice. With respect to the New York City account, for approximately two years, the New York City account has been subject to a competitive bid process in which we have participated, relating to a five-year contract. In October 2003, we agreed to new rates with the New York City account for the period from July 1, 2003 through June 30, 2004. We expect the New York City account to complete the competitive bid process regarding the five-year contract, sometime in the first half of 2004. The loss of one or both of the New York State and New York City accounts would result in reduced membership and revenue and require us to reduce, reallocate or absorb administrative expenses associated with these accounts.

Total revenue increased 5.4%, or $276.9 million, to $5,382.5 million for the year ended December 31, 2003, from $5,105.6 million for the year ended December 31, 2002 primarily due to an increase in premium and administrative service fee revenue, offset by decreases in investment and other income.

Premium revenue increased $247.4 million, or 5.3%, to $4,875.4 million for the year ended December 31, 2003, from $4,628.0 million for the year ended December 31, 2002. The increase in premium revenue was primarily due to growth in our commercial managed care segment. Commercial managed care premium revenue was $4,099.5 million for the year ended December 31, 2003, a 10.1% increase compared to the year ended December 31, 2002. The increase in commercial managed care premium revenue was primarily attributable to increased cost of benefits provided and retention on our retrospectively rated contracts of approximately $209.0 million. The remaining increase was due to rate increases and membership growth.

The premium growth in commercial managed care was partially offset by the anticipated decline in our other insurance products premium. The decrease in other insurance products premium was the

result of the migration of insured indemnity contracts to self-funded contracts and premium refunds for prior years related to our Medicare Supplemental product.

On a PMPM basis, premium for the year ended December 31, 2003 increased 10.0%, to $137.17, from $124.65 for the year ended December 31, 2002. Commercial managed care PMPM premium increased to $133.01 for the year ended December 31, 2003, from $120.90 for the year ended December 31, 2002 due to premium rate and retention increases. Excluding the New York City and New York State PPO, commercial managed care PMPM premium increased to $277.21 for the year ended December 31, 2003, compared to $250.72 for the year ended December 31, 2002 due to premium rate increases. Other insurance products and services PMPM premium increased to $164.30 for the year ended December 31, 2003, from $142.89 for the year ended December 31, 2002, due primarily to declining membership in unprofitable experience rated products.

Administrative service fee revenue increased 12.5%, or $49.6 million, to $445.8 million for the year ended December 31, 2003, from $396.2 million for the year ended December 31, 2002. The increase was primarily due to growth in self-funded commercial managed care membership and increased BlueCard fees, reduced in part by lower administrative service fees attributable to our CMS contracts for the Medicare Part A and Part B programs. Approximately $49.1 million of the increase was a result of 149,000 new national account customers and the migration of approximately 50,000 insured large group PPO and indemnity contracts to self-funded contracts. Total BlueCard fees increased 14.6% or $6.5 million, to $51.1 million for the year ended December 31, 2003, from $44.6 million for the year ended December 31, 2002 due to an increase in transaction volume. Administrative service fees attributable to our CMS contracts for the Medicare Part A and Part B programs decreased $6.0 million or 4.7% to $121.3 million for the year ended December 31, 2003 from $127.3 million for the year ended December 31, 2003. The decrease was attributable to lower expenses attributable to administration of the CMS contract.

Investment income, net of investment expenses, which consists predominantly of interest and dividend income, decreased 21.0%, or $13.6 million, to $51.2 million for the year ended December 31, 2003, from $64.8 million for the year ended December 31, 2002 due to lower interest rates. Net realized gains of $11.8 million for the year ended December 31, 2003 were primarily the result of net gains on corporate bond sales and a net increase in the market value of warrants classified in our balance sheet as other long-term equity investments. Net realized gains of $2.6 million for the year ended December 31, 2002 were primarily the result of net gains on government and corporate bond sales and the sale of common stock.

Other expenses, net of $1.7 million for the year ended December 31, 2003, decreased $15.7 million from other income, net of $14.0 million for the year ended December 31, 2002, due to non–recurring transactions during 2002. Specifically, the year ended December 31, 2002 included a gain of $8.0 million relating to insurance settlements for property and equipment lost at our World Trade Center headquarters, a $5.4 million gain related to the recovery of amounts previously recorded against net income, interest earned on advances to hospitals of $2.5 million, interest received on outstanding hospital advances previously considered uncollectible of $1.9 million and late payment fee income of $0.7 million.

Total cost of benefits provided increased 5.4%, or $214.8 million, to $4,162.2 million for the year ended December 31, 2003, from $3,947.4 million for the year ended December 31, 2002. This reflects a 10.1% increase in costs of benefits provided on a PMPM basis, offset by a 4.3% decline in member months due to the migration of membership from fully-insured to self-funded contracts. Total cost of benefits provided on a PMPM basis for the year ended December 31, 2003 increased to $117.10 from $106.32 for the year ended December 31, 2002. Commercial managed care cost of benefits provided on PMPM basis increased 9.9% to $114.23 for the year ended December 31, 2003, from $103.97 for the year ended December 31, 2002. Excluding the New York City and New York State PPO accounts, the commercial managed care cost of benefits provided on a PMPM basis increased 11.2% to $227.58 for the year ended December 31, 2003, from $204.67 for the year ended December 31, 2002. Costs of benefits provided in our other insurance products and services segment for the year ended December 31, 2003 increased 15.4%, on a PMPM basis, to $135.85 from $117.72 for the year ended December 31, 2002.

The total medical loss ratio increased to 85.4% for the year ended December 31, 2003, from 85.3% for the year ended December 31, 2002, resulting from a 10.1% increase in PMPM cost of benefits provided, offset by a 10.0% increase in average premium yield, which is the change in PMPM premium revenue. Cost of benefits provided for the years ended December 31, 2003 and 2002 included $57.0 million and $47.8 million, respectively, of favorable prior period reserve development on prospectively rated contracts. The prior period development during 2003 included $34.9 million for the New York State Market Stabilization Pool. The medical loss ratio in our commercial managed care segment decreased to 85.9% for the year ended December 31, 2003, from 86.0% for the year ended December 31, 2002. Excluding the New York City and New York State PPO accounts (see note 1 to the table on page 30 of this report), the medical loss ratio in our commercial managed care segment increased to 82.1% for the year ended December 31, 2003, from 81.6% for the year ended December 31, 2002 due to increases in the ratio for our commercial products offset, in part, by a decrease in the ratio for our Medicare+Choice product. The medical loss ratio for other insurance products and services increased to 82.7% for the year ended December 31, 2003, from 82.4% for the year ended December 31, 2002. The increase was due to higher loss ratios for the indemnity and direct pay products, offset by net recoveries from the New York State Market Stabilization Pool which impacted premiums and claims in 2003.

Administrative expenses increased 5.2%, or $43.6 million, to $876.7 million for the year ended December 31, 2003, from $833.1 million for the year ended December 31, 2002 due to the following:

- Premium sales and use taxes, included as a component of administrative expense, increased $61.3 million, to $70.5 million for the year ended December 31, 2003, from $9.2 million for the year ended December 31, 2002, substantially due to increased premium taxes. As a result of our for-profit conversion, all of our health insurance premiums (other than HMO premiums) became subject to premium tax in November 2002. Therefore, the volume of premiums subject to premium taxes significantly increased in 2003 compared to 2002. In addition, as a result of the New York State budget legislation enacted in May 2003, the premium tax rate for accident and health insurers increased to 1.75% from 1.0%, retroactive to January 1, 2003.

- Salary and benefit expense decreased $76.2 million due to the reduction of staffing levels and a reduction in restructuring expenses. The reduction in staffing levels is a result of the IBM outsourcing agreement and our efforts to streamline operations.
- Professional service fees increased $14.0 million as a result of the IBM outsourcing agreement. The outsourcing commenced on July 1, 2002; therefore 2003 reflects a full year of professional fees related to the agreement whereas 2002 reflects six months of professional fees.
- Corporate insurance expense increased $9.4 million. As a result of our for-profit conversion, the cost of our directors and officers liability insurance significantly increased effective November 2002.
- Increased occupancy costs of $7.7 million relating to the transition from several leased properties, which temporarily replaced our World Trade Center office, to a long-term leased facility in Brooklyn, New York.
- Unoccupied leased office space resulted in a $13.4 million charge in 2003. We concluded that certain unoccupied leased office space would not be utilized in the future. As a result, in accordance with SFAS 146, "Accounting for Costs Associated with Exit or Disposal Activities," administrative expenses include a charge of $13.4 million, representing the difference between the market value of potential sublease rental income and the remaining lease obligations for the three floors.
- Administrative expense for the year ended December 31, 2002 reflected 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.

Income from continuing operations before income taxes increased 10.9%, or $33.9 million, to $343.6 million for the year ended December 31, 2003, from $309.7 million for the year ended December 31, 2002. This improvement was primarily driven by increased self-funded commercial managed care membership and improved underwriting performance. The income tax expense of $142.5 million reduced income from continuing operations and net income to $201.1 million for the year ended December 31, 2003. The income tax benefit of $67.9 million (as described in note 6 to the financial statements) increased income from continuing operations to $377.6 million for the year ended December 31, 2002. Taking into account our loss from discontinued operations during 2002, our net income for the year ended December 31, 2002 was $376.5 million.

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 HMO 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.

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 is 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 members from 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 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, proceeds of $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 prospectively rated 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 accounts, 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.

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.

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 January 22, 2004, the New York State Superintendent of Insurance, or Superintendent, approved the payment of a dividend to WellChoice from Empire in the amount of $120.0 million, which will be paid during the first quarter of 2004. On June 17, 2003, the Superintendent approved the payment of a dividend to WellChoice from Empire in the amount of $140.0 million, which was paid on June 30, 2003. Dividends paid to WellChoice from its subsidiaries in 2002 totaled $225.0 million. These dividends have been accounted for as an equity transfer from a subsidiary to the parent of a consolidated group. In 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.

At December 31, 2003, total investments and cash and cash equivalents at WellChoice (the parent holding company) was $363.2 million. A stand-alone condensed balance sheet of WellChoice, Inc. is presented in Schedule II of the supplemental schedules to our financial statements. See page F-36 of our 2003 Annual Report on Form 10-K.

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. Our 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, 2003 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, 2003 consisted of an investment in a mutual fund indexed to the S&P 500, our common stock investment in WebMD, our investment in non-redeemable preferred stock of several companies and equity investments held in our nonqualified deferred compensation plans. As of December 31, 2003 our marketable equity portfolio was 4.5% of the total marketable investment portfolio.

In October 2003, we renewed our existing credit and guaranty agreement with The Bank of New York, as Issuing Bank and Administrative Agent, and several other financial institutions as agents and lenders, which provides us with a credit facility. We are able to borrow under the credit facility, subject to customary conditions, for general working capital purposes. The total outstanding amounts under the credit facility cannot exceed $100.0 million. The facility has a term of 364 days with a current maturity date of October 15, 2004, 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, 2003, 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 dividends mentioned above, will be sufficient to fund continuing operations and capital expenditures for the foreseeable future based on current assets and projected future cash flows.

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Cash from operating activities increased $112.4 million to $295.1 million for the year ended December 31, 2003, from $182.7 million for the year ended December 31, 2002. The increase in operating cash flow was primarily due to the following:

- Increased premiums and administrative fees collected resulting from increases in membership and rates partially offset by an increase in cost of benefits paid contributed approximately $153.8 million in additional cash flow for the year ended December 31, 2003 when compared to December 31, 2002.
- We made premium tax payments of $69.0 million for the year ended December 31, 2003 compared to premium tax payments of $1.6 million for the year ended December 31, 2002. The increase is attributed to the Company's for-profit conversion and an increase in the premium tax rate.
- Income tax payments for the year ended December 31, 2003 were $79.9 million compared to $90.5 million for the year ended December 31, 2002. The decrease is attributable to a federal tax payment made in 2002 of approximately $22.0 million relating to 2001 partially offset by a $15.4 million increase in state income tax payments in 2003 compared to 2002. The increase in state income tax payments is related to the Company's for-profit conversion.
- For the year ended December 31, 2003, we returned advanced premium relating to our New York State account of $36.3 million compared to $75.8 million returned for the year ended December 31, 2002. The reduction in the amount returned is due to the fact that we were holding a smaller amount of advanced premium, which is available to be returned to the state.
- In 2002, operating cash flow reflects $46.5 million in World Trade Center insurance proceeds, net of recovery expense.
- Our managed cash overdraft liability (outstanding check liability) increased to $198.0 million at December 31, 2003 from $170.3 million at December 31, 2002.
- In 2003, we received approximately $44.1 million in Market Stabilization Pool recoveries. The increase is attributable to distributions for prior years. The distributions were offset by approximately $19.7 in premium refunds related to the distributions received.
- In 2003, we made payments totaling $20.5 million relating to outsourcing and restructuring initiatives undertaken in 2002, compared to $2.2 million paid in 2002. These payments were primarily severance and stay bonus related.
- Group and other contract liabilities resulted in approximately $0.7 million in operating cash outflow in 2003 compared to an inflow of $16.3 million in 2002. This decrease is primarily attributable to activity related to our New York City account.

Cash used in investing activities decreased $43.9 million to $85.6 million for the year ended December 31, 2003, from $129.5 million for the year ended December 31, 2002. This decrease is primarily due to agency bonds in our investment portfolio being called due to declining interest rates. Cash

received for these bonds were reinvested in cash equivalents. Fixed asset purchases for the year ended December 31, 2003 were $43.5 million, of which $26.9 million was spent on leasehold improvements and capital expenditures to prepare our facility in Brooklyn, New York, for occupancy beginning September 2003. Fixed asset purchases for the year ended December 31, 2002 were $33.7 million, of which $2.0 million was spent on capital expenditures to prepare Metrotech for occupancy.

Net cash provided by financing activities of $0.6 million for the year ended December 31, 2003, represents new capital leases related to office equipment, offset in part by payments for existing capital lease obligations. 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.

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 non-cash items. Some of the non-cash items impacting net income include the net deferred income tax benefit of $151.4 million, litigation reserve releases of $15.4 million 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.

Market Stabilization Pools

The New York State Community Rating Law requires insurers and HMOs writing small employer (groups with less than 50 eligible employees) and individual (non-group) business to participate in certain market stabilization pools. Under the Community Rating Law there are two major Pools: a pool for direct pay and small group contracts excluding Medicare Supplemental contracts ("non-Med Supp Pool") and a pool for Medicare Supplemental contracts ("Med Supp Pool"). Both Pools operate on a calendar year basis.

For Pool years prior to 1996, payments to and from the Pools were based on demographic data submitted by insurers. The non-Med Supp Pool also contained a component that reimbursed insurers for a portion of claim costs related to certain specified medical conditions. Effective January 1, 1996, the Community Rating Law was amended. The Community Rating Law, as amended, changed the pooling

mechanism from one based on demographics and specified medical conditions to a method based on the experience for approximately fifty medical markers on medical conditions.

The revised Community Rating Law required that the demographic and specified medical conditions approach be phased out over a four-year period. The revised methodology is complex and, as a result, implementing regulations were not issued until 2002. During this period, an interim method to distribute the portion of the Pools based on the new methodology for non-Med Supp Pool funds was developed for Pool years 1996 through 1998. Also during this time, the New York State Insurance Department determined that the demographic approach was permissible under the 1996 law and would continue to be the method used for the Med Supp Pool.

Distributions from the non-Med Supp Pool have been made through 1998 and distributions for the Med Supp Pool have been made for years through 1996 and for the years 2000 through 2003. In 2002, we received a distribution for non-Med Supp Pool year 1998 of $1.7 million. In 2003, we received a distribution from the Pool for Med Supp Pool years 2000, 2001, 2002 and 2003 of $12.6 million, $12.8 million, $12.8 million and $5.9 million, respectively.

As of December 31, 2003, we had not established a receivable or payable for non-Med Supp Pool years 1999 through 2003 and Med Supp Pool years 1997 through 1999, due to the general uncertainty surrounding the ultimate disposition of payments to or receipts from the Pools and the lack of data necessary to appropriately estimate such amounts. Our ultimate payment to or receipts from these Pools may have a material impact to our financial statements.

As result of the Med Supp Pool distributions received in 2003 for Med Supp Pool years 2000, 2001 and 2002, our Medicare Supplemental product loss ratio fell below the minimum medical loss ratio allowed under New York insurance regulations. As a result, we were required to issue premium refunds totaling $19.7 million.

Off-Balance Sheet Arrangements

We had no off-balance sheet arrangements as of and for the year ended December 31, 2003 that had or could have a material impact to our financial statements.

Contractual Obligations

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

	2004	2005	2006	2007	2008	Thereafter
Lease commitments:						
Operating leases	$35.6	$30.5	$31.8	$31.4	$31.5	$275.8
Capital leases	12.4	12.7	12.9	13.1	13.4	23.8
IBM agreement	99.7	102.1	84.7	72.0	66.4	206.0
Other purchase obligations	11.5	7.8	7.5	7.2	6.7	1.8
Projected other postretirement benefits[1]	7.9	8.4	8.8	9.2	9.2	47.3

(1) Projected benefit payments in the "Thereafter" column reflect projected payments from 2009–2013.

Operating and Capital Leases

Our lease terms generally range from one to 27 years with certain early termination or renewal provisions. 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 $1.4 million per year until 2012.

IBM Agreement

In June 2002, we entered into a ten-year agreement with IBM to enhance and 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 and providing certain core applications software development will total approximately $586.1 million over the remaining term of the agreement, which we anticipate to be less than the costs which we would have otherwise incurred had we continued to operate the data center and technical help desk ourselves.

Pursuant to the IBM agreement, we have undertaken to work jointly with IBM to enhance and modernize our systems applications. Some of the systems application software development will be performed overseas from IBM's offices in Bangalore, India or, in the event this facility becomes unavailable during the life of the agreement, services will be provided from a replacement facility. These applications include technological enhancements based on the ongoing requirements of our business and solutions developed based upon our specifications. We will own the software developed by IBM under the agreement, other than the claims payment system described below.

We anticipate that the systems applications will be integrated with a new claims payment system being developed by deNovis, a privately-held, start-up company, in coordination with IBM. The new claims payment system will be licensed to us when it is completed. The development of the system has been delayed by deNovis and as a result we do not expect the system to be ready for acceptance by us in accordance with its specifications any earlier than 2006—an approximate two-year delay from the original July 2004 date we had agreed upon with IBM in June 2002. We do not believe this delay will

have any material impact on our operations because our existing claims payment system is adequate to meet our needs.

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 the following milestones: (1) receipt of the production ready claims payment system; (2) installation of the production ready claims payment system; (3) completion of testing of the production ready claims payment system; and (4) our acceptance of the production ready claims payment system. None of these milestones have been completed and we do not expect any of them to be achieved before 2006. 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 that begins upon the payment of the final installment, we will pay IBM an annual fee of $10.0 million for maintenance and support services.

We had agreed to purchase $65.0 million in modernization and other additional services from IBM (including integration services provided by IBM in connection with the claims payment system) over a five-year period beginning in 2002, with annual target purchase rates through 2006. In September 2003, IBM and we agreed to reduce our commitment by $10.0 million to $55.0 million and to spread out the annual target purchase rate over a seven-year period ending in 2008. In addition, we accelerated the repayment of $7.3 million of price concessions granted under the original contract.

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, the aggregate purchase commitment will be increased by an amount equal to 10% per annum of purchases so delayed. The amount that we will actually spend for these additional services could be less or greater than the annual target purchase rate. We expect that our spending on modernization and additional IBM services will continue to be at levels consistent with our overall expectations of administrative expenses as a percentage of premiums earned and administrative service fees.

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.

Under the terms of the agreement we cannot perform or engage a third party to perform any of the data center or technical help desk services, or more than 20% of the core applications software development services, outsourced to IBM without the written consent of IBM. For purposes of completing the contractual commitments table on page 41 of this report, we have included an estimate of all services relating to the data center, technical help desk and core applications software development as well as our purchase commitment related to modernization and other additional services.

Other Purchase Obligations

Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

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, 2003, 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.

Critical Accounting 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 retrospectively rated 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 claim experience is based on a number of factors, including prior claims experience. We continually review theses estimates and adjust them 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 in which 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. We record the revenue earned under our contracts with CMS 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. These costs include payments to primary care physicians, specialists, hospitals, pharmacies, outpatient care facilities and the costs associated with administering such care. Costs of benefits are recorded net of pharmacy rebates, coordination of benefits and pool recoveries.

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 considerable 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, these differences would be recorded as additional cost of benefits provided in subsequent accounting periods and our future earnings would be adverse affected. To the extent the claims experience is less than estimated based on our underlying assumptions, these differences would be recorded as a reduction in cost of benefits provided in subsequent accounting periods.

The Unpaid Claims and Claims Adjustment Expense shown in our balance sheet as of December 31, 2003 consisted of the following components:

	($ in millions)
Pending and incurred but not yet reported, or IBNR, claims	$571.2
Claims adjustment expense reserve	18.9
Other claim related reserves	19.4
Total	$609.5

As reflected in this table, approximately 94% of the liability for Unpaid Claims and Claims Adjustment Expense is for pending and IBNR claims. Of the estimate for pending and IBNR claims, approximately 79% is for claims incurred in the most recent three months. Estimates of these three months' claims are based on projected per member per month, or PMPM, costs and the actual member

counts during this period. The following table presents the impact on Unpaid Claims and Claims Adjustment Expense of changes in the annualized cost trend underlying the projected PMPM costs for the most recent three months.

Increase/(Decrease) in Claim Cost Trend	Increase/(Decrease) in Unpaid Claim Estimate
	($ in millions)
(3)%	$(27.3)
(2)%	(18.2)
(1)%	(9.1)
1%	9.1
2%	18.3
3%	27.4

Estimates of the remaining pending and IBNR claims for those claims incurred more than three months prior to the reporting date were based on claims actually paid during this period and completion factors developed from historical payment lag patterns. A completion factor is the ratio of the claims for a given month that are paid to date as of the reporting date to the ultimate amount expected to be paid for that month. The following shows the impact on Unpaid Claims and Claims Adjustment Expense of changes in the completion factors used in projecting the ultimate cost for claims incurred over three months prior to the reporting date.

Increase/(Decrease) in Completion Factor	Increase/(Decrease) in Unpaid Claim Estimate
	($ in millions)
(0.3)%	$ 40.9
(0.2)%	27.2
(0.1)%	13.6
0.1%	(10.3)
0.2%	(17.0)
0.3%	(22.6)

It should be noted that the dollar amounts shown in the tables above would not necessarily flow directly to income from continuing operations. In prospectively rated business, we are at risk for negative experience—where actual claim costs and other expenses are greater than those expected—and benefit from positive experience—where claim costs and other expenses are less than those expected. By contrast, in retrospectively rated business, the customer is at risk. Generally speaking only the portion of the reserve change which affects prospectively rated business impacts income from continuing operations. At December 31, 2003, approximately 48.0% of the $571.2 million of reserve for Pending and IBNR claims were held for prospectively rated business.

We believe that the recorded unpaid claim liability is adequate to cover our ultimate liability for unpaid claims as of December 31, 2003. Actual claim payments and other items may differ from our estimates. Assuming a hypothetical 1% difference between our December 31, 2003 estimates of unpaid claims and actual claims payable for our prospectively rated business, net income from continuing operations

for the year ended December 31, 2003, would increase or decrease by approximately $1.7 million and earnings per share would increase or decrease by approximately $0.02 per share.

As shown in Note 5 of the Notes to the Consolidated Financial Statement, there was $82.1 million of favorable reserve development in 2003 for claims incurred in 2002 and prior years. Our revised estimate of the liability on 2002 and prior years' claims was lower than our original estimate at December 31, 2002. This favorable development was the result of:

- $34.9 million related to amounts we received with respect to the New York State Medicare Supplemental Stabilization Pool for years 2000, 2001 and 2002;
- $44.3 million favorable development of general claim liability; and
- $2.9 million amortization of premium deficiency reserve in one of our subsidiaries.

Of the $44.3 million favorable development of general claim liability, $23.8 million relates to 2002, $14.8 million to 2001, and $5.7 million to 2000 and prior. As a result of the $34.9 million net Pool receipts, we distributed approximately $19.7 million of premium refunds to Medicare Supplemental contract holders during the fourth quarter of 2003.

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.

Retirement Benefits

Pension Benefits

We sponsor defined benefit cash-balance pension plans for our employees. As discussed in Note 14 of the Notes to the Consolidated Financial Statements, we account for these plans in accordance with Financial Accounting Standards No. 87, *Employers' Accounting for Pensions* ("FAS 87"). FAS 87 requires us to make significant assumptions including estimating the expected return on pension plan assets and the discount rate used to determine the current pension obligation. Changes to these assumptions will affect pension expense.

One important factor in determining our pension expense is the assumption for expected return on plan assets. As of December 31, 2003, our expected long-term rate of return on plan assets was 7.5% (which was reduced from 8.0% for our 2002 expense recognition). The expected rate of return assumption is determined by taking into account our expectations regarding future rates of return for the investment portfolio, with consideration given to the distribution of investments by asset class and

historical rates of return for each class. A 0.5% decrease (increase) in the expected return on plan assets would increase (decrease) pension expense by approximately $2.3 million.

We apply this assumed long-term rate of return on assets to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over five years. This produces the expected return on plan assets that we include as a component of pension expense. Each year, the gain or loss from asset performance, which is measured as the difference between this expected return and the actual return on plan assets for that year, is deferred and recognized in the market related value of assets as 20% increments for each of the five years following the gain or loss. The net deferral of past asset gains and losses affects the calculated value of plan assets and, ultimately, future pension expense.

Our pension plans have $59.9 million of cumulative unrecognized losses as of the December 31, 2003 measurement date. Generally, these losses are amortized into expense each year on a straight-line basis over the remaining expected future-working lifetime of active participants (currently approximately 12 years), to the extent that such losses exceed 10% of the greater of the projected benefit obligation and the market related value of assets. The estimated impact to the 2004 pension expense as a result of the amortization of these losses is approximately $1.3 million.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our measurement date. At our last measurement date (December 31, 2003), we lowered our discount rate to 6.0% (from 6.5% as of December 31, 2002 and 7.0% as of December 31, 2001). Changes in the discount rates over the past three years have resulted in an increase to pension expense from what it otherwise would have been. The net effect on liabilities attributable to changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FAS 87.

At December 31, 2003, our prepaid benefit cost for the qualified and supplemental pension plans combined was $53.5 million compared to $45.2 million at December 31, 2002. The prepaid benefits cost represents the end of period excess of the fair value of plan assets over the benefit obligation plus or minus amounts not yet recognized. Net pension income included as a component of administrative expense was $7.4 million, $6.0 million and $8.7 million for the years ended December 31, 2003, 2002 and 2001, respectively. For the year ended December 31, 2003, we did not contribute any funding into our cash balance pension plans and based on the current funded status, do not anticipate any contributions during 2004.

Other Postretirement Benefits

We provide most employees certain life, medical, vision and dental benefits upon retirement. As discussed in Note 2 to the Notes to the Consolidated Financial Statements we account for these plans in accordance with Financial Accounting Standards No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions* ("FAS 106"). In accordance with FAS 106, we use various actuarial assumptions including the discount rate and the expected trend in healthcare costs to estimate the costs and benefit obligations for our retiree health plan.

At December 31, 2003, we lowered our discount rate to 6.0% (from 6.5% for our 2003 expense recognition). The assumed healthcare cost trend rate used in measuring the other benefit obligations was 10% in 2003 for all participants under age 65, 30.7% for participants in Medicare HMOs and 9.0% for participants age 65 and over in indemnity plans, decreasing gradually each year until ultimately leveling out at 4.5% in 2009.

At December 31, 2003, our liability for postretirement benefits other than pensions was $142.7 million compared to $143.7 million at December 31, 2002. Expected future benefit payments with respect to liabilities under these plans can be found in the "Liquidity and Capital Resources" section of this report.

Recent Accounting Pronouncements

In December 2003, the Financial Accounting Standard Board issued SFAS No. 132 (Revised 2003), *Employers' Disclosures about Pensions and Other Postretirement Benefits*. This Statement amends Statements No. 87, Employers' Accounting for Pensions, No. 88, *Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits*, and No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. However, the Statement does not change the recognition and measurement requirements of those Statements. This Statement retains the disclosure requirements contained in SFAS No. 132, *Employers' Disclosures about Pensions and Other Postretirement Benefits*, which it replaces and requires additional disclosure. Additional new disclosure includes actual mix of plan assets by category, a description of investment strategies and policies used, a narrative description of the basis for determining the overall expected long-term rate of return on asset assumption and aggregate expected contributions.

On December 8, 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, was signed into law. The MMA introduced a voluntary Medicare part D prescription drug benefit and created a new 28% federal subsidy for the sponsors of the postretirement prescription drug benefits that are at least actuarially equivalent to the new Medicare Part D benefit. Under SFAS No. 106-1, *Accounting for Postretirement Benefits Other Than Pensions*, sponsors must consider the two new features in measuring the Accumulated Postretirement Benefit Obligation ("APBO") and net periodic postretirement benefit cost. In accordance with SFAS No. 106-1, the Company made a one-time election to defer recognition of the impact on SFAS No. 106-1 accounting. Any measures of APBO and net periodic postretirement benefit cost in the financial statements and the related footnotes for the year ended December 31, 2003 do not reflect the effects of the MMA. Currently, specific authoritative guidance on accounting for the federal subsidy is pending and that guidance when issued could require the Company to change previously reported information. The Company does not anticipate that the adoption of SFAS 106-1 will materially affect the financial statements.

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 factors used to determine whether unrealized losses are considered other than temporary are the length of time the security has been in an unrealized loss position, the market to book value ratio and other relevant qualitative considerations. 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, 2003 of approximately $44.8 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, 2003 and December 31, 2002 (at fair value):

	December 31, 2003	Percent of Total	December 31, 2002	Percent of Total
		(dollars in millions)		
Total fixed maturity				
Aaa	**$ 995.3**	**78.4%**	$ 892.3	72.9%
Aa	**72.7**	**5.7**	70.7	5.8
A	**193.1**	**15.2**	251.3	20.6
Baa	**8.6**	**0.7**	8.5	0.7
Total fixed maturity	**$1,269.7**	**100.0%**	$1,222.8	100.0%
Total fixed maturity corporate securities:				
Industrial	**$ 28.8**	**6.7%**	$ 37.2	10.1%
Finance	**347.5**	**80.8**	251.3	68.2
Utility	**5.3**	**1.2**	20.4	5.5
Asset-backed securities	**13.5**	**3.1**	30.0	8.2
Other	**35.1**	**8.2**	29.5	8.0
Total fixed maturity corporate securities	**$ 430.2**	**100.0%**	$ 368.4	100.0%
Total mortgage-related securities:				
Mortgage pass through certificates	**$ 6.3**	**3.0%**	$ 12.0	6.9%
Collateralized mortgage obligations	**203.6**	**97.0**	162.6	93.1
Total mortgage-related securities	**$ 209.9**	**100.0%**	$ 174.6	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 non-redeemable preferred stock of several companies. Our investment in non-redeemable 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, 2003 to be a decrease in fair value of $5.0 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, 2003 was 3.1 years.