

Item 7. 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, 2004. This review should be read in conjunction with the consolidated financial statements and other data presented herein.

The statements contained in this Annual Report on Form 10-K, including those set forth in "Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations" and elsewhere in this report (including but not limited to those set forth in "Item 1. – Business – Company Overview," "—Our Strategy," "—Customers," "—Information Systems and Telecommunications Infrastructure," "—Collaborations") include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or the PSLRA. When used in this report, the words or phrases "believes," "anticipates," "intends," "will likely result," "estimates," "projects" or similar expressions are intended to identify such forward-looking statements. Any of these forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

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

Overview

We are the largest health insurance company in the State of New York based on total preferred provider organization, or PPO, and health maintenance organization, or HMO, membership, which includes members under our insured and administrative services only, or ASO, plans. We provide managed care and traditional indemnity products to approximately 5.0 million members. We have licenses with the Blue Cross Blue Shield Association, a national trade association of Blue Cross Blue Shield licensees whose primary function is to promote and preserve the integrity of the Blue Cross Blue Shield names and marks, as well as to provide certain coordination among the member plans. Our licenses 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 principal health products are offered both on an insured and self-funded, or ASO basis and, in some instances, a combination of insured and self-funded, which includes minimum premium arrangements. Minimum premium arrangements provide coverage under separate self-funded and insured group contracts. Benefit payments made under the self-funded contract, up to a pre-established limit, are the responsibility of the group. 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, including charges for risk, profit, administration and reimbursement of benefits made under the insured contract of minimum premium arrangements. 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. Benefit payments made under self-funded contracts are the responsibility of the group, and accordingly no premium is recorded by us for these payments. 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, investment income and net realized investment gains or losses.

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, premium taxes, commission payments to brokers and other general 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 88.4% of our membership as of December 31, 2004. Our commercial managed care segment includes group PPO, HMO (including Medicare+Choice), EPO, and other products (point of service, or POS, and dental-only coverage) as well as our PPO business under our accounts with New York City and New York State. Our other insurance products and services segment consists of our indemnity and individual products. Our indemnity products include traditional indemnity products and government contracts with CMS to act as a fiscal intermediary and carrier. Our individual products include Medicare supplemental, state sponsored plans, government mandated individual plans and individual hospital-only and hospital and medical products. 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 PPO account members are covered under insured plans. Groups enrolled under minimum premium arrangements are reported as insured members.

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

Our business operates in a highly competitive environment, both in New York and New Jersey as well as nationally. Our largest competitors in the New York metropolitan area include national and regional health insurers, including UnitedHealth Group and its subsidiaries, Aetna Inc., Health Insurance Plan of New York and Group Health Incorporated, and our competition for national accounts includes UnitedHealth Group, Cigna Corporation and Aetna as well as other "Blue" plans.

Income Taxes

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, we continued to take the deduction on our tax returns for periods after the conversion. However, we assumed, for financial statement reporting purposes, that the deduction would be disallowed. The Company's ability to utilize the 833(b) deduction was exhausted in 2003.

We have substantial tax credit carryovers. At December 31, 2004, for income tax purposes, our alternative minimum tax credit carryforwards, which have no expiration, were approximately \$218.6 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.

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. We expect to incur federal, state and local income taxes at the rate of approximately 38% of pre-tax net income.

Capitated Provider Arrangements

Our cost of benefits provided under capitated arrangements is not significant. Payments under capitated arrangements totaled \$122.3 million for the year ended December 31, 2004, representing 2.7% of total cost of benefits provided.

We currently maintain a single global capitation arrangement to provide hospital and medical benefits for approximately 1,100 members enrolled in our Medicare+Choice product. Payments made under this arrangement totaled \$9.3 million for the year ended December 31, 2004. The premiums earned in excess of costs of benefits provided under this arrangement was approximately \$1.1 million for the year ended December 31, 2004.

Other capitated arrangements are in place to manage and assume risk for certain benefits covered under specific insured products. The following sets forth the membership and respective benefits under these capitated arrangements at December 31, 2004:

| <u>Benefit</u> | <u>Membership</u> (in thousands) |
|-------------------------------|-------------------------------------|
| Mental health | 841 |
| Laboratory services | 492 |
| Vision | 378 |
| Hearing | 122 |
| Dental | 96 |

Approximately 28.8% of our insured membership is provided one or more benefits under a capitated program.

We also have capitated arrangements with service providers for certain disease management programs. At December 31, 2004, we had approximately 128,000 members under capitated disease management programs and 503,000 members under a capitated utilization management program for eye care services.

Selected Membership Data and Results of Operations

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

| (Members in Thousands) | <u>2004</u> | <u>2003</u> | <u>2002</u> |
|--|--------------|--------------|--------------|
| Products and services: | | | |
| Commercial managed care: | | | |
| Group PPO, HMO, EPO and other (1)(2) | 2,558 | 2,301 | 2,019 |
| New York City and New York State PPO | 1,823 | 1,805 | 1,786 |
| Total commercial managed care | <u>4,381</u> | <u>4,106</u> | <u>3,805</u> |
| Other insurance products and services: | | | |
| Indemnity | 364 | 428 | 567 |
| Individual | 210 | 220 | 236 |
| Total other insurance products and services | <u>574</u> | <u>648</u> | <u>803</u> |
| Overall total | <u>4,955</u> | <u>4,754</u> | <u>4,608</u> |
| Customers: | | | |
| Large group | 2,986 | 2,931 | 2,903 |
| Small group and middle market | 472 | 444 | 394 |
| Individuals | 266 | 269 | 290 |
| National accounts | 1,231 | 1,110 | 1,021 |
| Overall total | <u>4,955</u> | <u>4,754</u> | <u>4,608</u> |
| Funding type: | | | |
| Commercial managed care: | | | |
| Insured | 2,678 | 2,620 | 2,597 |
| Self-funded | 1,703 | 1,486 | 1,208 |
| Total commercial managed care | <u>4,381</u> | <u>4,106</u> | <u>3,805</u> |
| Other insurance products and services: | | | |
| Insured | 327 | 398 | 463 |
| Self-funded | 247 | 250 | 340 |
| Total other insurance products and services | <u>574</u> | <u>648</u> | <u>803</u> |
| Overall total | <u>4,955</u> | <u>4,754</u> | <u>4,608</u> |

(1) Our HMO product includes Medicare+Choice. As of December 31, 2004, 2003 and 2002, we had approximately 56,000, 50,000 and 55,000 members, respectively, enrolled in Medicare+Choice.

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

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

| (\$ in millions) | Year ended December 31, | | |
|---|-------------------------|-----------|-----------|
| | 2004 | 2003 | 2002 |
| Commercial Managed Care: | | | |
| Total revenue | \$4,930.3 | \$4,425.0 | \$4,000.6 |
| Income from continuing operations before income tax expense | \$ 339.6 | \$ 292.6 | \$ 253.4 |
| Medical loss ratio: | | | |
| Commercial managed care total | 86.6% | 85.9% | 86.0% |
| Commercial managed care, excluding New York City and New York State PPO (1) | 83.0% | 82.1% | 81.6% |
| Administrative expense ratio (2) | 13.3% | 14.0% | 13.9% |
| Other Insurance Products and Services: | | | |
| Total revenue | \$ 896.7 | \$ 957.5 | \$1,105.0 |
| Income from continuing operations before income tax expense | \$ 47.8 | \$ 51.0 | \$ 56.3 |
| Medical loss ratio | 84.4% | 82.7% | 82.4% |
| Administrative expense ratio (2) | 28.6% | 28.0% | 27.8% |

- (1) We present the commercial managed care medical loss ratio, excluding New York City and New York State PPO, because these accounts differ from our standard PPO product in that they are hospital-only accounts which have lower premiums relative to claim expense than accounts with full medical and hospital coverage. The lower premiums and the size of these accounts distort our performance when the total medical loss ratio is 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 38.9% and 43.0% of our managed care and other insurance products and services members, respectively. Therefore, in the following table, we provide the information needed to calculate premium equivalents and 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:

| (\$ in millions) | Year ended December 31, | | |
|--|-------------------------|----------------|----------------|
| | 2004 | 2003 | 2002 |
| Commercial Managed Care: | | | |
| Premiums earned | \$4,548.6 | \$4,099.5 | \$3,723.0 |
| Administrative service fees | 323.1 | 274.1 | 212.2 |
| Claims paid for our self-funded health business | <u>3,250.4</u> | <u>2,408.0</u> | <u>1,696.8</u> |
| Premium Equivalent | \$8,122.1 | \$6,781.6 | \$5,632.0 |
| Administrative expense ratio, premium equivalent basis | 8.0% | 9.0% | 9.7% |
| Other Insurance Products and Services: | | | |
| Premiums earned | \$ 706.0 | \$ 775.9 | \$ 905.0 |
| Administrative service fees | 179.1 | 171.7 | 184.0 |
| Claims paid for our self-funded health business | <u>459.9</u> | <u>547.3</u> | <u>651.1</u> |
| Premium Equivalent | \$1,345.0 | \$1,494.9 | \$1,740.1 |
| Administrative expense ratio, premium equivalent basis | 18.8% | 17.7% | 17.4% |

Year Ended December 31, 2004 Compared to Year Ended December 31, 2003

As of December 31, 2004, total enrollment was approximately 5.0 million members, a 4.2% increase from December 31, 2003. The increase in overall enrollment was driven by a 6.7% increase in commercial managed care enrollment, offset by an 11.4% decrease in other insurance products and services enrollment. The net increase in overall enrollment was the result of:

- Growth of 10.6%, or 213,000 members, in group PPO, EPO and other due primarily to a combination of new national account customers in our PPO and EPO products and net membership increases in our existing accounts;
- Growth of 15.0%, or 44,000 members, in our group HMO products; and
- A decrease in other insurance product and services enrollment of approximately 74,000 members, due to cancelled business, including the loss of a large self-funded national account, and, to a lesser extent, the continued migration of members to commercial managed care products.

Our self-funded enrollment increased 12.3%, or approximately 214,000 members, and at December 31, 2004 represented approximately 39.4% of our total enrollment, 38.9% of commercial managed care enrollment, and 43.0% of other insurance product and services enrollment. The migration of insured business to self-funded arrangements, new self-funded enrollment and growth within existing self-funded accounts resulted in the increase in self-funded enrollment. The migration to self-funded enrollment consisted primarily of approximately 16,000 members from insured large group PPO and 27,000 members from insured indemnity products. New self-funded accounts resulted in approximately 112,000 new members (predominantly national accounts), offset in part by a 13,000 decline in enrollment from group cancellations. We expect self-funded enrollment to continue to increase through the continued migration of insured business to self-funded arrangements and new self-funded accounts. While this trend will reduce our insured premium and claim expense, we do not expect it to have a material impact on net income.

As of December 31, 2004, our New York State account covered approximately 998,000 members, or 20.1% of our total membership and 22.8% of our commercial managed care membership, and our New York City account covered approximately 824,000 members, or 16.6% of our total membership and 18.8% 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 retention or administrative expense pricing covering a three-year period through December 31, 2005, though both parties retain the right to terminate the contract upon six months' notice. For over three 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. At this time, there is no official timetable for awarding the five-year contract. However, we agreed to new rates with the New York City account through June 30, 2005. 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 8.3%, or \$444.5 million, to \$5,827.0 million for the year ended December 31, 2004, from \$5,382.5 million for the year ended December 31, 2003 primarily due to an increase in premium and administrative service fee revenue.

Premium revenue increased \$379.2 million, or 7.8%, to \$5,254.6 million for the year ended December 31, 2004, from \$4,875.4 million for the year ended December 31, 2003. The increase in premium revenue was the result of growth in our commercial managed care segment. Commercial managed care premium revenue was \$4,548.6 million for the year ended December 31, 2004, a 11.0%, or \$449.1 million, increase compared to the year ended December 31, 2003. The net increase in commercial managed care premium revenue was the result of the following:

- Premium rate increases and membership growth contributed \$382.2 million in additional revenue, primarily in our group HMO and Medicare+Choice products;

- An increase of approximately \$237.7 million due to the increased cost of benefits provided and premium rate increases in our New York City and New York State PPO accounts; and
- A decrease in premium resulting from the conversion of large group accounts to minimum premium arrangements and the conversion of insured groups to self-funded arrangements. Although these conversions did not materially impact net income, they resulted in a reduction of premium revenue of approximately \$170.8 million.

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 enrollment losses, and to a lesser extent, the migration of insured indemnity contracts to self-funded contracts and minimum premium arrangements. In addition, 2003 premium revenue was reduced for premium refunds related to prior years for our Medicare Supplemental product.

Minimum premium arrangements differ from our standard insurance product in that they have significantly lower premiums. The lower premiums associated with these arrangements distort our premium on a PMPM basis when compared to the prior year since we did not have these arrangements in place. Therefore, we present premium, on a PMPM basis, for the year ended December 31, 2004, excluding minimum premium arrangements (1):

| | Year Ended December 31, | | |
|---|-------------------------|----------|--------|
| | 2004 | 2003 | Change |
| Total | \$149.23 | \$134.60 | 10.9% |
| Commercial managed care | \$145.71 | \$131.90 | 10.5% |
| Commercial managed care excluding New York City and New York State PPO (2) | \$295.28 | \$269.59 | 9.5% |
| Other insurance products and services | \$176.63 | \$150.95 | 17.0% |

- (1) Premium revenue on a PMPM basis, for the year ended December 31, 2004, inclusive of minimum premium arrangements, for Total, Commercial managed care, Commercial managed care, excluding New York City and New York State PPO, and Other insurance products and services were \$146.80, \$143.21, \$276.86 and \$175.11, respectively. We did not have any minimum premium arrangements during the year ended December 31, 2003.
- (2) We present commercial managed care premium, on a PMPM basis, 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. The lower premiums and the size of these accounts distort our performance when the total PMPM premium is presented.

The increase in total and commercial managed care premium, on a PMPM basis, for the year ended December 31, 2004 was the result of premium rate increases and increased cost of benefits provided on our New York City and New York State PPO accounts. The PMPM premium increase in commercial managed care excluding the New York City and New York State PPO for the year ended December 31, 2004 was the result of premium rate increases. Other insurance products and services PMPM premium increased for the year ended December 31, 2004 due primarily to declining membership in lower priced products and rate increases. In addition, 2003 premium revenue was reduced for premium refunds related to prior years for our Medicare Supplemental product.

Administrative service fee revenue increased 12.7%, or \$56.4 million, to \$502.2 million for the year ended December 31, 2004, from \$445.8 million for the year ended December 31, 2003. The increase was primarily due to the following:

- Approximately \$41.1 million of the increase is attributable to new self-funded customers, the migration of approximately 43,000 insured contracts to self-funded contracts, as well as growth within existing accounts and rate increases;

- Total BlueCard fees increased 19.0%, or \$9.7 million, to \$60.8 million for the year ended December 31, 2004, from \$51.1 million for the year ended December 31, 2003 due to an increase in transaction volume; and
- Administrative service fees attributable to our CMS contracts for the Medicare Part A and Part B programs increased \$5.6 million or 4.6% to \$126.9 million for the year ended December 31, 2004 from \$121.3 million for the year ended December 31, 2003. The increase resulted from reimbursement for additional expenses attributable to administration of the CMS contracts.

Investment income, net of investment expenses, which consists predominantly of interest and dividend income, of \$57.8 million for the year ended December 31, 2004 increased 12.9%, or \$6.6 million, from the year ended December 31, 2003. This increase was due to an increase in interest and dividend income resulting from higher invested balances, a larger concentration of long-term and short-term securities and an increase in short-term interest rates. Net realized gains of \$11.7 million and \$11.8 million for the year ended December 31, 2004 and 2003, respectively, were primarily the result of net gains on the sale of marketable securities.

Other income, net for the year ended December 31, 2004 was \$0.7 million compared to other expense, net of \$1.7 million for the year ended December 31, 2003.

Total cost of benefits provided increased 9.0%, or \$374.3 million, to \$4,536.5 million for the year ended December 31, 2004, from \$4,162.2 million for the year ended December 31, 2003. This reflects a 10.3% increase in costs of benefits provided on a PMPM basis, offset by a 1.2% decline in member months due to the migration of membership from fully-insured to self-funded contracts.

Lower claim costs associated with minimum premium arrangements distort our claim expense on a PMPM basis when compared to the prior year since we did not have these arrangements in place. Therefore, we present cost of benefits provided, on a PMPM basis, for the year ended December 31, 2004, excluding minimum premium arrangements (1):

| | <u>Year Ended December 31,</u> | | |
|--|--------------------------------|-------------|---------------|
| | <u>2004</u> | <u>2003</u> | <u>Change</u> |
| Total | \$129.30 | \$114.92 | 12.5% |
| Commercial managed care | \$126.72 | \$113.28 | 11.9% |
| Commercial managed care excluding New York City and New York State PPO (2) | \$246.71 | \$221.34 | 11.5% |
| Other insurance products and services | \$149.41 | \$124.82 | 19.7% |

- (1) The cost of benefits provided, on a PMPM basis, for the year ended December 31, 2004, inclusive of minimum premium arrangements, for Total, Commercial managed care, Commercial managed care excluding New York City and New York State PPO, and Other insurance products and services were \$126.74, \$124.07, \$229.87 and \$147.80, respectively. We did not have any of these arrangements during the year ended December 31, 2003.
- (2) We present commercial managed care cost of benefits provided on a PMPM basis, 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. The lower premiums and the size of these accounts distort our performance when the cost of benefits provided on a PMPM basis is presented.

The total medical loss ratio increased to 86.3% for the year ended December 31, 2004, from 85.4% for the year ended December 31, 2003. Cost of benefits provided for the year ended December 31, 2004 and 2003 included \$19.2 million and \$57.0 million, respectively, of favorable prior period reserve development on prospectively rated contracts on a net basis. The favorable prior period reserve development for the year ended

December 31, 2003 included \$34.9 million of claim credits as a result of distributions from the New York Market Stabilization Pool for Pool Years 2000, 2001, and 2002. The increase in total and commercial managed care cost of benefits provided, on a PMPM basis, for the year ended December 31, 2004 was the result of medical cost increases particularly in outpatient and pharmacy costs. Excluding the New York City and New York State PPO accounts (see note 1 to the table on page 51 of this report), the medical loss ratio in our commercial managed care segment increased to 83.0% for the year ended December 31, 2004, from 82.1% for the year ended December 31, 2003 due to increases in medical loss ratios for our commercial and Medicare+Choice HMO products. The increase in other insurance products and services PMPM cost of benefits provided for the year ended December 31, 2004 was primarily due to the receipt in 2003 of Medicare Supplemental demographic pool claim credits of \$34.9 million, or \$6.79 on a PMPM basis, and a decrease in membership in lower cost products, such as Medicare Supplemental.

Administrative expenses increased 3.0%, or \$26.4 million, to \$903.1 million for the year ended December 31, 2004, from \$876.7 million for the year ended December 31, 2003, due to the following:

- Increased employee compensation and benefit expense of \$21.1 million due to an increase in medical benefit expense, higher average salaries and the amortization of restricted stock awards and restricted stock unit awards, offset in part by a decrease in employee restructuring costs;
- Professional service fees increased \$15.3 million. These services related to increased health services activities, corporate projects, outsourcing arrangements and our Sarbanes-Oxley Act compliance effort;
- Broker commissions increased \$10.0 million due to premium growth in the small group and middle market customer segment;
- An increase in inter-plan claim activity resulted in a \$5.0 million increase in fees related to the BlueCard program; and
- A \$4.9 million increase in claims adjustment expense as a result of growth in our unpaid claims liability.

These increases were offset by:

- During the third quarter of 2003, we concluded that certain unoccupied leased office space would not be utilized in the future and recognized an expense of \$13.4 million, representing the net present value difference between the fair value of estimated sublease rentals and the remaining lease obligation for this space;
- A \$8.4 million decrease in depreciation expense related to capitalized software. The majority of the capitalized costs related to the development of Internet web portals that were fully depreciated at the end of the 2003; and
- A \$7.5 million decrease in expenses related to reserves held for claims and contractual disputes.

Income from continuing operations before income taxes increased 12.7%, or \$43.8 million, to \$387.4 million for the year ended December 31, 2004, from \$343.6 million for the year ended December 31, 2003. This improvement was primarily driven by commercial managed care membership and rate increases as well as a declining administrative expense ratio, which we expect to continue. Income tax expense of \$141.2 million for the year ended December 31, 2004 includes a benefit of \$5.7 million resulting from a settlement of a prior year IRS audit issue relating to the tax basis used in determining the gain or loss on the sale of our former corporate headquarters. Our effective tax rate for the year ended December 31, 2004 was 36.4%. Excluding the non-recurring benefit related the settlement of the prior year IRS audit, the effective tax rate for the year ended December 31, 2004 was approximately 38%. Income tax expense of \$142.5 million for the year ended December 31, 2003 included additional tax expense related to the reversal of deferred state tax assets due to changes in New York State tax law and establishing contingent tax liabilities for IRS audits, including the one that was settled in 2004. In addition, for the year ended December 31, 2004, a larger proportion of our pre-tax income came from our insurance company, which is not subject to New York State income tax, compared to the year ended December 31, 2003. We expect to incur federal, state and local income taxes at the rate of approximately 38% of pre-tax net income in 2005.

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 approximately 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 approximately 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 approximately 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 approximately 149,000 new members.

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 New York City and New York State contracts of approximately \$185.6 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 10.1%, to \$134.60, from \$122.21 for the year ended December 31, 2002. Commercial managed care PMPM premium increased to \$131.90 for the year ended December 31, 2003, from \$119.88 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 \$269.59 for the year ended December 31, 2003, compared to \$243.92 for the year ended December 31, 2002 due to premium rate increases. Other insurance products and services PMPM premium increased to \$150.95 for the year ended December 31, 2003, from \$132.82 for the year ended December 31, 2002, due primarily to premium rate increases and a decrease in membership in lower priced products offset by premium refunds for prior years related to our Medicare Supplemental product.

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, 2002. 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 10.3% increase in costs of benefits provided on a PMPM basis, offset by a 4.4% 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 \$114.92 from \$104.23 for the year ended December 31, 2002. Commercial managed care cost of benefits provided on PMPM basis expense increased 9.9% to \$113.28 for the year ended December 31, 2003, from \$103.10 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 expense increased 11.2% to \$221.34 for the year ended December 31, 2003, from \$199.11 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 14.1%, on a PMPM basis, to \$124.82 from \$109.43 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 10.3% increase in PMPM cost of benefits provided, offset by a 10.1% 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 51 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 as 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.

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 its subsidiary, Empire HealthChoice Assurance, Inc., or Empire, in the amount of \$120.0 million, which was paid on February 11, 2004. On September 30, 2004, the Superintendent approved the payment of a dividend to WellChoice from Empire in the amount of \$75.0 million, which was paid on September 30, 2004. These dividends have been accounted for

as an equity transfer from a subsidiary to the parent of a consolidated group. Since we converted to a for-profit company in 2002 through December 31, 2004, WellChoice received dividends of \$560.0 million from its subsidiaries. On December 24, 2004, the Superintendent approved the payment of a dividend to WellChoice from Empire in the amount of \$125.0 million. The dividend was approved by Empire's Board on January 6, 2005 and was paid on February 4, 2005. The Company intends to continue to seek additional dividends from Empire and its other regulated subsidiaries. There can be no assurance that the Superintendent or other state regulators will grant approval for the applicable regulated subsidiary to pay future dividends.

At December 31, 2004, total investments and cash and cash equivalents at WellChoice (the parent holding company) was \$565.8 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-41-42.

Our subsidiaries' primary source of cash is from premiums and fees received and investment income. The primary uses of cash include healthcare benefit expenses and administrative expenses, which includes brokers' and agents' commissions. 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, 2004 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, 2004 consisted of an investment in a mutual fund indexed to the S&P 500, our common stock investments and equity investments held in our nonqualified deferred compensation plans. As of December 31, 2004 our marketable equity portfolio was 3.4% of the total marketable investment portfolio.

In October 2004, 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 14, 2005, 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 0.75%, or LIBOR plus a margin of between 0.875% and 2.0%, with the applicable margin to be determined based on our financial strength rating. As of December 31, 2004, 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, 2004 compared to year ended December 31, 2003

Cash flows from operating activities increased \$44.2 million to \$339.3 million for the year ended December 31, 2004 from \$295.1 million for the year ended December 31, 2003. The net increase in operating cash flow was primarily due to the following:

- Membership growth, premium rate increases and an increase in paid claims related to our New York State and New York City accounts resulted in approximately \$288.3 million in additional cash flow for the year ended December 31, 2004 when compared to the year ended December 31, 2003.
- Increased cost of benefits resulted in additional payments of \$325.4 million for the year ended December 31, 2004 when compared to the year ended December 31, 2003.
- In 2004, we received approximately \$20.9 million in Market Stabilization and Stop Loss Pool distributions compared to \$44.2 million received in 2003.
- In 2004, we issued \$7.5 million in premium refunds related to the Medicare Supplemental product compared to \$23.3 million in 2003.
- Increased self-funded membership and BlueCard transaction fees generated \$60.1 million in additional cash flow for the year ended December 31, 2004 when compared to the year ended December 31, 2003.
- Payments for administrative expenses increased \$49.8 million for the year ended December 31, 2004. The increase was due to increased administrative expenses and timing of payroll disbursements and payments to vendors.
- Taxes paid for the year ended December 31, 2004 increased \$8.5 million to \$88.4 million compared to taxes paid of \$79.9 million for the year ended December 31, 2003. The increase is due to higher taxable income offset by 2003 overpayments applied to the current year.
- Our managed cash overdraft liability, which represents our outstanding check liability, increased \$17.4 million to \$215.4 million for the year ended December 31, 2004 compared to an increase of \$27.8 for the year ended December 31, 2003.
- Advanced premium liability related to our New York State account increased \$46.7 million to \$160.6 million for the year ended December 31, 2004 due to current year contract receipts compared to a decrease of \$23.9 million for the year ended December 31, 2003. The decrease in 2003 is due to reimbursement of excess premium collected in prior years.
- A reduction in Advances to Hospitals resulted in \$9.2 million of cash flow for the year ended December 31, 2004 compared to cash used of \$10.7 million for the year ended December 31, 2003. The decrease is due to a reduction in hospital advances issued in 2004 when compared to 2003 and collection of advances issued in prior years.

Cash used in investing activities of \$277.4 million for the year ended December 31, 2004 represents an increase of \$191.8 million compared to cash flow used in investing activities of \$85.6 million for the year ended December 31, 2003. During 2004, we reinvested maturing securities in long-term investments, as appropriate; by contrast in 2003 maturing and called securities were reinvested in cash equivalents. Fixed asset purchases of \$33.3 million for the year ended December 31, 2004 decreased \$10.2 million compared to fixed asset purchases of \$43.5 million for the year ended December 31, 2003. The decline is due to a decrease in leasehold and capital expenditures for our facility in Brooklyn, New York that was completed in 2003.

Net cash used in financing activities of \$1.0 million for the year ended December 31, 2004 consists of \$4.1 million of cash received from employee stock purchase and compensation programs offset by payments of \$4.3 million for capital lease obligations and \$0.8 million for expenses incurred as a result of a secondary public common stock offering.

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 distribution 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.

Market Stabilization Pools

The New York State Community Rating Law requires insurers and HMOs writing small employer (groups with fewer than 50 eligible employees) and individual (non-group) business to participate in certain market stabilization pools established primarily for the purpose of spreading claim risk among carriers. 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, changing 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 (“NYSID”) 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 from the Med Supp Pool have been made for years through 1997 and for the years 2000 through the first quarter of 2004. In addition, partial distributions were received for Med Supp Pool years 1998 through 1999.

Contributions and recoveries under the Pools are estimated based on interpretations of applicable regulations and are recorded as an addition or a reduction to cost of benefits provided. These estimates are adjusted as new information becomes known and such adjustments are included in current period operations. In November 2004, the NYSID convened a Technical Advisory Committee of Department and industry representatives to begin the implementation of the non-Medicare Supplemental pool for 1999 and subsequent. However, the implementation process is still incomplete. It is still not possible to make an estimate of potential receivables or payables. Consequently, we did not establish a receivable or payable for non-Med Supp Pool years 1999 through 2004. For Med Supp Pool years 1998 through 1999, we did not establish a receivable due to the general uncertainty surrounding the source of funds to make payments from the Pools. Our ultimate payment to or receipts from these Pools may have a material impact to our financial statements.

Off-Balance Sheet Arrangements

We had no off-balance sheet arrangements as of and for the year ended December 31, 2004 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:

| | <u>2005</u> | <u>2006</u> | <u>2007</u> | <u>2008</u> | <u>2009</u> | <u>Thereafter</u> |
|---|-------------|-------------|-------------|-------------|-------------|-------------------|
| Lease commitments: | | | | | | |
| Operating leases | \$34.7 | \$34.6 | \$33.9 | \$34.1 | \$32.6 | \$240.7 |
| Capital leases | 12.7 | 12.9 | 13.1 | 13.4 | 13.1 | 10.6 |
| IBM agreement | 80.8 | 67.6 | 60.0 | 58.0 | 55.7 | 125.1 |
| Other purchase obligations (1) | 17.9 | 8.0 | 7.1 | 6.1 | 4.9 | 0.4 |
| Projected other postretirement benefits (2) | 8.4 | 8.5 | 8.6 | 8.6 | 8.8 | 44.1 |

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- (1) Excludes unpaid claim and claim adjustment expense, which represents an estimate for unreported claims or claims that have been received but not yet adjudicated for payment. This liability is excluded from the table above because it is a short-term obligation, since approximately 90% of unreported claims are paid within the subsequent six-month period and virtually all claims are paid within twelve months. See Critical Accounting Estimates under, "Cost of Benefits" for more detail related to this liability.
 - (2) Projected benefit payments in the "Thereafter" column reflect projected payments from 2010-2014.

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 \$1.6 million per year until 2012.

IBM Agreement

In June 2002, we entered into a ten-year Master Services Agreement with IBM to enhance and modernize our systems applications and operate our data center and technical help desk. Our payments to IBM for software application services and for operating our data center and technical help desk are based upon actual utilization of services billed at the rates established in the agreement. Under the terms of the IBM 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 in-scope core applications software services, outsourced to IBM without the written consent of IBM. 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 \$447.2 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 our systems applications. Some of the systems application software development is being performed overseas from IBM's offices in Bangalore, India. In the event this facility becomes unavailable during the life of the agreement, IBM has agreed to provide these services 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.

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 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 \$23.4 million with respect to any WellChoice termination without cause commencing in the beginning of 2005 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 within 12 months 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.

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. As of December 31, 2004, Empire exceeded 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. As of December 31, 2004, 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 has proposed revised regulations that would increase the required reserves gradually over the next six years to twelve and one half percent of annual premium income. The regulations, as proposed, will affect all HMOs and we expect we will meet the revised standards. Empire HealthChoice HMO is also subject to the Blue Cross Blue Shield Association capital and surplus licensure requirement that is applicable to Empire and as of December 31, 2004, Empire HealthChoice HMO satisfies that requirement.

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 these 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 insured 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 Market Stabilization and Stop Loss 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 adversely 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, 2004 consisted of the following components (\$ in millions):

| | |
|--|---------|
| Pending and incurred but not yet reported, or IBNR, claims | \$644.5 |
| Claim adjustment expense reserve | 20.5 |
| Other claim related reserves | 13.8 |
| Total | \$678.8 |

As reflected in this table, approximately 95% 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 75% 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.

| <u>Increase/(Decrease) in Claim Cost Trend (bp)</u> | <u>Increase/(Decrease) in Unpaid Claim Estimate</u> (\$ in millions) |
|---|---|
| (300) | \$(30.9) |
| (200) | (20.6) |
| (100) | (10.3) |
| 100 | 10.3 |
| 200 | 20.6 |
| 300 | 30.8 |

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.

| <u>Increase/(Decrease) in Completion Factor (bp)</u> | <u>Increase/(Decrease) in Unpaid Claim Estimate</u> (\$ in millions) |
|--|---|
| (30) | \$ 44.7 |
| (20) | 29.8 |
| (10) | 14.9 |
| 10 | (8.2) |
| 20 | (15.1) |
| 30 | (21.3) |

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, 2004, approximately 46% of the \$644.5 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, 2004. Actual claim payments and other items may differ from our estimates. Assuming a hypothetical 1% difference between our December 31, 2004 estimates of unpaid claims and actual claims payable for our prospectively rated business, income from continuing operations for the year ended December 31, 2004, would increase or decrease by approximately \$1.9 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 \$31.1 million of favorable reserve development in 2004 for claims incurred in 2003 and prior years. Our revised estimate of the liability on 2003 and prior years' claims was lower than our original estimate at December 31, 2003. This favorable development was the result of:

- \$22.3 million of favorable development of general claim liability;
- \$5.3 million related to revaluation of 2003 Stop Loss Pool distributions and revaluation of prior years' true-up estimates of Market Stabilization Pool distributions; and
- \$3.5 million related to litigation settlement and revaluation of pending litigation liabilities.

Of the \$22.3 million favorable development of general claim liability, \$11.6 million relates to 2003, \$0.7 million to 2002, and \$10.0 million to 2001 and prior.

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, 2004 and 2003, our expected long-term rate of return on plan assets was 7.5% (which was reduced from 8.0% in 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 \$2.2 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 \$81.5 million of cumulative unrecognized losses as of the December 31, 2004 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 2005 pension expense as a result of the amortization of these losses is approximately \$1.9 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, 2004), we lowered our discount rate to 5.75% (from 6.0% as of December 31, 2003 and 6.5% as of December 31, 2002). 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, 2004, our prepaid benefit cost for the qualified and supplemental pension plans combined was \$60.7 million compared to \$53.5 million at December 31, 2003. 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 \$6.9 million, \$7.4 million, and \$6.0 million for the years ended December 31, 2004, 2003, and 2002, respectively. For the year ended December 31, 2004, we did not contribute any funding into our qualified cash balance pension plan and based on the current funded status, do not anticipate any contributions during 2005. For the year ended December 31, 2004, we contributed \$0.3 million into our supplemental cash balance pension plan and anticipate contributions of \$0.4 million during 2005.

Other Postretirement Benefits

We provide most employees certain life, medical, vision and dental benefits upon retirement. As discussed in Note 2 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 health care costs to estimate the costs and benefit obligations for our retiree health plan.

At December 31, 2004, we lowered our discount rate to 5.75% (from 6.0% for our 2004 expense recognition). The assumed health care cost trend rate used in measuring the other benefit obligations was 9.75% in 2004 for participants under age 65 in EPO and PPO plans, 10.5% for participants under age 65 in other plans, 3.61% for participants in Medicare HMOs and 9.75% for participants age 65 and over in indemnity plans, decreasing gradually each year until ultimately leveling out at 4.5% in 2013.

At December 31, 2004, our liability for postretirement benefits other than pensions was \$144.6 million compared to \$142.7 million at December 31, 2003. 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 March 2004, the Emerging Issues Task Force ("EITF") reached a final consensus on Issue No. 03-1, "The Meaning of Other-Than-Temporary Impairment and its Application to Certain Investments ("EITF 03-1")." EITF 03-1 provides accounting guidance regarding the determination of when an impairment of debt and marketable equity securities and investments accounted for under the cost method should be considered other-than-temporary and recognized in income. An EITF 03-1 consensus reached in November 2003 also requires certain quantitative and qualitative disclosures for debt and marketable equity securities classified as available-for-sale or held-to-maturity under SFAS No. 115, "Accounting for Certain Investments in Debt and Equity Securities," that are impaired at the balance sheet date but for which an other-than-temporary impairment has not been recognized. We have complied with the disclosure requirements of EITF 03-1 which were effective December 31, 2003. In September 2004, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position ("FSP") FSP EITF 03-1-1, "Effective Date of Paragraphs 10-20 of EITF Issue No. 03-1," which defers the effective date for the measurement and recognition guidance contained in paragraphs 10-20 of EITF 03-1 pending the development of further guidance. We will continue to monitor this developments concerning this Issue and are currently unable to determine the impact of EITF 03-1 on our financial position or results of operations.

In December 2004, the FASB issued SFAS No. 123 (revised 2004), "Share-Based Payment" ("SFAS 123R"), which replaces SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123") and supercedes APB Opinion No. 25, "Accounting for Stock Issued to Employees." SFAS 123R requires all share-based payments to employees, including grants of employee stock options, to be recognized in the financial statements based on their fair values, beginning with the first interim or annual period after June 15, 2005, with early adoption encouraged. The pro forma disclosures previously permitted under SFAS 123, no longer will be an alternative to financial statement recognition. We are required to adopt SFAS 123R in the third quarter of fiscal 2005, beginning July 1, 2005. Under SFAS 123R, we must determine the transition method to be used at date of adoption, the appropriate fair value model to be used for valuing share-based payments and the amortization method for compensation cost. The transition methods include prospective and retroactive adoption options. Under the retroactive options, prior periods may be restated either as of the beginning of the year of adoption or for all periods presented. The prospective method requires that compensation expense be recorded for all unvested stock options and restricted stock at the beginning of the first quarter of adoption of SFAS 123R, while the retroactive methods would record compensation expense for all unvested stock options and restricted stock beginning with the first period restated. We anticipate adopting the prospective method and expect that the adoption of SFAS 123R will have an impact similar to the current pro forma disclosure for existing options under SFAS 123 in Footnote 2 to our consolidated financial statements. In addition, the expense associated with future grants derived from the fair value model selected, will not have a material adverse effect on our financial position, results of operations or cash flows.

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.

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