

WELLPOINT INC
Form 10-K
February 26, 2007
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

x

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended **December 31, 2006**

OR

..

**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number 001-16751

WELLPOINT, INC.

(Exact name of registrant as specified in its charter)

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Indiana
(State or other jurisdiction of
incorporation or organization)

35-2145715
(I.R.S. Employer Identification No.)

120 Monument Circle
Indianapolis, Indiana
(Address of principal executive offices)

46204
(Zip Code)

Registrant's telephone number, including area code: **(317) 488-6000**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value \$0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes No

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act.

Large accelerated filer

Accelerated filer

Non-accelerated filer

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes No

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the Registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the Registrant are affiliates) as of June 30, 2006 was approximately \$45,015,102,335.

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As of February 12, 2007, 612,428,063 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the Registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 16, 2007.

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WELLPOINT, INC.

Indianapolis, Indiana

Annual Report to Securities and Exchange Commission

December 31, 2006

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This Annual Report on Form 10-K, including the Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words may, will, should, anticipate, estimate, expect, plan, believe, predict, potential, intend and similar expressions are intended to identify forward-looking statements. Forward-looking statements are subject to known and unknown risks and uncertainties that could cause actual results to differ materially from those projected. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us which attempt to advise interested parties of the factors which affect our business, including Risk Factors set forth in Part I Item 1A hereof and our reports filed with the Securities and Exchange Commission from time to time.

References in this Annual Report on Form 10-K to the term WellPoint or the Company refer to WellPoint, Inc. and its direct and indirect subsidiaries, as the context requires, after the merger of Anthem, Inc. and WellPoint Health Networks Inc. on November 30, 2004. References to the term WHN refers to WellPoint Health Networks Inc. prior to the merger. References to the terms we, our, or us, refer to WellPoint.

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PART I

ITEM 1. BUSINESS.

General

We are the largest health benefits company in terms of commercial membership in the United States, serving over 34 million medical members as of December 31, 2006. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York city metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. We also serve our members throughout the country as UniCare. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

We offer a broad spectrum of network-based managed care plans to the large and small employer, individual, Medicaid and senior markets. Our managed care plans include preferred provider organizations, or PPOs, health maintenance organizations, or HMOs, point-of-service plans, or POS plans, traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs, hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management and other administrative services. We also provide an array of specialty and other products and services including life and disability insurance benefits, pharmacy benefit management, specialty pharmacy, dental, vision, behavioral health benefit services, long-term care insurance and flexible spending accounts.

For our insured products, we charge a premium and assume all or a portion of the health care risk. Under self-funded and partially insured products, we charge a fee for services, and the employer or plan sponsor reimburses us for all or most of the health care costs. Approximately 93% of our 2006 operating revenue was derived from premium income, while approximately 7% was derived from administrative fees and other revenues.

Through December 31, 2006, our customer base primarily included Large Groups with 51 to 4,999 eligible employees (47% of our medical members at December 31, 2006) and Individuals under age 65 and Small Groups of one to 50 eligible employees, also known as ISG (17% of our medical members as of December 31, 2006). Other major customer types included National Accounts (multi-state employer groups with 5,000 or more employees, accounting for 15% of our medical members at December 31, 2006), BlueCard Host (enrollees of non-owned BCBS plans who receive benefits in our BCBS markets, accounting for 12% of our medical members at December 31, 2006), Senior (over age 65 individuals enrolled in Medicare Supplement or Medicare Advantage policies, accounting for 4% of our medical members at December 31, 2006) and State Sponsored Programs (primarily Medicaid and State Children's Health Insurance Plans, accounting for 5% of our medical members at December 31, 2006).

We market our products through an extensive network of independent agents and brokers (primarily for Individual, Small Group and Senior customers) and through our in-house sales force that are compensated on a commission basis for new sales and retention of existing business (primarily for Large Group customers). National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force.

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The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Our managed care plans and products are designed to encourage

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providers and members to participate in quality, cost-effective health benefit plans by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our leading market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses.

Our results of operations depend in large part on accurately predicting health care costs and on our ability to manage future health care costs through underwriting standards, medical management, product design and negotiation of favorable provider contracts.

We believe health care is local, and feel that we have the strong local presence required to understand and meet local customer needs. Our local presence and national expertise have created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and health care professionals.

Our vision is to transform health care and become the most valued company in our industry. Our mission is to improve the lives of people we serve and the health of our communities. One of the strategies to achieve our vision and fulfill our mission is automation of interactions with customers, brokers, agents, employees and other stakeholders through web-enabled technology and enhancing internal operations. We continue to develop our e-business strategy with the goal of becoming widely regarded as an e-business leader in the health benefits industry. The strategy includes not only sales and distribution of health benefits products on the Internet, but also implementation of advanced capabilities that improve service benefiting customers, agents, brokers, and partners while optimizing administrative costs.

On January 8, 2007, we unveiled a comprehensive plan to help address the growing ranks of the uninsured. Our plan is a blend of public and private initiatives aimed at ensuring universal coverage for children and providing new and more attractive options for the uninsured. This plan is part of our mission to improve the lives of the people we serve and the health of our communities.

We recently announced the launch of *360° Health*, a program to integrate all care management programs and tools into a centralized, consumer-friendly resource that assists patients in navigating the health care system, using their health benefits and accessing the most comprehensive and appropriate care available. Additionally, we recently began collaboration with 19 other Blue Cross and Blue Shield plans to launch the nation's largest private database of health care information. Blue Health IntelligenceSM, or BHI, is a unique resource that will improve health care quality by providing the most detailed view available of health care trends, best practices and comparative costs through a claims database of 79 million people. BHI will strengthen the movement toward greater health care transparency and informed decision making by employers and, ultimately, providers and consumers.

WellPoint is a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended) and is required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding its website and the availability of certain documents filed with or furnished to the Securities and Exchange Commission, or SEC. Our Internet website is www.wellpoint.com. We make available free of charge, or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. WellPoint, Inc., which name changed from Anthem, Inc. effective November 30, 2004, is an Indiana corporation incorporated on July 17, 2001.

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As required by NYSE Rule 303A.12, in 2006 we filed with the NYSE the annual chief executive officer certificate with no qualifications, indicating that the chief executive officer is unaware of any violations of the NYSE corporate governance standards. In addition, we are filing certifications required by Section 302 of the Sarbanes-Oxley Act of 2002 as exhibits to this Annual Report on Form 10-K.

Recent Transactions

We intend to continue our expansion through organic growth and strategic acquisitions and transactions. Listed below are the more significant transactions that we recently completed:

We maintain a common stock repurchase program as authorized by our Board of Directors. Repurchases are made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. During the year ended December 31, 2006, we repurchased and retired approximately 60.7 million shares at an average price of \$74.91, for an aggregate cost of \$4.6 billion. On March 15, May 16, August 17 and December 7, 2006, our Board of Directors authorized increases of \$1.0 billion, \$1.0 billion, \$0.5 billion and \$1.0 billion, respectively, in our common stock repurchase program, which increased the total authorized common stock repurchases to \$5.5 billion since the current program's inception in 2005. As of December 31, 2006, \$0.9 billion remained authorized by our Board of Directors for future repurchases. Subsequent to December 31, 2006, we repurchased and retired approximately 6.0 million shares for an aggregate cost of approximately \$463.5 million, leaving approximately \$486.3 million for authorized future repurchases as of February 12, 2007. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of surplus capital.

On December 28, 2005 (December 31, 2005 for accounting purposes) we completed our acquisition of WellChoice, Inc., or WellChoice. Under the terms of the merger agreement, the stockholders of WellChoice received consideration of \$38.25 in cash and 0.5191 of a share of WellPoint common stock for each share of WellChoice common stock outstanding. In addition, WellChoice stock options and other awards were converted to WellPoint awards in accordance with the merger agreement. The purchase price including cash, fair value of stock and stock awards and estimated transaction costs was approximately \$6.5 billion. WellChoice merged with and into WellPoint Holding Corp., a direct and wholly-owned subsidiary of WellPoint, with WellPoint Holding Corp. as the surviving entity in the merger.

On July 11, 2005, we announced that an agreement was reached with representatives of more than 700,000 physicians nationwide involved in two multi-district class-action lawsuits against us and other health benefits companies. As part of the agreement, we agreed to pay \$135.0 million to physicians and to contribute \$5.0 million to a not-for-profit foundation whose mission is to promote higher quality health care and to enhance the delivery of care to the disadvantaged and underserved. In addition, up to \$58.0 million will be paid in legal fees. As a result of the agreement, we incurred a pre-tax expense of \$103.0 million during the year ended December 31, 2005, or \$0.10 EPS, which represented the final settlement amount of the agreement that was not previously accrued. Appeals of the settlement initially filed by certain physicians have been resolved. Final cash payments under the agreement totaling \$209.5 million, including accrued interest, were made on October 5 and 6, 2006.

On June 9, 2005, we completed our acquisition of Lumenos, Inc., or Lumenos, for approximately \$185.0 million in cash paid to the stockholders of Lumenos. Lumenos is recognized as a pioneer and market leader in consumer-driven health programs.

On April 25, 2005, our Board of Directors approved a two-for-one split of shares of common stock, which was effected in the form of a 100% common stock dividend. All shareholders of record on May 13, 2005 received one additional share of WellPoint common stock for each share of common stock held on that date. The additional shares of common stock were distributed to shareholders of record in the form of a stock dividend on May 31, 2005. All applicable historical weighted average share and per share amounts and all references to stock compensation data and market prices of our

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common stock for all periods presented in this Annual Report on Form 10-K have been adjusted to reflect this two-for-one stock split.

On November 30, 2004, Anthem, Inc., or Anthem, and WellPoint Health Networks Inc., or WHN, completed their merger. WHN merged with and into Anthem Holding Corp., a direct and wholly-owned subsidiary of Anthem, with Anthem Holding Corp. as the surviving entity in the merger. In connection with the merger, Anthem amended its articles of incorporation to change its name to WellPoint, Inc., or WellPoint. As a result of the merger, each WHN stockholder received consideration of \$23.80 in cash and one share of WellPoint common stock for each share of WHN common stock held. In addition, WHN stock options and other awards were converted to WellPoint awards in accordance with the merger agreement. The purchase price including cash, fair value of stock and stock awards and estimated transaction costs was approximately \$15.8 billion.

Industry Overview

The health benefits industry has experienced significant change in the last decade. The increasing focus on health care costs by employers, the government and consumers has led to the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans and CDHPs, are among the various forms of managed care products that have developed over the past decade. Through these types of products, insurers attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver health care to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the medical system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, smoking cessation and weight management. Members are charged periodic, pre-paid premiums and pay co-payments, coinsurance and deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization. An HMO plan may also require members to select one of the network primary care physicians to coordinate their care and approve any specialist or other services.

Recently, economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger, more extensive networks, more member choice related to coverage, physicians and hospitals, and a desire for greater flexibility for customers to assume larger deductibles and co-payments in return for lower premiums. CDHPs, which are relatively high deductible PPO products and which are often paired with some type of member health care expenditure account that can be used at the member's discretion to help fund member out-of-pocket costs, help to meet this demand. CDHPs also usually incorporate member education, wellness, and care management programs, to help customers make better informed health care decisions. We believe we are well-positioned in each of our regions to respond to these market preferences.

Each of the BCBS companies, of which there were 39 independent primary licensees as of December 31, 2006, works cooperatively in a number of ways that create significant market advantages, especially when competing for very large multi-state employer groups. As a result of this cooperation, each BCBS company is able to take advantage of other BCBS licensees' substantial provider networks and discounts when any member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard®, and is a source of revenue for providing member services in our states for individuals who are customers of BCBS plans not affiliated with us.

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Competition

The managed care industry is highly competitive, both nationally and in our regional markets. Competition continues to be intense due to aggressive marketing, business consolidations, a proliferation of new products and increased quality awareness and price sensitivity among customers.

Health benefits industry participants compete for customers mainly on the following factors:

price;

quality of service;

access to provider networks;

access to care management and wellness programs;

innovation, breadth and flexibility of products and benefits;

reputation (including National Committee on Quality Assurance, or NCQA, accreditation status);

brand recognition; and

financial stability.

Over the last few years, a health plan's ability to interact with employers, members and other third parties (including health care professionals) via the Internet has become a more important competitive factor. During the last several years, we have made significant investments in technology to enhance our electronic interaction with employers, members and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with an advantage over our competition. In addition, our provider networks in our regions enable us to achieve cost-efficiencies and service levels enabling us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, product value and brand recognition.

To build our provider networks, we compete with other health benefits plans for contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a

health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that commission structure, support services, reputation, prior relationships, quality and price of the products are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to our competitors in all of our regions.

Reportable Segments

Through December 31, 2006, we managed our operations through three reportable segments: Health Care, Specialty and Other.

Health Care

Our Health Care segment is an aggregation of various operating segments, principally differentiated by geographic areas within which we offer similar health benefit products and services, including commercial

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accounts, Senior, Medicaid and other State Sponsored businesses. These geographic areas include California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. In addition, UniCare provides services throughout the country.

Specialty

Our Specialty segment is comprised of businesses providing life and disability insurance benefits, pharmacy benefit management, specialty pharmacy, dental, vision, behavioral health benefit services and long-term care insurance. We ceased underwriting workers compensation business effective December 31, 2005; however, we continue to provide network rental and medical management services to workers compensation carriers.

Other

Our Other segment is comprised of our Medicare processing business, including National Government Services, Inc., which name changed from AdminaStar Federal, Inc. effective November 17, 2006, United Government Services, LLC and Empire Medicare Services, Inc.; Arcus Healthy Living Services, Inc., which works to develop innovative means to promote quality care, well being and education; Arcus Financial Services, Inc., which provides a number of products to WellPoint-owned health plans associated with tax-advantaged accounts such as Health Savings Accounts, Flexible Spending Accounts and Health Reimbursement Accounts; intersegment revenue and expense eliminations; and corporate expenses not allocated to our Health Care or Specialty segments.

For additional information regarding the operating results of our segments, see the Management's Discussion and Analysis of Financial Condition and Results of Operations and Note 19 to our audited consolidated financial statements for the year ended December 31, 2006 included in this Form 10-K.

We announced a new organizational structure designed to facilitate our 2010 strategic plan. This new structure capitalizes on our unique local presence, and emphasizes company-wide innovation and strong customer focus. As a result of this new organizational structure we are organized around two strategic business units: Commercial and Consumer Business, or CCB, and Specialty, Senior and State-Sponsored Business, or 4SB. In addition, our government services business includes the Federal Employee Program and National Government Services, Inc., which acts as a Medicare contractor in several regions across the nation. We expect to revise our reportable segments in the first quarter of 2007 in accordance with the new organizational structure which reflects how our chief operating decision maker evaluates the performance of our business beginning January 1, 2007.

Products and Services

Health Care

A general description of our health benefit products and services is provided below:

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Preferred Provider Organization. PPO products offer the member an option to select any health care provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans. CDHPs provide consumers with increased financial responsibility, choice and control regarding how their health care dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future health care needs.

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Traditional Indemnity. Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization. HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a primary care physician, or PCP, from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service. POS products blend the characteristics of HMO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

Management Services. In addition to fully insured products, we provide administrative services to large group employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical management, claims processing and administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

Senior Plans. We offer a wide variety of senior plans, products and options such as Medicare supplemental plans, Medicare Advantage and Medicare Part D Prescription Drug Plans, or Medicare Part D. Medicare supplemental plans typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare. Medicare Part D offers a prescription drug plan to Medicare eligible members. We offer Medicare Part D to eligible Medicare beneficiaries in all 50 states. Our Medicare-approved drug discount cards afford Medicare beneficiaries, without facilitated prescription drug coverage, access to our drug discounts. We are also the United States default plan for point of service facilitated, enrollment, as defined by the Centers for Medicare & Medicaid Services, or CMS.

BlueCard. BlueCard host members are generally members who reside in or travel to a state in which a WellPoint subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-WellPoint controlled BCBS licensee, who is the home plan. We perform certain administrative functions for BlueCard host members, for which we receive administrative fees from the BlueCard members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicaid Plans and Other State-Sponsored Programs. We have contracts to serve members enrolled in Medicaid, State Children's Health Insurance Programs and other publicly funded health care programs for low income and/or high medical risk individuals. We currently provide services in California, Colorado, Connecticut, Indiana, Kansas, Massachusetts, Nevada, New York, New Hampshire, Ohio, Texas, Virginia, West Virginia and Wisconsin.

Specialty

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Pharmacy Products. We offer pharmacy services and pharmacy benefit management services to our members. Our pharmacy services incorporate features such as drug formularies (where we develop lists of

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preferred, cost effective drugs), a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Pharmacy benefit management services provided by us include management of drug utilization through outpatient prescription drug formularies, retrospective review and drug education for physicians, pharmacists and members. Two of our subsidiaries are also licensed pharmacies and make prescription dispensing services available through mail order for pharmacy benefit management clients. In July 2005, we launched Precision Rx Specialty Solutions, a full service specialty pharmacy designed to help improve quality and cost of care by coordinating a relatively new class of prescription medications commonly referred to as biopharmaceuticals, also known as specialty medications.

In September 2005, we were awarded contracts to offer Medicare Part D to eligible Medicare beneficiaries in all 50 states. We began offering these plans to customers through our health benefit subsidiaries throughout the country and providing administrative services for Medicare Part D offerings through our pharmacy benefits management companies on January 1, 2006.

Life Insurance. We offer an array of competitive group life insurance benefit products to both large and small group customers in conjunction with our health plans. The life products include term life, accidental death and dismemberment.

Disability. We offer short-term and long-term disability programs, usually in conjunction with our health plans.

Behavioral Health. We offer specialized behavioral health plans and benefit management. These plans cover mental health and substance abuse treatment services on both an inpatient and an outpatient basis. We have implemented employee assistance and behavioral managed care programs for a wide variety of businesses throughout the United States. These programs are offered through our subsidiaries and through third party behavioral health networks.

Dental. Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both an insured and self-funded basis.

Vision Services. Our vision plans include networks within the states we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both an insured and self-funded basis.

Long-Term Care Insurance. We offer long-term care insurance products to our California members through a subsidiary. The long-term care products include tax-qualified and non-tax qualified versions of a skilled nursing home care plan and comprehensive policies covering skilled, intermediate and custodial long-term care and home health services.

Other

Medicare Fiscal Intermediary Operations. Through contracts held by National Government Services, Inc., United Government Services, LLC, Anthem Health Plans of Maine, Inc., Anthem Health Plans of New Hampshire, Inc., Empire Medicare Services division of EmpireHealthChoice Assurance, Inc. and Blue Cross and Blue Shield of Georgia Inc., we serve as fiscal intermediaries providing administrative services for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons who are disabled or with end-stage renal

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disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies. As a fiscal intermediary, we are compensated for our services on a cost reimbursement basis.

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Customer Types

Our products are generally developed and marketed with an emphasis on the differing needs of various customer groups. In particular, our product development and marketing efforts take into account the differing characteristics between the various customer groups served by us, including individuals and small employers, large employers, seniors and Medicaid recipients, as well as the unique needs of educational and public entities, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and under-served markets. Each business unit is responsible for product design, pricing, enrolling, underwriting and servicing customers in specific customer groups. We believe that one of the keys to our success has been the focus on distinct customer groups defined generally by employer size and geographic region, which better enables us to develop benefit plans and services that meet the unique needs of the distinct markets.

In each geographic region, we balance the need to customize products with the efficiencies of product standardization. Overall, we seek to establish pricing and product designs to achieve an appropriate level of profitability for each of our customer categories. As of December 31, 2006, our customer types included the following categories:

Large Group includes employer customers with 51 to 4,999 employees eligible to participate as a member in one of our health plans. In addition, Large Group includes customers with 5,000 or more eligible employees with less than 5% of eligible employees located outside of the headquarter's state. These groups are generally sold through brokers or consultants working with industry specialists from our in-house sales force. Large Group cases may be experience rated or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, reputation and our ability to effectively service large complex accounts. Large Group also includes members in the Federal Employee Program, or FEP. As a BCBSA licensee, we participate in a nationwide contract with the Federal government whereby we cover Federal employees and their dependents in our multi-state service area. Service area is defined as the geographic area in which we are licensed to sell BCBS products. We participate in the overall financial risk for medical claims on a pooled basis with the other participating BCBS companies, and are reimbursed for our costs plus a fee. Large Group accounted for 47% of our medical members at December 31, 2006.

Individual (under 65) and small groups are defined as members who purchase health insurance services as individuals or through employers with one to 50 eligible employees. While individual policies are generally sold through independent agents and brokers or our in-house sales force, small groups are sold almost exclusively through independent agents and brokers. Small group cases are sold on a fully-insured basis. Individual business is also sold on a fully-insured basis and is usually medically underwritten at the point of initial issuance. Individual and small group customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Account turnover is generally higher with individual and small groups as compared to large groups. Individuals and small groups accounted for 17% of our medical members at December 31, 2006.

National Accounts are defined as multi-state employer groups primarily headquartered in a WellPoint service area with 5,000 or more eligible employees, with at least 5% or more eligible employees located in a service area outside of the headquarter's state. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We have a significant advantage when competing for very large National Accounts due to our ability to access the national provider networks of BCBS companies and take advantage of their provider discounts in their local markets. National Accounts represented 15% of our medical members at December 31, 2006.

BlueCard host customers are defined as enrollees of other BCBS plans, or the home plans, who receive health care services in our BCBSA licensed markets. BlueCard host membership accounted for 12% of our medical members at December 31, 2006.

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Senior customers are defined as members age 65 and over with Medicare Supplement or Medicare Advantage policies. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Rates are filed with and in some cases approved by state insurance departments. The Medicare Advantage program is the managed care alternative to the federally funded Medicare program. Most of the premium is paid directly by the Federal government on behalf of the participant who may also be charged a small premium. Medicare Supplement and Medicare Advantage products are marketed in the same manner. Senior business accounted for 4% of our medical members at December 31, 2006.

State Sponsored program membership is defined as eligible members with state sponsored managed care alternatives for the Medicaid and State Children's Health Insurance programs that we manage. Total State Sponsored program business accounted for 5% of our medical members at December 31, 2006.

We expect to revise our customer type definitions in the first quarter of 2007 in accordance with the new organizational structure which reflects how our chief operating decision maker evaluates the performance of our business beginning January 1, 2007.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain some or all of the financial risk associated with their employees' health care costs. Some customers choose to purchase stop-loss coverage to limit their retained risk. These customers are reported with our self-funded business.

The following tables set forth our medical membership by customer type and funding arrangement:

	December 31	
	2006	2005¹
<i>(In thousands)</i>		
Customer Type:		
Large Group	16,014	16,362
Individual and Small Group (ISG)	5,654	5,645
National Accounts	5,044	4,776
BlueCard	4,279	3,915
Total National	9,323	8,691
Senior	1,229	1,224
State Sponsored ²	1,881	1,934
Total medical membership by customer type	34,101	33,856
Funding Arrangement:		
Self-Funded	16,745	16,584
Fully-Insured	17,356	17,272
Total medical membership by funding arrangement	34,101	33,856

¹ Medical membership data for 2005 has been reclassified to conform to the current presentation. Our reclassifications for minimum premium amendments to fully-insured contracts resulted in an increase in self-funded membership and a corresponding decrease in fully-insured membership, with no impact on total medical membership.

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- ² During the quarter ended December 31, 2006, our ownership of a joint venture in Puerto Rico changed from a 50 percent ownership of a Medicaid managed care subsidiary to a smaller percentage ownership in the joint venture's parent company. Accordingly, as of December 31, 2006 and going forward, we no longer include the 222,000 members related to this investment in our reported enrollment.

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For additional information regarding the change in medical membership between years, see the Management's Discussion and Analysis of Financial Condition and Results of Operations included in this Form 10-K.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that provide health care services to our members are guided by regional and national standards for network development, reimbursement and contract methodologies.

We attempt to provide market-based hospital reimbursement along industry standards. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. We use multi-year contracting strategies, including case or fixed rates, to limit our exposure to medical cost inflation and increase cost predictability. In all regions, we seek to maintain broad provider networks to ensure member choice while implementing programs designed to improve the quality of care received by our members.

It is generally our philosophy not to delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement. However, in certain markets we believe capitation can be a useful method to lower costs and reduce underwriting risk, and we therefore have some capitation contracts.

Depending on the consolidation and integration of physician groups and hospitals, reimbursement strategies vary across markets. Fee-for-service is our predominant reimbursement methodology for physicians. We generally use a resource-based relative value system, or RBRVS, fee schedule to determine fee-for-service reimbursement. However, we also use proprietary fee schedules in certain markets. The RBRVS structure was developed and is maintained by CMS, and is used by the Medicare program and other major payers. The RBRVS and proprietary systems are independent of submitted fees and therefore are not as vulnerable to inflation. In addition, we have implemented and continue to expand physician incentive contracting, which recognizes clinical quality and performance as a basis for reimbursement.

Like our physician contracts, our hospital contracts provide for a variety of reimbursement arrangements depending on the network. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. Most hospitals are reimbursed on a fixed amount per day for covered services (per diem) or a case rate basis similar to Medicare (Diagnosis Related Groups). Other hospitals are reimbursed on a discount from approved charge basis for covered services. Hospital outpatient services are reimbursed based on fixed case rates, fee schedules or percent of charges. To improve predictability of expected cost, we frequently use a multi-year contracting approach and have been transitioning to case rate payment methodologies. Many of our hospital contracts have reimbursement linked to improved clinical performance, patient safety and medical error reduction.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost effective medical care. These medical management activities and programs are administered and directed by physicians and trained nurses employed by us. One of the goals of our medical management strategies is to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence.

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Precertification. A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the service being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. Most of our health plans have implemented precertification programs for certain high cost radiology studies, addressing an area of historically significant cost trends.

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Concurrent review. Another traditional medical management strategy we use is concurrent review, which is based on nationally recognized criteria developed by third-party medical specialists. With concurrent review, the requirements and intensity of services during a patient's hospital stay are reviewed, often by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting.

Formulary management. We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy. A medical policy group comprised of physician leaders from various areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and the American Cancer Society, determines our national policy for the application of new technologies.

Quality programs. We are actively engaged with our hospital networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incent hospitals to support national initiatives to improve clinical care, patient outcomes and reduce medication errors and hospital infections. We have demonstrated our leadership in developing hospital quality programs.

External review procedures. We work with outside experts through a process of external review to provide our members scientifically and clinically, evidenced-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Service management. In HMO and POS networks, primary care physicians serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have access to network physicians without a primary care physician serving as the coordinator of care.

Care Management Programs

We recently introduced our *360° Health* suite of integrated care management programs and tools, offered through our wholly-owned subsidiary, Health Management Corporation, or HMC. *360° Health* offers the following programs, among others, that have been proven to increase quality and reduce medical costs for our members:

Condition Management and *Maternity Management* programs serve as excellent adjuncts to physician care. A dedicated nurse and added support from our team of dietitians, exercise physiologists, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition.

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24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program includes a robust audiotape library, accessible by phone, with more than 400 health topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

Advanced Care Management reaches out to participants with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs. Advanced Care Management identifies candidates through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the *24/7 NurseLine*.

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Early Risk Management utilizes integrated information systems and sophisticated data analytics to assist our members to improve their compliance with evidence-based care guidelines, providing Personal Care Notes that alert members to potential gaps in care, enable more prudent health care choices, and assist in the realization of member out-of-pocket cost savings.

Healthy ReturnsSM, HMC's secure web-based solution, complements other programs by reinforcing telephonic coaching and mail campaigns. The web site engages participants in regularly assessing their health status, gives them feedback about their progress, and tracks important health measures such as blood pressure, weight and blood glucose levels.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the health care services provided to our members. Our ability to promote quality medical care has been recognized by the NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality health care measures, including the Health Plan Employer Data and Information Set, or HEDIS, have been incorporated into the oversight certification by NCQA. HEDIS measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For the HMO and POS plans, NCQA's highest accreditation is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance. For the PPO plans, NCQA's highest accreditation is granted to those plans that have excellent programs for quality improvement and consumer protection and that meet or exceed NCQA's standards. Overall, our managed care plans have been rated "Excellent", the highest accreditation, by NCQA.

We have committed to measuring our progress in improving the quality of care that our members receive through the Member Health Index, or MHI. Comprised of 20 clinically relevant measures, the MHI combines prevention, care management, clinical outcome and patient safety metrics.

Our wholly-owned clinical research and health outcomes research subsidiary, HealthCore, has supported biopharmaceutical manufacturers, health professionals, and health plans by enabling more effective medical management and increased physician adherence to evidence based care, and creating new knowledge on the value of clinical therapies, resulting in better care decisions.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current health care claim costs and emerging health care cost trends, combined with charges for administrative expenses, risk and profit. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

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In applying our pricing to each employer group and customer, we maintain consistent, competitive, strict underwriting standards. We employ our proprietary accumulated actuarial data in determining underwriting and pricing parameters. Where allowed by law and regulation, we underwrite individual policies based upon the medical history of the individual applying for coverage, small groups based upon case specific underwriting procedures and large groups based on each group's aggregate claim experience. Also, we employ credit underwriting procedures with respect to our self-funded products.

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In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. Any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA License

We have filed for registration of and maintain several service marks, trademarks and trade names at the federal level and in various states in which we operate. We have the exclusive right to use the BCBS names and marks for our health benefits products in California (Blue Cross only), Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin.

Each license requires an annual fee to be paid to the BCBSA. The fee is based upon enrollment and premium. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products.

We believe that the BCBS names and marks are valuable identifiers of our products and services in the marketplace. The license agreements, which have a perpetual term, contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks. Upon termination of the license agreements, we would cease to have the right to use the BCBS names and marks in one or more of the states that we are authorized to use the marks and the BCBSA could thereafter issue a license to use the BCBS names and marks in these states to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limits on our capital stock, impending financial insolvency, the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution.

The license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS names and marks, including:

minimum capital and liquidity requirements;

enrollment and customer service performance requirements;

participation in programs that provide portability of membership between plans;

disclosure to the BCBSA relating to enrollment and financial conditions;

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disclosures as to the structure of the BCBS system in contracts with third parties and in public statements;

plan governance requirements;

a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined net revenue attributable to health benefit plans within its service area must be sold, marketed, administered or underwritten under the BCBS names and marks;

a requirement that at least 66 2/3% of a licensee's annual combined national revenue attributable to health benefit plans must be sold, marketed, administered or underwritten under the BCBS names and marks;

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a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services;

a requirement that limits beneficial ownership of our capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors;

a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and

a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA.

Regulation

General

Our operations are subject to comprehensive and detailed state and federal regulation throughout the United States in the jurisdictions in which we do business. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

grant, suspend and revoke licenses to transact business;

regulate many aspects of our products and services;

monitor our solvency and reserve adequacy; and

scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

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The federal government, as well as the governments of the states in which we conduct our operations, have adopted laws and regulations that govern our business activities in various ways. These laws and regulations, which vary significantly by state, may restrict how we conduct our businesses and may result in additional burdens and costs to us. Areas of governmental regulation include but are not limited to:

licensure;

premium rates;

benefits;

service areas;

market conduct;

utilization review activities;

prompt payment of claims;

universal health care regulation based on the availability to individuals and small groups of a government sponsored health plan administered by a private contractor and funded by increased premium taxes;

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assessments for state run immunization programs;

requirements that pharmacy benefit managers pass manufacturers rebates to customers;

member rights and responsibilities;

sales and marketing activities;

quality assurance procedures;

plan design and disclosures, including mandated benefits;

collection, access or use of protected health information;

eligibility requirements;

provider rates of payment;

surcharges on provider payments;

provider contract forms;

provider access standards;

premium taxes and assessments for the uninsured and or underinsured;

underwriting, marketing and rating restrictions for small group products;

member and provider complaints and appeals;

underwriting and pricing;

financial arrangements;

financial condition (including reserves and minimum capital or risk based capital requirements);

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reimbursement or payment levels for government funded business; and

corporate governance.

These laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

Our Senior plans, Medicaid plans and other State-Sponsored programs are subject to extensive federal and state laws and regulations.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any state where we do not presently operate, we generally would have to obtain such a certificate. The time necessary to obtain such a certificate varies from state to state. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings.

Medicare Changes

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, became law in December 2003. The MMA significantly changed and expanded Medicare. In a pertinent part, the MMA added prescription drug benefits to Medicare for all Medicare eligible individuals starting January 1, 2006. Effective January 1, 2006, we began offering Medicare Part D approved prescription drug plans to Medicare eligible

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individuals in all regions of the country. In addition, we are also providing various administrative services for other entities offering prescription drug plans to their employees and retirees through our pharmacy benefit management companies and other affiliated companies.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed health care coverage for small employers having two to 50 employees and for individuals who meet certain eligibility requirements. It also requires guaranteed renewability of health care coverage for most employers and individuals. The law limits exclusions based on preexisting conditions for individuals covered under group policies to the extent the individuals had prior creditable coverage.

The Administrative Simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic health care transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers. We complied timely with requirements that have gone into effect, and intend to comply with future requirements on or before the compliance dates.

Other federal legislation includes the Gramm-Leach-Bliley Act, which generally placed restrictions on the disclosure of non-public information to non-affiliated third parties, and required financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to opt out of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. The Gramm-Leach-Bliley Act also gives banks and other financial institutions the ability to affiliate with insurance companies, which may lead to new competitors in the insurance and health benefits fields.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers who maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments

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certain reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice

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of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. The amount and timing of any future assessments, however, cannot be reasonably estimated and are beyond our control.

While the amount of any assessments applicable to life and health guaranty funds cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources.

Risk-Based Capital Requirements

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers, taking into account the risk characteristics of an insurer's investments and products. The RBC Model Act sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under these laws, an insurance company must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year.

The law requires increasing degrees of regulatory oversight and intervention as an insurance company's RBC declines. The RBC Model Act 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 and asset valuation reserve) to its risk-based capital. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciling insurance commissioner of a comprehensive financial plan for increasing its RBC, to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control in a rehabilitation or liquidation proceeding. As of December 31, 2006, the RBC levels of our insurance subsidiaries exceeded all RBC thresholds.

Employees

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At December 31, 2006, we had approximately 42,000 persons employed on a full-time basis. As of December 31, 2006, a small portion of employees were covered by collective bargaining agreements: 144 employees in the Sacramento, California area with the Office and Professional Employees International Union, Local 29; 119 employees in the greater Detroit, Michigan area with the International Brotherhood of Teamsters,

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Chauffeurs, Warehousemen and Helpers of America, Local No. 614; 17 employees in the New York city metropolitan area with the Office and Professional Employees International Union, Local 153; and 149 employees in Milwaukee, Wisconsin with the Office and Professional Employees International Union, Local 9. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

ITEM 1A. RISK FACTORS.

The following factors, among others, could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors, among others, may have a material adverse effect on our business, financial condition, and results of operations and you should carefully consider them. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

Changes in state and federal regulations, or the application thereof, may adversely affect our business, financial condition and results of operations.

Our insurance, managed health care and health maintenance organization, or HMO, subsidiaries are subject to extensive regulation and supervision by the insurance, managed health care or HMO regulatory authorities of each state in which they are licensed or authorized to do business, as well as to regulation by federal and local agencies. We cannot assure you that future regulatory action by state insurance or HMO authorities will not have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, changes in government regulations or policy with respect to, among other things, reimbursement levels, could also adversely affect our business, financial condition and results of operations. In addition, we cannot assure you that application of the federal and/or state tax regulatory regime that currently applies to us will not, or future tax regulation by either federal and/or state governmental authorities concerning us could not, have a material adverse effect on our business, operations or financial condition.

State legislatures and Congress continue to focus on health care issues. A number of states, including California, Connecticut, and Pennsylvania, are contemplating significant reform of their health insurance markets. These proposals include provisions affecting both public programs and privately-financed health insurance arrangements. Broadly stated, these proposals attempt to increase the number of insured by raising the eligibility levels for public programs and compelling individuals and employers to purchase health coverage. At the same time, they reform the underwriting and marketing practices of health plans. As these proposals are still being debated in the various legislatures, we cannot assure you that, if enacted into law, these proposals would not have a negative impact on our business, operations or financial condition.

From time to time, Congress has considered various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. Additionally, there have been legislative attempts to limit ERISA's preemptive effect on state laws. If adopted, such limitations could increase our liability exposure and could permit greater state regulation of our operations. Other proposed bills and regulations, including those related to HIPAA standard transactions and code sets, consumer-driven health plans and health savings accounts and insurance market reform, at state and federal levels may impact certain aspects of our business, including premium receipts, provider contracting, claims payments and processing and confidentiality of health information. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business. Further, as we continue to implement our e-business initiatives, uncertainty surrounding the regulatory authority and requirements in this area may make it difficult to ensure compliance.

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Our inability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits, maintain our current provider agreements or avoid a downgrade in our ratings may adversely affect our business and profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through underwriting criteria, medical management, product design and negotiation of favorable provider contracts. The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, inflation, new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations. Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant changes in our results of operations.

In addition to the challenge of managing health care costs, we face pressure to contain premium rates. Our customer contracts may be subject to renegotiation as customers seek to contain their costs. Alternatively, our customers may move to a competitor to obtain more favorable premiums. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates or a lack of sufficient increase in reimbursement rates for government-sponsored programs in which we participate. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, expenses, general economic conditions and other factors. Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

In addition, our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other health care providers. The failure to maintain or to secure new cost-effective health care provider contracts may result in a loss in membership or higher medical costs. In addition, our inability to contract with providers, or the inability of providers to provide adequate care, could adversely affect our business.

Claims-paying ability and financial strength ratings by recognized rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. Rating organizations continue to review the financial performance and condition of insurers. Each of the rating agencies reviews its ratings periodically and there can be no assurance that our current ratings will be maintained in the future. We believe our strong ratings are an important factor in marketing our products to customers, since ratings information is broadly disseminated and generally used throughout the industry. If our ratings are downgraded or placed under surveillance or review, with possible negative implications, the downgrade, surveillance or review could adversely affect our business, financial condition and results of operations. These ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock.

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A reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

A reduction in the number of enrollees in our health benefits programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; reductions in workforce by existing customers; negative publicity and news coverage; failure to attain or maintain nationally recognized accreditations; and general economic downturn that results in business failures.

There are risks associated with being a contractor with the Centers for Medicare & Medicaid Services to provide Medicare Part D Prescription Drug benefits.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, became law in December 2003. The MMA significantly changed and expanded Medicare coverage. The MMA added the availability of prescription drug benefits for all Medicare eligible individuals starting January 1, 2006. Effective January 1, 2006, we began offering Medicare approved prescription drug plans to Medicare eligible individuals nationwide. In addition, we are also providing various administrative services for other entities offering prescription drug plans to their employees and retirees through our pharmacy benefit management and other affiliated companies. We are also the United States default plan for point of service facilitated enrollment, as defined by the Centers for Medicare & Medicaid Services, or CMS. While we believe we have adequately reviewed our assumptions and estimates regarding this complex and recent program, including those related to collectability of receivables and establishment of liabilities, the actual results may be different than our assumptions and estimates. Risks associated with the Medicare prescription drug plans include potential uncollectability of receivables resulting from processing and/or verifying enrollment (including facilitated enrollment), inadequacy of underwriting assumptions, inability to receive and process information, uncollectability of premiums from members, increased pharmaceutical costs, and the underlying seasonality of this business.

We are subject to funding risks with respect to revenue received from participation in Medicare and Medicaid programs.

We participate as a payer in Medicare Advantage, Medicare Part D and Medicaid programs and receive revenues from the Medicare and Medicaid programs to provide benefits under these programs. Revenues for these programs are dependent upon annual funding from the federal government and/or applicable state governments. Funding for these programs is dependent upon many factors outside of our control including general economic conditions at the federal or applicable state level and general political issues and priorities. An unexpected reduction or inadequate government funding for these programs may adversely affect our revenues and financial results.

The health benefits industry is subject to negative publicity, which can adversely affect our business and profitability.

The health benefits industry is subject to negative publicity. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by: adversely affecting our ability to market our products and services; requiring us to change our products and services; or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the Blue Cross and Blue Shield Association or other Blue Cross and Blue Shield Association licensees may

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adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, financial condition and results of operations.

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We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, legislative reform, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. This environment has produced and will likely continue to produce significant pressures on the profitability of health benefits companies.

We are dependent on the services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group members. Such independent agents and brokers are typically not exclusively dedicated to us and may frequently also market health care products of our competitors. We face intense competition for the services and allegiance of independent agents and brokers. We cannot assure you that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, financial condition and results of operations.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where we are able to shift risk to employer groups. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

From time to time, we have implemented price increases in certain of our health care businesses. While these price increases may improve profitability, there can be no assurance that this will occur. Subsequent unfavorable changes in the relative profitability between our various products could have a material adverse effect on our financial condition and results of operations.

Our pharmacy benefit management companies operate in an industry faced with a number of risks and uncertainties in addition to those we face with our core health care business.

The following are some of the pharmacy benefit industry-related risks that could have a material adverse effect on our business, financial condition and results of operations:

the application of federal and state anti-remuneration laws;

compliance requirements for pharmacy benefit manager fiduciaries under ERISA, including compliance with fiduciary obligations under ERISA in connection with the development and implementation of items such as formularies, preferred drug listings and therapeutic intervention programs, contracting network practices, specialty drug distribution and other transactions and potential liability regarding the use of patient-identifiable medical information;

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a number of federal and state legislative proposals are being considered that could adversely affect a variety of pharmacy benefit industry practices, including without limitation, the receipt of rebates from pharmaceutical manufacturers, the regulation of the development and use of formularies, and legislation imposing additional rights to access to drugs for individuals enrolled in managed care plans;

the application of federal and state laws and regulations related to the operation of Internet and mail-service pharmacies;

our inability to contract on favorable terms with pharmaceutical manufacturers.

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The failure to adhere to these or other relevant laws and regulations could expose our pharmacy benefit management business to civil and criminal penalties. There can be no assurance that our business will not be subject to challenge under various laws and regulations or contractual arrangements. Any such noncompliance or challenge may have a material adverse effect on our business, financial condition and results of operations.

As a holding company, we are dependent on dividends from our subsidiaries. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends and maintenance of minimum levels of capital.

We are a holding company whose assets include all of the outstanding shares of common stock of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. As a holding company, we depend on dividends from our subsidiaries. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the National Association of Insurance Commissioners, or NAIC, and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Our regulated subsidiaries are currently in compliance with the risk-based capital or other similar requirements imposed by their respective states of domicile. As discussed in more detail below, we are a party to license agreements with the Blue Cross and Blue Shield Association which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

We face risks related to litigation.

We are, or may be in the future, a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include: claims relating to the denial of health care benefits; claims relating to the rescission of health insurance policies; medical malpractice actions; allegations of anti-competitive and unfair business activities; provider disputes over compensation and termination of provider contracts; disputes related to self-funded business; disputes over co-payment calculations; disputes related to the pharmacy benefit management business; claims related to the failure to disclose certain business practices; and claims relating to customer audits and contract performance.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic, treble or punitive damages may be sought. We currently have insurance coverage for some of these potential liabilities. Other potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance, and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition.

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In addition, we are also involved in pending and threatened litigation of the character incidental to the business transacted, arising out of our operations and our 2001 demutualization, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews include routine and special investigations by various state insurance departments, state attorneys general and the U.S. Attorney General. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. We believe that any liability that may result from any one of these actions, or in the aggregate, is unlikely to have a material adverse effect on our consolidated results of operations or financial position.

For additional information concerning legal actions affecting us, see Part I, Item 3, Legal Proceedings.

We are a party to license agreements with the Blue Cross and Blue Shield Association that entitle us to the exclusive and in certain areas non-exclusive use of the Blue Cross and Blue Shield names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations.

We use the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the Blue Cross and Blue Shield Association. Our license agreements with the Blue Cross and Blue Shield Association contain certain requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks, including: minimum capital and liquidity requirements imposed by the Blue Cross and Blue Shield Association; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the Blue Cross Blue and Shield Association relating to enrollment and financial conditions; disclosures as to the structure of the Blue Cross and Blue Shield system in contracts with third parties and in public statements; plan governance requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue attributable to health benefit plans within its service areas must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that at least 66 2/3% of a licensee's annual combined national net revenue attributable to health benefit plans must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the Blue Cross and Blue Shield Association against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

The standards under the license agreements may be modified in certain instances by the Blue Cross and Blue Shield Association. For example, from time to time there have been proposals considered by the Blue Cross and Blue Shield Association to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to make its provider networks available to insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the Blue Cross and Blue Shield names and marks in one or more of our geographic territories. Furthermore, the Blue Cross and Blue Shield Association would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these states to another entity. Events that could cause the termination of a license agreement with the Blue Cross Blue and Shield Association include failure to comply with minimum capital requirements imposed by the Blue Cross and Blue Shield Association, a change of control or violation of the Blue Cross and Blue Shield Association ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee

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seeking its dissolution. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace. Accordingly, termination of the license agreements could have a material adverse effect on our business, financial condition and results of operations.

Upon termination of a license agreement, the Blue Cross and Blue and Shield Association would impose a Re-establishment Fee upon us, which would allow the Blue Cross and Blue Shield Association to re-establish a Blue Cross and or Blue Shield presence in the vacated service area. Through December 31, 2006 the fee was set at \$83.41 per licensed enrollee. As of December 31, 2006, we reported 28.5 million Blue Cross and or Blue Shield enrollees. If the Re-establishment Fee was applied to our total Blue Cross and or Blue Shield enrollees, we would be assessed approximately \$2.4 billion by the Blue Cross and Blue Shield Association.

Our investment portfolios are subject to varying economic and market conditions, as well as regulation. If we fail to comply with these regulations, we may be required to sell certain investments.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. We cannot assure you that our investment portfolios will produce positive returns in future periods. Our regulated subsidiaries are subject to state laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our 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.

As a Medicare fiscal intermediary, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties.

Like a number of other Blue Cross and Blue Shield companies, we serve as a fiscal intermediary for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers. Part B also includes coverage for durable medical equipment such as diabetic supplies and wheelchairs. As a fiscal intermediary, we receive reimbursement for certain costs and expenditures, which is subject to adjustment upon audit by CMS. The laws and regulations governing fiscal intermediaries for the Medicare programs are complex, subject to interpretation and can expose a fiscal intermediary to penalties for non-compliance. If we fail to comply with these laws and regulations, we could be subject to criminal fines, civil penalties or other sanctions.

Regional concentrations of our business may subject us to economic downturns in those regions.

Most of our revenues are generated in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of an economic downturn in these states. If economic conditions in these states deteriorate, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations.

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Large-scale medical emergencies may have a material adverse effect on our business, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, there have been various incidents of suspected bioterrorist activity in the United States. To date, these incidents have resulted in related isolated incidents of illness and death. However, federal and state law enforcement officials have issued warnings about additional potential terrorist activity involving biological and other weapons. In addition, natural disasters such as the hurricanes experienced in the southeastern part of the United States in 2005 and the potential for a wide-spread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of wide-spread areas. If the United States were to experience widespread bioterrorist or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, financial condition and results of operations or, in the event of extreme circumstances, our viability.

We have built a significant portion of our current business through mergers and acquisitions and we expect to pursue acquisitions in the future.

The following are some of the risks associated with acquisitions that could have a material adverse effect on our business, financial condition and results of operations:

some of the acquired businesses may not achieve anticipated revenues, earnings or cash flow;

we may assume liabilities that were not disclosed to us or which were under-estimated;

we may be unable to integrate acquired businesses successfully and realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;

acquisitions could disrupt our ongoing business, distract management, divert resources and make it difficult to maintain our current business standards, controls and procedures;

we may finance future acquisitions by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;

we may also incur additional debt related to future acquisitions; and

we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. As a holding company, we are not able to repay our indebtedness except through dividends from subsidiaries, some of which are restricted in their ability to pay such dividends under applicable insurance law and undertakings. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

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As of December 31, 2006, we had indebtedness outstanding of approximately \$7.0 billion and had available borrowing capacity under our revolving credit facility of approximately \$1.2 billion, which credit facility expires on September 30, 2011. Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

As a holding company, we have no operations and are dependent on dividends from our subsidiaries for cash to fund our debt service and other corporate needs. Our subsidiaries are separate legal entities. Furthermore,

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our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. State insurance laws restrict the ability of our regulated subsidiaries to pay dividends, and in some states we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. We cannot assure you that our subsidiaries will be able to pay dividends or otherwise contribute or distribute funds to us in an amount sufficient to pay the principal of or interest on the indebtedness owed by us.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreements. If we default under our credit agreements, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreements to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreements is accelerated, we may be unable to repay or finance the amounts due. Indebtedness could also limit our ability to pursue desirable business opportunities, and may affect our ability to maintain an investment grade rating for our indebtedness.

The value of our intangible assets may become impaired.

Due largely to our recent acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately \$22.8 billion as of December 31, 2006, representing approximately 44% of our total assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our balance sheet. In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

We face intense competition to attract and retain employees.

We are dependent on retaining existing employees and attracting and retaining additional qualified employees to meet current and future needs and achieving productivity gains from our investments in technology. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, financial condition and results of operations.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business, reputation and profitability.

As part of our normal operations, we collect, process and retain sensitive and confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of sensitive or confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive or confidential member information, whether by us or by one of our vendors, could have a material adverse

effect on our business, reputation and results of operations.

The failure to effectively maintain and modernize our information systems and e-business organization could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. Our information systems require an ongoing commitment of

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significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable to such third parties' failure to perform adequately.

As a result of our merger and acquisition activities, we have acquired additional systems. Our failure to maintain effective and efficient information systems, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could have a material adverse effect on our business, financial condition and results of operations. In addition, as we convert or migrate members to our more efficient and effective systems, the risk of disruption in our customer service is increased during the migration or conversion process and such disruption could have a material adverse effect on our business, financial condition and results of operations.

Also, our vision for the future includes becoming a premier e-business organization by modernizing interactions with customers, brokers, agents, providers, employees and other stakeholders through web-enabling technology and redesigning internal operations. The goal of our e-business strategy is to become widely regarded as an e-business leader in the health benefits industry. The strategy includes not only sales and distribution of health benefits products on the Internet, but also implementation of advanced self-service capabilities benefiting customers, agents, brokers, providers, partners and employees. We cannot assure you that we will be able to realize successfully our e-business vision or integrate e-business operations with our current method of operations. The failure to maintain successful e-business capabilities could result in competitive and cost disadvantages to us as compared to our competitors.

We are dependent on the success of our relationship with a large vendor for a significant portion of our information system resources and certain other vendors for various other services.

We have an agreement with International Business Machines Corporation, or IBM, pursuant to which we outsourced a portion of our core applications development as well as a component of our data center operations and help desk to IBM. We are dependent upon IBM for these support functions. If our relationship with IBM is terminated for any reason, we may not be able to find an alternative partner in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the demands of our customers and, in turn, our business, financial condition and results of operations may be harmed. The contract with IBM includes several service level agreements, or SLAs, related to issues such as performance and job disruption with significant financial penalties if these SLAs are not met. We also outsource a component of our data center to another vendor, which could assume much of the IBM work and mitigate business disruption should a termination with IBM occur. We may not be adequately indemnified against all possible losses through the terms and conditions of the agreement. In addition, some of our termination rights are contingent upon payment of a fee, which may be significant.

We have also entered into agreements with large vendors pursuant to which we have outsourced certain functions such as data entry related to claims and billing processes and call center operations for member and provider queries as well as certain Medicare Part D sales. If these vendor relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition and results of operations may be harmed.

We may experience difficulties integrating the business of WellChoice with our business and may incur substantial costs in connection with the integration, which could cause us to lose many of the anticipated potential benefits of the acquisition.

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We acquired WellChoice with the expectation that the acquisition will result in various benefits, including, among others, benefits relating to a stronger and more diverse network of doctors and other health care providers, expanded and enhanced affordable health care services, enhanced revenues, a strengthened market position for us across the United States, cross-selling opportunities, technology, cost savings and operating efficiencies. Achieving the anticipated benefits of the acquisition is subject to a number of uncertainties, including whether

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we integrate WellChoice in an efficient and effective manner, and general competitive factors in the marketplace. Failure to achieve these anticipated benefits could result in increased costs, decreases in the amount of expected revenues and diversion of management's time and energy and could materially impact our business, financial condition and results of operations.

Indiana law, and other applicable laws, and our articles of incorporation and bylaws, may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar health provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval (or an exemption), no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company, insurance company or HMO. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Further, the Indiana corporation law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors. The Indiana corporation law also contains control share acquisition provisions that limit the ability of certain shareholders to vote their shares unless their control share acquisition is approved in advance.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the Blue Cross and Blue Shield Association. By agreement between us and the Blue Cross and Blue Shield Association, these ownership limits may be increased. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the Blue Cross and Blue Shield Association, such license agreements are subject to termination upon a change of control and re-establishment fees would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws: permit our Board of Directors to issue one or more series of preferred stock; divide our Board of Directors into three classes serving staggered three-year terms; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose

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restrictions on shareholders' ability to fill vacancies on our Board of Directors; prohibit shareholders from calling special meetings of shareholders; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and impose restrictions on shareholders' ability to amend our articles of incorporation and bylaws.

Certain hedging activities may affect the value of our common stock.

The New York Public Asset Fund (the "Fund") sold 7,000,000 shares of our common stock in a public offering which closed on September 22, 2006. Concurrently, the Fund sold in a private sale approximately 5,900,000 shares of our common stock to affiliates of J.P. Morgan Securities, Inc. ("JP Morgan"). The Fund used substantially all of the net proceeds from its sale of the shares to purchase two tranches of cash settled, equity-linked notes, each tranche relating to approximately 6,336,550 of our shares, which will mature approximately 6.5 and 12.5 months, respectively, after September 22, 2006. These notes were issued by an affiliate of JPMorgan, and the return on these notes is linked to the future performance of our common stock.

At the time of the offering, we were advised that JPMorgan Chase Bank, National Association (London Branch) ("JPMorgan Chase Bank") expected to enter into hedging transactions through one or more of its affiliates in connection with the issuance of the equity-linked notes to the Fund. We were further advised that after establishing its initial hedge, JP Morgan Chase Bank and/or its affiliates would modify its hedge position from time to time prior to the maturity or early redemption of the equity-linked notes by entering into or unwinding various derivatives and/or purchasing or selling our common stock. In particular, these hedging transactions are likely to occur shortly before the maturity or early repayment of the equity-linked notes. Holders of the equity-linked notes may demand early redemption at any time prior to their maturity.

The effect, if any, of these transactions on the market price for our common stock will depend on market conditions and cannot be ascertained at this time, but any of these activities could reduce the price of our common stock and/or lead to periods of heightened volatility in the price of our common stock. We do not make any representations or prediction as to the direction or magnitude of any effect that the transactions described above may have on the price of the shares of our common stock. In addition, no representation is made that JPMorgan Chase Bank and/or its affiliates will engage in these transactions or that these transactions, once commenced, will not be discontinued without notice.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

any requirement to restate financial results in the event of inappropriate application of accounting principles;

a significant failure of internal controls over financial reporting;

failure of our prevention and control systems related to employee compliance with internal policies, including data security;

provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;

failure to protect our proprietary information; and

failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES

We have set forth below a summary of our principal office space (locations greater than 100,000 square feet). We believe that our facilities will be sufficient to meet our needs for the foreseeable future.

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Location	Amount (Square Feet) of Building Owned or Leased and Occupied by WellPoint	Principal Usage
370 Basset Rd., North Haven, CT	566,000	Operations
220 Virginia Ave., Indianapolis, IN ¹	557,000	Operations
21555 Oxnard St., Woodland Hills, CA ¹	421,000	Operations
11 Corporate Woods, Albany, NY ¹	375,000	Operations
1831 Chestnut St., St. Louis, MO	312,000	Operations
DCS, 2015 Staples Mill Rd., Richmond, VA	295,000	Operations
700 Broadway, Denver, CO	285,000	Operations
3350 Peachtree Rd., Atlanta, GA ¹	272,000	Operations
9901 Linn Station Rd., Louisville, KY ¹	255,000	Operations
DCN, 2015 Staples Mill Rd., Richmond, VA	249,000	Operations
13550 Triton Office Park Blvd., Louisville, KY ¹	234,000	Operations
4241 Irwin Simpson Rd., Mason, OH ¹	224,000	Operations
15 MetroTech Center, Brooklyn, NY ¹	217,000	Operations
4361 Irwin Simpson Rd., Mason, OH	213,000	Operations
2000 & 2100 Corporate Center Drive, Newbury Park, CA ¹	211,000	Operations
2 Gannett Dr., South Portland, ME	208,000	Operations
400 S. Salina St., Syracuse, NY ¹	203,000	Operations
120 Monument Circle, Indianapolis, IN ¹	202,000	Principal executive offices
3000 Goff Falls Rd., Manchester, NH ¹	201,000	Operations
2221 Edward Holland Drive, Richmond, VA ¹	193,000	Operations
8115-8125 Knue Road, Indianapolis, IN ¹	184,000	Operations
6740 N. High St., Worthington, OH	178,000	Operations
85 Crystal Run, Middletown, NY ¹	172,000	Operations
1351 Wm. Howard Taft, Cincinnati, OH	167,000	Operations
6737 West Washington St., West Allis, WI ¹	159,000	Operations
5151-5155 Camino Ruiz, Camarillo, CA ¹	149,000	Operations
2357 Warm Springs Rd., Columbus, GA	147,000	Operations
233 S. Wacker Drive, Chicago, IL ¹	146,000	Operations
602 S. Jefferson St., Roanoke, VA	131,000	Operations
4553 La Tienda Drive, Thousand Oaks, CA ¹	120,000	Operations
2825 West Perimeter Road, Indianapolis, IN ¹	111,000	Operations
3 Huntington Quadrangle, Melville, NY ¹	109,000	Operations
11 West 42 nd St., New York, NY ¹	105,000	Operations

¹ Leased property

Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted.

ITEM 3. LEGAL PROCEEDINGS.**Litigation*****Multi-District Litigation Settlement Agreement***

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In May 2000, a case titled *California Medical Association vs. Blue Cross of California, et al.* (the CMA Litigation), was filed in U.S. district court in San Francisco against Blue Cross of California (BCC), a subsidiary of WellPoint Health Networks Inc. (WHN) at the time, and now a Company subsidiary. The lawsuit alleges that BCC violated the Racketeer Influenced and Corrupt Organizations Act (RICO).

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In August 2000, WHN was added as a defendant to *Shane v. Humana, et al.*, a class-action lawsuit brought on behalf of health care providers nationwide alleging RICO violations (the Shane Litigation). Effective upon the November 30, 2004 merger with WHN, WHN became a wholly owned subsidiary of the Company. On September 26, 2002, Anthem was added as a defendant to the Shane Litigation.

In May 2003, in a case titled *Kenneth Thomas, M.D., et al., v. Blue Cross Blue Shield Association, et al.* (the Thomas Litigation), several medical providers filed suit in federal district court in Miami, Florida against the Blue Cross and Blue Shield Association (BCBSA) and Blue Cross and Blue Shield plans across the country, including the Company and WellChoice. The suit alleges that the BCBSA and the Blue Cross and Blue Shield plans violated RICO and challenges many of the same practices as the CMA Litigation and the Shane Litigation.

In October 2000, the federal Judicial Panel on Multidistrict Litigation (MDL) issued an order consolidating the CMA Litigation, the Shane Litigation and various other pending managed care class-action lawsuits against the Company and other companies before District Court Judge Federico Moreno in the Southern District of Florida for purposes of pretrial proceedings. A mediator was appointed by Judge Moreno and the parties conducted court-ordered mediation. On December 9, 2004, Judge Moreno issued a new scheduling order extending the expert discovery deadline to February 7, 2005 and setting trial for September 6, 2005.

On July 11, 2005, the Company entered into a settlement agreement (the Agreement) with representatives of more than 700,000 physicians nationwide to resolve the CMA Litigation, the Shane Litigation, the Thomas Litigation and certain other similar cases brought by physicians. Under the Agreement, the Company agreed to make cash payments totaling up to \$198.0 million, of which \$135.0 million is to be paid to physicians and \$5.0 million contributed to a not-for-profit foundation whose mission is to promote higher quality health care and to enhance the delivery of care to the disadvantaged members of the public. In addition, up to \$58.0 million will be paid in legal fees to be determined by the court. The Company also has agreed to implement and maintain a number of operational changes such as standardizing the definition of medical necessity in physician contracts, creating a formalized Physician Advisory Committee and modifying some of the Company's claims payment and physician contracting provisions. The Agreement was subject to, and conditioned upon, review and approval by the U.S. District Court for the Southern District of Florida. The court preliminarily approved the settlement in an order filed July 15, 2005. The hearing for final approval was held on December 2, 2005 in Miami, Florida. The Court issued a final order approving the settlement on December 22, 2005, and issued an amended final order approving the settlement on January 4, 2006. As a result of the Agreement, the Company incurred a pre-tax expense of \$103.0 million, or \$0.10 per diluted share after tax, for the year ended December 31, 2005, which represents the final settlement amount of the Agreement that was not previously accrued. Appeals of the settlement initially filed by certain physicians have been resolved. Final cash payments under the Agreement totaling \$209.5 million, including accrued interest, were made on October 5 and 6, 2006.

The WellChoice transaction was closed on December 28, 2005, after the settlement was reached with the plaintiffs in the CMA Litigation, the Shane Litigation and the Thomas Litigation. The former WellChoice company, which was merged with and into a wholly-owned subsidiary of WellPoint, continues to be a defendant in the Thomas Litigation, and is not affected by the settlement between the Company and plaintiffs. The Company believes that any liability that may result from this action is unlikely to have a material adverse effect on its financial position or results of operations.

Other Litigation

Prior to WHN's acquisition of the group benefit operations (GBO) of John Hancock Mutual Life Insurance Company (John Hancock), John Hancock entered into a number of reinsurance arrangements, including with respect to personal accident insurance and the occupational accident component of workers' compensation insurance, a portion of which was originated through a pool managed by Unicover Managers, Inc. Under these arrangements, John Hancock assumed risks as a reinsurer and transferred certain of such risks to other companies. Similar reinsurance arrangements were entered into by John Hancock following WHN's

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acquisition of the GBO of John Hancock. These various arrangements have become the subject of disputes, including a number of legal proceedings to which John Hancock is a party. The Company is currently in arbitration with John Hancock regarding these arrangements. The Company believes that the liability that may result from this matter is unlikely to have a material adverse effect on its consolidated financial position or results of operations.

In various California state courts, the Company is defending a number of individual lawsuits and two purported class actions alleging the wrongful rescission of individual health insurance policies. The suits name the Company as well as BCC and BC Life & Health Insurance Company (BCL&H), both Company subsidiaries. The lawsuits generally allege breach of contract, bad faith and unfair business practices in a purported practice of rescinding new individual members following the submission of large claims. In December 2006, the California Medical Association filed a motion to intervene in one of the class actions. The motion has not been heard. In addition, the California Department of Managed Health Care and California Department of Insurance are conducting investigations of the allegations. The parties have agreed to mediate most of these lawsuits and the mediation has resulted in the resolution of some of these lawsuits. BCC and BCL&H recently announced an initiative to revise their rescission policies and practices in California.

In various California state courts, several hospitals have filed suits against BCC and WHN for payment of claims denied where the member was rescinded. These lawsuits are currently in the process of moving into arbitration. In addition, a recent suit brought against BCC, BCL&H and WHN by a non-contracting hospital in a California state court is a purported class action. This suit also seeks to recover for payment of claims denied where the member was rescinded. In December 2006, this purported class of hospitals also filed a motion to intervene in one of the individual class action cases referenced above. The motion has not been heard. The Company denies any wrongdoing. The Company intends to vigorously defend these proceedings; however, their ultimate outcome cannot be presently determined.

Other Contingencies

From time to time, the Company and certain of its subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. The Company, like HMOs and health insurers generally, excludes certain health care services from coverage under its HMO, PPO and other plans. The Company is, in its ordinary course of business, subject to the claims of its enrollees arising out of decisions to restrict or deny reimbursement for certain services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on the Company. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, the Company is also involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and its 2001 demutualization, and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general and the U.S. Attorney General. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions, or in the aggregate, is unlikely to have a material adverse effect on its consolidated financial position or results of operations.

Table of Contents**ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS.**

The Company did not submit any matters to a vote of security holders during the fourth quarter of 2006.

PART II**ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.****Market Prices**

The Company's Common Stock, par value \$0.01 per share, is listed on the NYSE under the symbol "WLP". On February 12, 2007, the closing price on the NYSE was \$80.69. As of February 12, 2007, there were 146,423 shareholders of record of the Common Stock. The following table presents high and low sales prices for the Common Stock on the NYSE for the periods indicated.

	High	Low
2006		
First Quarter	\$ 80.37	\$ 71.62
Second Quarter	77.70	65.50
Third Quarter	79.93	72.12
Fourth Quarter	79.07	70.15
2005		
First Quarter ¹	\$ 63.98	\$ 54.58
Second Quarter ¹	71.23	58.20
Third Quarter	77.40	65.06
Fourth Quarter	80.40	70.25

¹ The market prices for the Company's stock reflect the two-for-one stock split, which was approved by the Board of Directors on April 25, 2005.

Dividends

No cash dividends have been paid on our common stock. The declaration and payment of future dividends will be at the discretion of our Board of Directors and must comply with applicable law. Future dividend payments will depend upon our financial condition, results of operations, future liquidity needs, potential acquisitions, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. In addition, we are a holding company whose primary assets are 100% of the capital stock or other equity instrument of Anthem Insurance Companies, Inc., Anthem Southeast, Inc., Anthem Holding Corp., WellPoint Holding Corp., WellPoint Acquisition, LLC, WellPoint Insurance Services, Inc., Lumenos, Inc. and ATH Holding Company, LLC. Our ability to pay dividends to our shareholders, if authorized by our Board of Directors, is significantly dependent upon the receipt of dividends from our insurance subsidiaries. The payment of dividends by our insurance subsidiaries without prior approval of the insurance department of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in

excess of these amounts are subject to prior approval by the respective insurance departments.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under the Company's equity compensation plans is set forth in or incorporated by reference into Part III Item 12 of this Form 10-K.

Table of Contents**Issuer Purchases of Equity Securities**

The following table presents information related to our repurchases of common stock for the periods indicated.

Period	Total Number of Shares Purchased ¹	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs ²	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
<i>(In millions, except share and per share data)</i>				
October 1, 2006 to October 31, 2006	2,137,134	\$ 76.91	2,137,017	\$ 335.6
November 1, 2006 to November 30, 2006	4,517,109	74.33	4,515,292	
December 1, 2006 to December 31, 2006	788,315	76.61	654,000	949.8
	7,442,558	75.31	7,306,306	

¹ Total number of shares purchased includes 136,252 shares delivered to or withheld by the Company in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.

² Represents the number of shares repurchased through our repurchase program authorized by our Board of Directors. During the year ended December 31, 2006, the Company repurchased approximately 60.7 million shares at a cost of \$4.6 billion under the program. Remaining authorization under the program is \$949.8 million as of December 31, 2006.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from October 30, 2001, the date of our initial public offering, through December 31, 2006, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Morgan Stanley Healthcare Payor Index (the "MS Healthcare Payor Index"). The graph assumes an investment of \$100 on October 30, 2001 in each of our common stock, the S&P 500 Index and the MS Healthcare Payor Index (and the reinvestment of all dividends). The performance shown is not necessarily indicative of future performance.

The comparisons shown in the graph below are based on historical data and the Company cautions that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from D.F. King & Co., Inc., a source believed to be reliable, but the Company is not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed soliciting materials or to be filed with the Securities and Exchange Commission, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent that we specifically incorporate it by reference into such filing.

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	October 30,	December 31,	December 31,	December 31,	December 31,	December 31,	December 31,
	2001	2001	2002	2003	2004	2005	2006
WellPoint, Inc.	\$ 100	\$ 121	\$ 154	\$ 183	\$ 281	\$ 390	\$ 385
S&P 500 Index	\$ 100	\$ 109	\$ 85	\$ 109	\$ 121	\$ 127	\$ 147
MS Healthcare Payor Index	\$ 100	\$ 112	\$ 113	\$ 164	\$ 248	\$ 352	\$ 331

* Based upon an initial investment of \$100 on October 30, 2001 with dividends reinvested

Table of Contents**ITEM 6. SELECTED FINANCIAL DATA.**

The table below provides selected consolidated financial data of WellPoint. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2006. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes and Management's Discussion and Analysis of Financial Condition and Results of Operations included in this Form 10-K.

	2006	As of and for the Years Ended December 31			
		2005 ¹	2004 ¹	2003	2002 ¹
<i>(In millions, except where indicated and except per share data)</i>					
Income Statement Data					
Total operating revenue ^{2,3}	\$ 56,074.6	\$ 43,918.4	\$ 20,353.7	\$ 16,429.9	\$ 12,963.2
Total revenue ³	56,953.0	44,541.3	20,707.9	16,724.2	13,255.0
Net income	3,094.9	2,463.8	960.1	774.3	549.1
Per Share Data					
Basic net income per share	\$ 4.93	\$ 4.03	\$ 3.15	\$ 2.80	\$ 2.31
Diluted net income per share	4.82	3.94	3.05	2.73	2.26
Other Data (unaudited)					
Benefit expense ratio ⁴	81.2%	80.2%	81.8%	80.7%	82.2%
Selling, general and administrative expense ratio ⁴	15.7%	16.6%	17.1%	18.9%	19.4%
Income before income taxes as a percentage of total revenue	8.6%	8.7%	7.0%	7.2%	6.1%
Net income as a percentage of total revenue	5.4%	5.5%	4.6%	4.6%	4.1%
Medical membership (<i>In thousands</i>)	34,101	33,856	27,728	11,927	11,053
Balance Sheet Data					
Cash and investments ³	\$ 20,812.2	\$ 20,336.0	\$ 15,792.2	\$ 7,478.2	\$ 6,726.4
Total assets ³	51,759.8	51,287.2	39,663.3	13,408.9	12,413.6
Long-term debt ³	6,493.2	6,324.7	4,289.5	1,662.8	1,659.4
Total liabilities ³	27,184.0	26,294.1	20,204.3	7,409.0	7,051.3
Total shareholders' equity	24,575.8	24,993.1	19,459.0	5,999.9	5,362.3

¹ The net assets for WellChoice, Inc. and the net assets of and results of operations for Lumenos, Inc., WellPoint Health Networks Inc., and Trigon Healthcare, Inc. are included from their respective acquisition dates of December 28, 2005 (effective December 31, 2005 for accounting purposes), June 9, 2005, November 30, 2004, and July 31, 2002.

² Operating revenue is obtained by adding premiums, administrative fees and other revenue.

³ Certain prior year amounts have been reclassified to conform to the current year presentation.

⁴ The benefit expense ratio represents benefit expenses as a percentage of premium revenue. The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

References to the terms we, our, or us used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations, or MD&A, refer to WellPoint, Inc. (name changed from Anthem, Inc. effective November 30, 2004), an Indiana holding company, and unless the context otherwise requires, its direct and indirect subsidiaries.

Certain prior year amounts have been reclassified to conform to current year presentation.

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The structure of our Management's Discussion and Analysis of Financial Condition and Results of Operations is as follows:

- I. Executive Summary
- II. Overview
- III. Significant Transactions
- IV. Membership December 31, 2006 Compared to December 31, 2005
- V. Cost of Care
- VI. Results of Operations Year Ended December 31, 2006 Compared to the Year Ended December 31, 2005
- VII. Membership December 31, 2005 Compared to December 31, 2004
- VIII. Results of Operations Year Ended December 31, 2005 Compared to the Year Ended December 31, 2004
- IX. Critical Accounting Policies and Estimates
- X. Liquidity and Capital Resources
- XI. Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

I. Executive Summary

We are the largest health benefits company in terms of commercial membership in the United States, serving over 34 million medical members as of December 31, 2006. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. We also serve customers throughout the country as UniCare. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

No other health benefits company has the leading local market presence in as many geographic areas. This market position offers advantages in attracting physicians and hospitals to our networks at attractive rates and in helping to keep our products affordable.

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Operating revenue for the year ended December 31, 2006 was \$56.1 billion, an increase of \$12.2 billion, or 28%, over the year ended December 31, 2005. Operating revenue increases were primarily driven by the December 28, 2005 acquisition of WellChoice, Inc., or WellChoice, described in **Significant Transactions** below, as well as premium rate increases across all customer types, the addition of the New York state prescription drug contract and Medicare Part D Prescription Drug Plan, or Medicare Part D, enrollment.

We have successfully executed our strategy to deliver on our long-term goal of achieving at least 15% growth in fully diluted earnings per share, or EPS, and exceeded our goal in 2006 as our EPS increased by 22%. We have accomplished this by focusing on profitable enrollment growth with innovative product offerings, pricing with discipline, implementing initiatives to optimize the cost of care, continuing to leverage administrative costs over a larger membership base, further penetrating our specialty businesses and by using our cash flow effectively.

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We intend to continue expanding through a combination of organic growth and strategic acquisitions and transactions in both existing and new markets. Our growth strategy is designed to enable us to take advantage of the additional economies of scale provided by increased overall membership as well as providing us access to new and evolving technologies and products. In addition, we believe geographic diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. While we have achieved strong growth as a result of strategic mergers and acquisitions, we have also achieved organic growth in our existing markets by providing excellent service, offering competitively priced products and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Effective January 1, 2006, we began marketing Medicare Part D to eligible Medicare beneficiaries in all 50 states. As of December 31, 2006, we had approximately 1.6 million Medicare Part D members. See also Part I, Item 1A, Risk Factors, for additional information regarding Medicare Part D.

II. Overview

Through December 31, 2006, we managed our operations through three reportable segments: Health Care, Specialty and Other.

Our Health Care segment includes strategic business units delineated primarily by geographic areas within which we offer similar products and services, including commercial accounts, individual, senior and government programs such as the Federal Employee Program, or FEP, and Medicaid. We offer a diversified mix of managed care products, including preferred provider organizations, or PPOs, health maintenance organizations, or HMOs, traditional indemnity benefits and point of service, or POS plans. We also offer a variety of hybrid benefit plans, including consumer-driven health plans, or CDHPs, hospital only and limited benefit products. Additionally, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical management, care management and other administrative services.

Our Specialty segment is comprised of businesses providing specialty products and services such as group life and disability insurance benefits, pharmacy benefit management, or PBM, specialty pharmacy, dental, vision, behavioral health benefit services and long-term care insurance. We ceased underwriting workers compensation business effective December 31, 2005; however, we continue to provide network rental and medical management services to workers compensation carriers.

Our Other segment is comprised of our Medicare processing business, including National Government Services, Inc., which name changed from AdminaStar Federal, Inc., effective November 17, 2006, United Government Services, LLC, and Empire Medicare Services, Inc.; Arcus Healthy Living Services, Inc., which works to develop innovative means to promote quality care, well being and education; Arcus Financial Services, Inc., which provides a number of products to WellPoint-owned health plans associated with tax-advantaged accounts such as Health Savings Accounts, Flexible Spending Accounts and Health Reimbursement Accounts; intersegment revenue and expense eliminations; and corporate expenses not allocated to our Health Care or Specialty segments.

We have announced a new organizational structure designed to support our 2010 strategic plan. This new structure capitalizes on our unique local presence and emphasizes company-wide innovation and strong customer focus. As a result of this new organizational structure we are organized around two strategic business units: Commercial and Consumer Business, or CCB, and Specialty, Senior and State-Sponsored Business, or 4SB. In addition, our government services business includes the Federal Employees Program and National Government Services, Inc., which acts as a Medicare contractor in several regions across the nation. We expect to revise our reportable segments in the first quarter of 2007 in accordance with the new organizational structure, which reflects how our chief operating decision maker evaluates the performance of

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our business beginning January 1, 2007. See Note 19 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

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Our operating revenue consists of premiums, administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including care management programs. Other revenue is principally generated from member co-payments and deductibles associated with the mail-order sale of drugs by our PBM companies.

Our benefit expense includes costs of care for health services consumed by our members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug costs. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises.

Our selling expense consists of external broker commission expenses, and generally varies with premium volume. Our general and administrative expense consists of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Other costs are variable or discretionary in nature. Certain variable costs, such as premium taxes, vary directly with premium volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium, but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels, and thus salary and benefit expense. Discretionary costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our cost of drugs consists of the amounts we pay to pharmaceutical companies for the drugs we sell via mail order through our PBM. This amount excludes the cost of drugs related to affiliated health customers recorded in benefit expense. Our cost of drugs can be influenced by the volume of prescriptions at our PBM, as well as cost changes, driven by prices set by pharmaceutical companies and mix of drugs sold.

Our results of operations depend in large part on our ability to accurately predict and effectively manage health care costs through effective contracting with providers of care to our members and our medical and care management programs. Several economic factors related to health care costs, such as regulatory mandates of coverage and direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating health care costs as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

This MD&A should be read in conjunction with our audited consolidated financial statements for the year ended December 31, 2006 included in this Form 10-K.

III. Significant Transactions

Stock Repurchase Program

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We maintain a common stock repurchase program as authorized by our Board of Directors. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. During the year ended December 31, 2006, we repurchased and retired approximately 60.7 million shares at an average share price of \$74.91, for an aggregate cost of \$4.6 billion. On March 15, May 16, August 17 and

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December 7, 2006, our Board of Directors authorized increases of \$1.0 billion, \$1.0 billion, \$0.5 billion and \$1.0 billion, respectively, in our common stock repurchase program, which increased the total authorized common stock repurchases to \$5.5 billion since the current program's inception in 2005. As of December 31, 2006, \$0.9 billion remained authorized for future repurchases. Subsequent to December 31, 2006, we repurchased and retired approximately 6.0 million shares for an aggregate cost of approximately \$463.5 million, leaving approximately \$486.3 million for authorized future repurchases at February 12, 2007. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of surplus capital.

Acquisition of WellChoice, Inc.

On December 28, 2005 (December 31, 2005 for accounting purposes), WellPoint completed its acquisition of WellChoice. The acquisition of WellChoice strengthened our leadership in providing health benefits to National Accounts and provided us with a strategic presence in New York City, the headquarters of more Fortune 500 companies than any other U.S. city. Under the terms of the merger agreement, the stockholders of WellChoice (other than subsidiaries of WellPoint) received consideration of \$38.25 in cash and 0.5191 of a share of WellPoint common stock for each share of WellChoice common stock outstanding. In addition, WellChoice stock options and other awards were converted to WellPoint awards in accordance with the merger agreement. The purchase price including cash, fair value of stock and stock awards and estimated transaction costs was approximately \$6.5 billion.

Multi-District Litigation Settlement Agreement

On July 11, 2005, we announced that an agreement was reached with representatives of more than 700,000 physicians nationwide involved in two multi-district class-action lawsuits against us and other health benefits companies. As part of the Multi-District Litigation Settlement Agreement, or the Agreement, we agreed to pay \$135.0 million to physicians and to contribute \$5.0 million to a not-for-profit foundation whose mission is to promote higher quality health care and to enhance the delivery of care to the disadvantaged and underserved. In addition, up to \$58.0 million will be paid in legal fees. As a result of the Agreement, we incurred a pre-tax expense of \$103.0 million during the year ended December 31, 2005, or \$0.10 EPS, which represents the final settlement amount of the Agreement that was not previously accrued. Appeals of the settlement initially filed by certain physicians were resolved and final cash payments under the agreement totaling \$209.5 million, including accrued interest, were made on October 5 and 6, 2006.

Acquisition of Lumenos, Inc.

On June 9, 2005, we completed our acquisition of Lumenos, Inc., or Lumenos, for approximately \$185.0 million in cash paid to the stockholders of Lumenos. Lumenos is recognized as a pioneer and market leader in consumer-driven health programs.

Two-For-One Stock Split

On April 25, 2005, WellPoint's Board of Directors approved a two-for-one split of shares of common stock, which was effected in the form of a 100 percent common stock dividend. All shareholders of record on May 13, 2005 received one additional share of WellPoint common stock for each share of common stock held on that date. The additional shares of common stock were distributed to shareholders of record in the form of a stock dividend on May 31, 2005. All historical weighted average share and per share amounts and all references to stock compensation data and market prices of our common stock for all periods presented in this MD&A have been adjusted to reflect this two-for-one stock split.

Merger with WellPoint Health Networks Inc.

On November 30, 2004, Anthem, Inc. and WellPoint Health Networks Inc., or WHN, completed their merger. The merger with WHN helped us to create the nation's leading health benefits company and the largest

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holder of Blue Cross and/or Blue Shield licenses in the country. Additionally, our merger with WHN increased our presence in several new strategic markets, most notably California. Under the terms of the merger agreement, the stockholders of WHN (other than subsidiaries of WHN) received consideration of \$23.80 in cash and one share of Anthem, Inc. common stock for each WHN share outstanding. In addition, WHN stock options and other awards were converted to WellPoint, Inc. awards in accordance with the merger agreement. The purchase price including cash, fair value of stock and stock awards and estimated transaction costs was approximately \$15.8 billion. Anthem, Inc., the surviving corporate parent, was renamed WellPoint, Inc. concurrent with the merger.

IV. Membership December 31, 2006 Compared to December 31, 2005

Through December 31, 2006, our medical membership included six different customer types: Large Group, Individual and Small Group, National Accounts, BlueCard, Senior and State Sponsored.

Large Group consists of those employer customers with 51 to 4,999 employees eligible to participate as a member in one of our health plans. In addition, Large Group includes customers with 5,000 or more eligible employees with less than 5% of eligible employees located outside of the headquarter s state. Large Group also includes members in the Federal Employee Program, or FEP, which provides health insurance coverage to United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management.

Individual and Small Group, or ISG, consists of individual customers under age 65 as well as those employer customers with one to 50 eligible employees.

National Accounts customers are multi-state employer groups primarily headquartered in a WellPoint service area with 5,000 or more eligible employees, with at least 5% of eligible employees located outside of the headquarter s state. Service area is defined as the geographic area in which we are licensed to sell BCBS products.

BlueCard host members represent enrollees of Blue Cross and/or Blue Shield plans not owned by WellPoint who receive health care services in our BCBSA licensed markets. BlueCard membership consists of estimated host members using the national BlueCard program. Host members are generally members who reside in or travel to a state in which a WellPoint subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-WellPoint controlled BCBSA licensee (i.e., the home plan). We perform certain administrative functions for BlueCard members, for which we receive administrative fees from the BlueCard members home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard claims received per member per month.

Senior members are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, or who have purchased Medicare Supplement benefit coverage.

State Sponsored membership represents eligible members with state sponsored managed care alternatives in Medicaid and State Children s Health Insurance programs.

We expect to revise our customer type definitions in the first quarter of 2007 in accordance with the new organizational structure, as described above, which reflects how our chief operating decision maker evaluates the performance of our business beginning January 1, 2007.

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In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who

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elect to retain some or all of the financial risk associated with their employees' health care costs. Some customers choose to purchase stop-loss coverage to limit their retained risk. These customers are reported with our self-funded business.

The following table presents our medical membership by customer type, funding arrangement and geographical region as of December 31, 2006 and 2005. Also included below are key metrics from our Specialty segment, including prescription volume for our PBM companies and membership by product. The membership data presented is unaudited and in certain instances includes estimates of the number of members represented by each contract at the end of the period.

	December 31			
	2006	2005 ¹	Change	% Change
<i>(In thousands)</i>				
Medical Membership				
Customer Type				
Large Group	16,014	16,362	(348)	(2)%
Individual and Small Group	5,654	5,645	9	
National Accounts	5,044	4,776	268	6
BlueCard	4,279	3,915	364	9
Total National	9,323	8,691	632	7
Senior	1,229	1,224	5	
State Sponsored	1,881	1,934	(53)	(3)
Total medical membership by customer type	34,101	33,856	245	1
Funding Arrangement¹				
Self-Funded	16,745	16,584	161	1
Fully-Insured	17,356	17,272	84	
Total medical membership by funding arrangement	34,101	33,856	245	1
Regional Membership				
East	13,879	13,800	79	1
Central	10,907	10,970	(63)	(1)
West	9,315	9,086	229	3
Total medical membership by region	34,101	33,856	245	1
Specialty Metrics				
PBM prescription volume ²	392,668	344,621	48,047	14
Behavioral health membership	16,937	15,669	1,268	8
Life and disability membership	5,970	5,826	144	2
Dental membership	5,270	5,195	75	1
Vision membership	1,536	816	720	88
Medicare Part D membership ³	1,568		1,568	NA

¹ Medical membership data for 2005 has been reclassified to conform to the current presentation. Our reclassifications for minimum premium amendments to fully-insured contracts resulted in an increase in self-funded membership and a corresponding decrease in fully-insured membership, with no impact on total medical membership.

² Represents prescription volume for the years ended December 31, 2006 and 2005.

³ Effective January 1, 2006, the Company began marketing Medicare Part D to eligible Medicare beneficiaries in all 50 states. Membership includes auto-assigned, stand-alone, Medicare Advantage, group waiver and external PBM members with the prescription drug plans. Certain of our Medicare Part D members are also Senior medical members.

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During the twelve months ended December 31, 2006, total medical membership increased approximately 245,000, or 1%, primarily due to increases in our BlueCard and National Accounts partially offset by the loss of 315,000 Large Group members in the state of Georgia, as well as approximately 95,000 members of another Large Group account, which was previously disclosed. Also, in December 2006, our ownership of a joint venture in Puerto Rico changed from a 50 percent ownership of a Medicaid managed care subsidiary to a smaller percentage in the joint venture's parent company. Accordingly, we no longer include the 222,000 members related to this investment in our reported enrollment.

Large Group membership decreased 348,000, or 2%, primarily due to the loss of the state of Georgia PPO contract and the other Large Group account previously disclosed, partially offset by new sales.

National Accounts membership increased 268,000, or 6%, primarily due to success in attracting new customers as they recognize the value of the BCBS networks and discounts.

BlueCard membership increased 364,000, or 9%, during the twelve months ended December 31, 2006, due to increased sales by other BCBSA licensees to accounts with members who reside in or travel to our licensed areas.

State Sponsored membership decreased 53,000, or 3%, primarily due to the membership accounting change related to our Puerto Rico joint venture investment discussed above. Partially offsetting this 222,000 member decrease, we added 68,000 new members from the acquisition of QualChoice Select, Inc. and won new business from five awards in 2006 due to our comprehensive array of health management services we make available to the nation's Medicaid recipients.

Self-funded medical membership increased 161,000, or 1%, primarily due to increases in our National Accounts and BlueCard businesses and shifts in the mix of business from fully-insured to self-funded, partially offset by the loss of the state of Georgia PPO contract and the other Large Group contract noted above, as well as the impact of the Puerto Rico joint venture membership accounting change. Fully-insured membership increased by 84,000 members, primarily due to the August 1, 2006 acquisition of QualChoice Select, Inc.

Our specialty metrics are derived from membership and activity from our specialty products. These products are often ancillary to our health business, and can therefore be impacted by growth in our medical membership.

Prescription volume in our PBM companies increased by 48,047,000, or 14%, during the year ended December 31, 2006, primarily due to growth in both our retail and mail order operations driven by the addition of Medicare Part D.

Behavioral health membership increased 1,268,000, or 8%, during the year ended December 31, 2006, primarily due to a 568,000 membership gain from the acquisition of Behavioral Health Network in New Hampshire in October 2006, as well as 347,000 new members from sales of our behavioral health products.

Vision membership increased 720,000, or 88%, due to the introduction of our Blue View Vision product and the associated conversion of 432,000 members of a competing plan in Virginia to this new product, as well as new sales in several markets.

V. Cost of Care

The following discussion summarizes our aggregate cost of care trends for the full year 2006 for our Large Group and ISG fully-insured businesses only. In order to provide a more meaningful comparison to the current period due to the acquisition of WellChoice, cost of care information as discussed below is presented as if WellPoint and WellChoice were combined for all of 2005. Accordingly, cost of care reported previously for WellPoint is not comparable to the information presented below.

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Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs for which we are responsible, which excludes member co-payments and deductibles. While our cost of care trend varies by geographic location, our aggregate cost of care was less than 8% for the full year 2006.

Costs for outpatient and inpatient services are the primary drivers of overall cost trends. Cost trend increases for outpatient services were primarily driven by higher per visit costs as more procedures are being performed during each visit to outpatient providers, particularly emergency room visits, as well as the impact of price increases included within certain provider contracts. However, we are seeing the positive impact of our expanding radiology management programs on our outpatient trends. These programs are designed to ensure appropriate use of radiology services by our members. Inpatient trends have been driven primarily by unit cost, a reflection of negotiated contract increases with hospitals. Utilization (admissions per 1,000 members) remains flat, while average length of hospital stay and hospital days per 1,000 members have both decreased slightly.

Pharmacy benefit cost trend increased primarily due to pharmacy unit cost (cost per prescription) trend. The unit cost trend in 2006 is reflecting a return to normal cost trends compared to 2005 when the unit cost trend was favorably impacted by merger synergies and improved pharmaceutical contracting following the merger with WHN, the non-renewal of pharmacy only business from a large state customer with historically high utilization and cost trends and the impact of lower utilization for the COX 2 Inhibitor therapeutic class of drugs. In addition, the increased use of specialty drugs, also known as biotech drugs, which generally have a higher cost and are being utilized more frequently, has increased the unit cost trend in 2006. These increases in unit costs were partially offset by increases in our generic usage rates and benefit plan design changes.

In response to cost trends, we continue to pursue contracting and plan design changes, promote and implement performance-based contracts that reward clinical outcomes and quality, and expand our radiology management, disease management and advanced care management programs. We recently announced the launch of *360° Health*, a program to integrate all care management programs and tools into a centralized, consumer-friendly resource that assists patients in navigating the health care system, using their health benefits and accessing the most comprehensive and appropriate care available. In addition, we are expanding our specialty pharmacy programs and continuously evaluate our drug formulary to ensure the most effective pharmaceutical therapies are available for our members.

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Our consolidated results of operations for the years ended December 31, 2006 and 2005 are discussed in the following section.

	Year Ended December 31			Comparable Basis ^{1,2}		
	2006	2005	% Change	Year Ended December 31, 2005	\$ Change	% Change
<i>(In millions, except per share data)</i>						
Premiums	\$ 51,971.9	\$ 40,680.0	28%	\$ 46,531.1	\$ 5,440.8	12%
Administrative fees	3,509.6	2,719.2	29	3,325.0	184.6	6
Other revenue	593.1	519.2	14	518.2	74.9	14
Total operating revenue	56,074.6	43,918.4	28	50,374.3	5,700.3	11
Net investment income	878.7	633.1	39	718.7	NM ₃	NM ₃
Net realized losses on investments	(0.3)	(10.2)	(97)	(5.4)	NM ₃	NM ₃
Total revenues	56,953.0	44,541.3	28	51,087.6	NM ₃	NM ₃
Benefit expense	42,218.8	32,625.2	29	37,676.0	4,542.8	12
Selling, general and administrative expense:						
Selling expense	1,654.5	1,474.2	12	1,549.6	104.9	7
General and administrative expense	7,163.2	5,798.5	24	6,770.0	393.2	6
Total selling, general and administrative expense	8,817.7	7,272.7	21	8,319.6	498.1	6
Cost of drugs	301.2	288.0	5	288.0	NM ₃	NM ₃
Interest expense	403.5	226.2	78	226.2	NM ₃	NM ₃
Amortization of other intangible assets	297.4	238.9	24	238.9	NM ₃	NM ₃
Total expenses	52,038.6	40,651.0	28	46,748.7	NM ₃	NM ₃
Income before income tax expense	4,914.4	3,890.3	26	4,338.9	NM ₃	NM ₃
Income tax expense	1,819.5	1,426.5	28	1,604.9	NM ₃	NM ₃
Net income	\$ 3,094.9	\$ 2,463.8	26	\$ 2,734.0	NM ₃	NM ₃
Average diluted shares outstanding	642.1	625.8	3	NM ₃	NM ₃	NM ₃
Diluted net income per share	\$ 4.82	\$ 3.94	22	NM ₃	NM ₃	NM ₃
Benefit expense ratio ⁴	81.2%	80.2%	100bp ⁵	81.0%		20bp ⁵
Selling, general and administrative expense ratio ⁶	15.7%	16.6%	(90)bp ⁵	16.5%		(80)bp ⁵
Income before income taxes as a percentage of total revenue	8.6%	8.7%	(10)bp ⁵	NM ₃		NM ₃
Net income as a percentage of total revenue	5.4%	5.5%	(10)bp ⁵	NM ₃		NM ₃

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

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- ¹ See below for discussion of comparable basis information.
- ² For certain line items impacted by our acquisition of WellChoice, comparable basis is not meaningful due to related capitalization and purchase accounting.
- ³ NM = Not meaningful.

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- ⁴ Benefit expense ratio = Benefit expense ÷ Premiums.
⁵ bp = basis point; one hundred basis points = 1%.
⁶ Selling, general and administrative expense ratio = Total selling, general and administrative expense ÷ Total operating revenue.

We discuss our 2006 and 2005 operations using comparable basis information, which is presented to provide a more meaningful prior-year comparison to the current year, due to our December 28, 2005 acquisition of WellChoice. Comparable basis information is not calculated in accordance with U.S. generally accepted accounting principles, or GAAP, and is not intended to represent or be indicative of the results of WellPoint had the acquisition been completed as of January 1, 2005. Comparable basis information for the year ended December 31, 2005 was calculated by adding the reclassified historical statements of income for WellPoint and WellChoice and includes no intercompany eliminations or pro forma adjustments.

	Year Ended December 31, 2005						
	As Reported	WellPoint, Inc.		As Reported	WellChoice, Inc.		WellPoint, Inc. Comparable Basis
		Reclassifications ¹	Reclassified		Reclassifications ¹	Reclassified	
<i>(In millions)</i>							
Premiums	\$ 41,216.7	\$ (536.7)	\$ 40,680.0	\$ 5,862.4	\$ (11.3)	\$ 5,851.1	\$ 46,531.1
Administrative fees	2,729.9	(10.7)	2,719.2	561.5	44.3	605.8	3,325.0
Other revenue (expense)	566.5	(47.3)	519.2	(1.0)		(1.0)	518.2
Total operating revenue	44,513.1	(594.7)	43,918.4	6,422.9	33.0	6,455.9	50,374.3
Net investment income	633.1		633.1	85.6		85.6	718.7
Net realized (losses) gains on investments	(10.2)		(10.2)	4.8		4.8	(5.4)
Total revenues	45,136.0	(594.7)	44,541.3	6,513.3	33.0	6,546.3	51,087.6
Benefit expense	33,219.9	(594.7)	32,625.2	5,078.4	(27.6)	5,050.8	37,676.0
Selling, general and administrative expense:							
Selling expense	1,474.2		1,474.2		75.4	75.4	1,549.6
General and administrative expense	5,798.5		5,798.5	986.3	(14.8)	971.5	6,770.0
Total selling, general and administrative expense	7,272.7		7,272.7	986.3	60.6	1,046.9	8,319.6
Cost of drugs	288.0		288.0				288.0
Interest expense	226.2		226.2				226.2
Amortization of other intangible assets	238.9		238.9				238.9
Total expenses	41,245.7	(594.7)	40,651.0	6,064.7	33.0	6,097.7	46,748.7
Income before income tax expense	3,890.3		3,890.3	448.6		448.6	4,338.9
Income tax expense	1,426.5		1,426.5	178.4		178.4	1,604.9
Net income	\$ 2,463.8	\$	\$ 2,463.8	\$ 270.2	\$	\$ 270.2	\$ 2,734.0
Benefit expense ratio ²	80.6%		80.2%	86.6%		86.3%	81.0%
Selling, general and administrative expense ratio ³	16.3%		16.6%	15.4%		16.2%	16.5%

¹ To reflect the reclassification of certain historical amounts to a consistent presentation format.

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² Benefit expense ratio = Benefit expense ÷ Premiums.

³ Selling, general and administrative expense ratio = Total selling, general and administrative expense ÷ Total operating revenue.

	Year Ended December 31, 2005						WellPoint, Inc. Comparable Basis
	WellPoint, Inc.		WellChoice, Inc.				
(In millions)	As Reported	Reclassifications ¹	Reclassified	As Reported	Reclassifications ¹	Reclassified	
Operating Revenue							
Health Care	\$ 42,597.5	\$ (730.5)	\$ 41,867.0	\$	\$ 6,292.6	\$ 6,292.6	\$ 48,159.6
Specialty	2,863.1	203.0	3,066.1		32.1	32.1	3,098.2
Other	(947.5)	(67.2)	(1,014.7)		131.2	131.2	(883.5)
Commercial Managed Care				5,530.7	(5,530.7)		
Other Insurance Products and Services				892.2	(892.2)		
Total operating revenue	\$ 44,513.1	\$ (594.7)	\$ 43,918.4	\$ 6,422.9	\$ 33.0	\$ 6,455.9	\$ 50,374.3
Operating Gain (Loss)²							
Health Care	\$ 3,459.0	\$ (41.0)	\$ 3,418.0	\$	\$ 371.6	\$ 371.6	\$ 3,789.6
Specialty	388.1	38.3	426.4		0.5	0.5	426.9
Other	(114.6)	2.7	(111.9)		(13.9)	(13.9)	(125.8)
Commercial Managed Care				331.5	(331.5)		
Other Insurance Products and Services				26.7	(26.7)		

¹ To reflect the reclassification of certain historical amounts to a consistent presentation format.

² We use operating gain (loss) to evaluate the performance of our reportable segments, as described in Statement of Financial Accounting Standards No.131, *Disclosure about Segments of an Enterprise and Related Information*. Operating gain (loss) is defined as operating revenue less benefit expense, selling expense, general and administrative expense and cost of drugs.

Premiums increased \$11.3 billion, or 28%, to \$52.0 billion in 2006. On a comparable basis, premiums increased \$5.4 billion, or 12%, primarily due to premium rate increases across all customer types, the addition of the New York state prescription drug contract and new enrollment in our Medicare Part D products.

Administrative fees increased \$790.4 million, or 29%, to \$3.5 billion in 2006. On a comparable basis, administrative fees increased \$184.6 million, or 6%, primarily due to self-funded membership growth in National Accounts, including BlueCard, and rate increases in Large Group and National Accounts. Self-funded membership growth was driven by successful efforts to attract large self-funded accounts and was attributable to our network breadth, discounts, service and increased focus on health improvement and wellness, as well as the popularity of the BlueCard program.

Other revenue principally includes amounts from mail-order prescription drug sales by our PBM companies, which provide services to members of our Health Care segment and third party clients. Other revenue increased \$73.9 million, or 14%, to \$593.1 million in 2006. On a comparable basis, other revenue increased \$74.9 million, or 14%, primarily due to revenue generated by growth in mail-order prescription revenue from both our Health Care segment and third parties. Increased mail-order prescription volume resulted from additional utilization of our PBM companies mail-order pharmacy option with the introduction of Medicare Part D.

Net investment income increased \$245.6 million, or 39%, to \$878.7 million in 2006 primarily resulting from invested assets acquired with the acquisition of WellChoice, growth in invested assets from reinvestment of cash generated from operations and higher interest rates. This growth was partially offset by the use of cash for repurchases of our common stock.

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A summary of our net realized gains (losses) on investments for the years ended December 31, 2006 and 2005 is as follows:

	Years Ended December 31		\$ Change
	2006	2005	
<i>(In millions)</i>			
Net realized losses from the sale of fixed maturity securities	\$ (47.9)	\$ (25.3)	\$ (22.6)
Net realized gains from the sale of equity securities	98.5	22.0	76.5
Other-than-temporary impairments credit related	(32.5)	(14.8)	(17.7)
Other-than-temporary impairments interest rate related	(23.7)		(23.7)
Other realized gains	5.3	7.9	(2.6)
Net realized losses	\$ (0.3)	\$ (10.2)	\$ 9.9

Net realized losses in 2006 primarily related to other-than-temporary impairments of investments and the sale of fixed maturity securities at a loss due to the restructuring of the combined portfolio after our acquisition of WellChoice at the end of 2005. Other-than-temporary impairments credit related were primarily due to the length of time that equity securities fair value was below their cost basis. Other-than-temporary impairments interest related were primarily due to the prevailing interest rate environment and our intent to hold fixed maturity securities until their anticipated recovery. See *Critical Accounting Policies and Estimates* in this MD&A for a discussion of our investment impairment review process. These losses were partially offset by realized gains on the sale of equity securities during 2006.

Net realized losses in 2005 primarily related to net realized losses on sales of fixed maturity securities due to the restructuring of the combined portfolio after our merger with WHN at the end of 2004 and credit-related other-than-temporary impairments of equity and fixed maturity securities. These realized losses were partially offset by net realized gains on sales of equity securities and other invested assets.

Benefit expense increased \$9.6 billion, or 29%, to \$42.2 billion in 2006. On a comparable basis, benefit expense increased \$4.5 billion, or 12%, primarily due to increased cost of care, which was driven by higher costs in outpatient and inpatient services, the addition of the New York State prescription drug contract and benefit expense for our Medicare Part D products.

On a comparable basis, our benefit expense ratio increased 20 basis points to 81.2% in 2006. This increase was primarily related to a change in business mix, primarily driven by the addition of the New York State prescription drug contract, growth in FEP and State Sponsored business, as well as the introduction of Medicare Part D. All of these products have a higher benefit expense ratio than the WellPoint average. These increases were partially offset by disciplined pricing and the non-recurrence of \$35.0 million of benefit expense recorded in the second quarter of 2005 related to the multi-district litigation settlement agreement, or MDL settlement agreement, discussed in Significant Transactions within this MD&A.

Selling, general and administrative expense increased \$1.5 billion, or 21%, to \$8.8 billion in 2006. On a comparable basis, selling, general and administrative expense increased \$498.1 million, or 6%. The increase in selling, general and administrative expense was primarily due to increases in volume-sensitive costs such as commissions, premium taxes and other expenses associated with growth in our business, as well as additional share-based compensation expense resulting from our January 1, 2006 adoption of Statement of Financial Accounting Standards No. 123 (revised 2004), *Share-Based Payment*, or FAS 123R. See Note 12 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

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On a comparable basis, our selling, general and administrative expense ratio decreased 80 basis points to 15.7% in 2006, primarily due to growth in premium income, continued expense control and further leveraging of general and administrative costs over a larger membership base. In addition, the 2005 selling, general and administrative expense ratio was negatively impacted by \$68.0 million, or 10 basis points, related to the MDL settlement agreement.

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Cost of drugs increased \$13.2 million, or 5%, to \$301.2 million in 2006. This increase is primarily attributable to increased mail-order prescription volume by our PBM companies, partially offset by higher utilization of generic prescription drugs.

Interest expense increased \$177.3 million, or 78%, to \$403.5 million in 2006, primarily due to additional interest expense on the debt incurred in conjunction with the acquisition of WellChoice.

Amortization of other intangible assets increased \$58.5 million, or 24%, to \$297.4 million in 2006, primarily due to additional amortization expense related to identifiable intangible assets with finite lives resulting from the acquisition of WellChoice.

Income tax expense increased \$393.0 million, or 28%, to \$1.8 billion in 2006, consistent with the increase in pre-tax income. The effective tax rate in 2006 and 2005 was 37.0% and 36.7%, respectively. The increase in the effective tax rate in 2006 was primarily related to increases in state taxes due to the addition of operations in New York following the acquisition of WellChoice.

Reportable Segments

We use operating gain to evaluate the performance of our reportable segments, as described in Statement of Financial Accounting Standards No. 131, *Disclosure about Segments of an Enterprise and Related Information*. Through December 31, 2006, our reportable segments were Health Care, Specialty and Other. Operating gain is calculated as total operating revenue less benefit expense, selling, general and administrative expense and cost of drugs. It does not include net investment income, net realized gains (losses) on investments, interest expense, amortization of other intangible assets or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management. For additional information, see Note 19 to our audited consolidated financial statements included in this Form 10-K. The discussions of segment results for the years ended December 31, 2006 and 2005 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies.

Health Care

Our Health Care segment's summarized results of operations for the year ended December 31, 2006 and 2005 are as follows:

	Year Ended December 31			Comparable Basis		
	2006	2005	% Change	2005	\$ Change	% Change
<i>(In millions)</i>						
Operating revenue	\$ 53,860.6	\$ 41,867.0	29%	\$ 48,159.6	\$ 5,701.0	12%
Operating gain	\$ 4,288.3	\$ 3,418.0	25%	\$ 3,789.6	\$ 498.7	13%
Operating margin	8.0%	8.2%	(20)bp	7.9%		10bp

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Operating revenue increased \$12.0 billion, or 29%, to \$53.9 billion in 2006. On a comparable basis, operating revenue increased \$5.7 billion, or 12%, primarily due to premium rate increases across all customer types, the addition of the New York state prescription drug contract and our Medicare Part D products.

Operating gain increased \$870.3 million, or 25%, to \$4.3 billion in 2006. On a comparable basis, operating gain increased \$498.7 million, or 13%, primarily due to disciplined pricing across all lines of business and continued expense control, the non-recurrence of \$103.0 million in benefit and general and administrative expense related to the MDL settlement agreement, as well as the addition of the New York state prescription drug

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contract and Medicare Part D. These increases were partially offset by the impact of increased share-based compensation expense following the adoption of FAS 123R in 2006.

The operating margin decreased by 20 basis points from 8.2% in 2005 to 8.0% in 2006. On a comparable basis, operating margin increased 10 basis points in 2006. The 2006 operating margin was impacted by 30 basis points related to increased share-based compensation following the adoption of FAS 123R, as well as 20 basis points related to a business mix shift, including the addition of lower margin governmental business. The 2005 operating margin included a 20 basis point impact related to the MDL settlement agreement.

Specialty

Our Specialty segment's summarized results of operations for the year ended December 31, 2006 and 2005 are as follows:

	Year Ended December 31			Comparable Basis		
	2006	2005	% Change	Year Ended December 31, 2005	\$ Change	% Change
<i>(In millions)</i>						
Operating revenue	\$ 3,566.2	\$ 3,066.1	16%	\$ 3,098.2	\$ 468.0	15%
Operating gain	\$ 523.6	\$ 426.4	23%	\$ 426.9	\$ 96.7	23%
Operating margin	14.7%	13.9%	80bp	13.8%		90bp

Operating revenue increased \$500.1 million, or 16%, to \$3.6 billion in 2006. On a comparable basis, operating revenue increased \$468.0 million, or 15%, primarily due to increased prescription volume by our PBM companies, including specialty pharmacy, driven by the addition of Medicare Part D, partially offset by the sale of our workers compensation business in Wisconsin in 2005.

Operating gain increased \$97.2 million, or 23%, to \$523.6 million in 2006. On a comparable basis, operating gain increased \$96.7 million, or 23%, primarily due to increased prescription volume by our PBM companies, as well as a change in estimate in noncurrent reserves for future policy benefits following the change of experience factors for waiver of premium reserves based on the recently released group term life mortality study. These increases were partially offset by the sale of our workers compensation business in Wisconsin in 2005.

Operating margin increased 80 basis points from 13.9% in 2005 to 14.7% in 2006. On a comparable basis, operating margin increased 90 basis points in 2006, primarily due to the change in estimate in reserves mentioned in the preceding paragraph, as well as increased prescription volume and higher utilization of generic prescription drugs in our mail-order PBM companies.

Other

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Our summarized results of operations for our Other segment for the year ended December 31, 2006 and 2005 are as follows:

	Year Ended December 31			Comparable Basis		
	2006	2005	% Change	Year Ended December 31, 2005	\$ Change	% Change
<i>(In millions)</i>						
Operating revenue from external customers	\$ 454.6	\$ 333.6	36%	\$ 464.8	\$ (10.2)	(2)%
Elimination of intersegment revenue	(1,806.8)	(1,348.3)	34%	(1,348.3)	(458.5)	34%
Total operating revenue	\$ (1,352.2)	\$ (1,014.7)	33%	\$ (883.5)	\$ (468.7)	53%
Operating loss	\$ (75.0)	\$ (111.9)	(33)%	\$ (125.8)	\$ 50.8	(40)%

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Operating revenue from external customers increased \$121.0 million, or 36%, to \$454.6 million in 2006. On a comparable basis, operating revenue from external customers decreased \$10.2 million, or 2%. On both a reported and comparable basis, the elimination of intersegment revenue increased \$458.5 million, or 34%, in 2006, reflecting additional sales by our PBM companies of Medicare Part D and specialty pharmacy products to our Health Care segment.

Operating loss decreased \$36.9 million, or 33%, to \$75.0 million in 2006. On a comparable basis, operating loss decreased \$50.8 million, or 40%, primarily due to lower expenses related to retention bonuses and other compensation costs associated with the merger between the former Anthem, Inc. and the former WellPoint Health Networks Inc.

VII. Membership December 31, 2005 Compared to December 31, 2004

The following table presents our medical membership by customer type, funding arrangement and geographical region as of December 31, 2005 and 2004. Also included below are key metrics from our Specialty segment, including prescription volume for our PBM companies and membership by product. The membership data presented is unaudited and in certain instances includes estimates of the number of members represented by each contract at the end of the period.

	WellPoint, Inc. as Reported December 31, 2005 ¹	WellChoice December 31, 2005 ²	WellPoint Without WellChoice December 31, 2005 ³	WellPoint, Inc. as Reported December 31, 2004	WellPoint Without WellChoice as Compared to WellPoint at December 31, 2004 Change	% Change
<i>(In thousands)</i>						
Medical Membership						
Customer Type						
Large Group	16,362	3,085	13,277	13,073	204	2%
Individual and Small Group (ISG)	5,645	349	5,296	5,199	97	2
National Accounts	4,776	1,235	3,541	3,212	329	10
BlueCard	3,915	(93)	4,008	3,463	545	16
Total National	8,691	1,142	7,549	6,675	874	13
Senior	1,224	147	1,077	1,059	18	2
State Sponsored	1,934	64	1,870	1,722	148	9
Total medical membership by customer type	33,856	4,787	29,069	27,728	1,341	5
Funding Arrangement						
Self-Funded	16,584	1,879	14,705	13,302	1,403	11
Fully-Insured	17,272	2,908	14,364	14,426	(62)	
Total medical membership by funding arrangement	33,856	4,787	29,069	27,728	1,341	5
Regional Membership						
East	13,800	5,030	8,770	8,508	262	3
Central	10,970	(125)	11,095	10,565	530	5

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West	9,086	(118)	9,204	8,655	549	6
Total medical membership by region	33,856	4,787	29,069	27,728	1,341	5

Specialty Metrics

PBM prescription volume ⁴	344,621		344,621	336,541	8,080	2
Behavioral health membership	15,669		15,669	11,753	NM ₅	NM ₅
Life and disability membership	5,826		5,826	5,306	NM ₅	NM ₅
Dental membership	5,195	265	4,930	5,048	NM ₅	NM ₅
Vision membership	816		816	773	43	6

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- ¹ Amounts reported at December 31, 2005, include membership from the WellChoice acquisition that closed on December 28, 2005 and from the Lumenos acquisition that closed on June 9, 2005.
- ² Represents membership at December 31, 2005, resulting from the WellChoice acquisition. Medical membership is shown net of overlapping BlueCard host membership.
- ³ WellPoint without WellChoice membership was calculated by subtracting membership resulting from the WellChoice acquisition from WellPoint, Inc.'s reported membership at December 31, 2005.
- ⁴ Represents annual PBM prescription volume for mail order and retail prescriptions for the full years ended December 31, 2005 and 2004.
- ⁵ Changes from prior period information are not meaningful due to different counting methodologies used by the former Anthem, Inc. and the former WellPoint Health Networks Inc.

During the twelve months ended December 31, 2005, total medical membership increased approximately 6,128,000, or 22%, primarily due to our acquisition of WellChoice and organic growth in all customer types. Excluding the impact of the WellChoice acquisition: BlueCard membership increased 545,000, or 16%, representing membership growth in other Blue Cross and Blue Shield licensees with members who reside in or travel to our licensed areas; National Accounts membership increased 329,000, or 10%, primarily due to new sales, as well as in-group increases in membership and members acquired from the acquisition of Lumenos; Large Group membership increased 204,000, or 2% primarily due to our acquisition of Lumenos as well as new sales throughout the year; State Sponsored membership increased 148,000, or 9% due to new sales, primarily in the West region; and ISG membership increased 97,000, or 2%, primarily due to the introduction of new, more affordable product designs and an overall increase in consumer awareness of our wide variety of quality products and services as well as efforts to market products to the uninsured.

Self-funded medical membership increased 3,282,000 or 25%, primarily due to our merger with WellChoice and increases in our BlueCard, National Accounts and Large Group businesses. Fully-insured membership increased by 2,846,000 or 20%, due to our merger with WellChoice. However, on a comparable basis, fully-insured membership decreased by 62,000 primarily due to a Large Group fully-insured account in the East region, which represented approximately 140,000 medical members, converting to self-funded during the third quarter of 2005. This was partially offset by growth in our ISG and State Sponsored businesses, as well as new sales and positive in-group change in Large Group.

Our specialty metrics are derived from membership and activity from our specialty products. These products are often ancillary to our health business, and can therefore be impacted by growth in our medical membership. Prescription volume at our PBM increased 8,080,000 prescriptions, or 2%, in 2005 primarily due to growth in both our mail order and retail operations.

Table of Contents**VIII. Results of Operations Year Ended December 31, 2005 Compared to the Year Ended December 31, 2004**

Our consolidated results of operations for the years ended December 31, 2005 and 2004 are discussed in the following section.

	Year Ended December 31			Comparable Basis ^{2,3} Year Ended December 31,		
	2005	2004 ¹	% Change	2004	\$ Change	% Change
<i>(In millions, except per share data)</i>						
Premiums	\$ 40,680.0	\$ 18,678.3	118%	\$ 38,050.3	\$ 2,629.7	7%
Administrative fees	2,719.2	1,457.0	87	2,493.0	226.2	9
Other revenue	519.2	218.4	138	489.2	30.0	6
Total operating revenue	43,918.4	20,353.7	116	41,032.5	2,885.9	7
Net investment income	633.1	311.7	103	563.1	NM ₄	NM ₄
Net realized (losses) gains on investments	(10.2)	42.5	(124)	75.9	NM ₄	NM ₄
Total revenues	44,541.3	20,707.9	115	41,671.5	NM ₄	NM ₄
Benefit expense	32,625.2	15,280.6	114	30,731.0	1,894.2	6
Selling, general and administrative expense:						
Selling expense	1,474.2	537.2	174	1,358.0	116.2	9
General and administrative expense	5,798.5	2,940.5	97	5,479.3	319.2	6
Total selling, general and administrative expense	7,272.7	3,477.7	109	6,837.3	435.4	6
Cost of drugs	288.0	95.0	203	269.8	18.2	7
Interest expense	226.2	142.3	59	190.4	NM ₄	NM ₄
Amortization of other intangible assets	238.9	61.4	289	104.5	NM ₄	NM ₄
Merger-related undertakings		61.5	(100)	61.5	NM ₄	NM ₄
Loss on repurchase of debt securities		146.1	(100)	146.1	NM ₄	NM ₄
Total expenses	40,651.0	19,264.6	111	38,340.6	NM ₄	NM ₄
Income before income tax expense	3,890.3	1,443.3	170	3,330.9	NM ₄	NM ₄
Income tax expense	1,426.5	483.2	195	1,238.3	NM ₄	NM ₄
Net income	\$ 2,463.8	\$ 960.1	157	\$ 2,092.6	NM ₄	NM ₄
Average diluted shares outstanding	625.8	314.6	99	NM ₄	NM ₄	NM ₄
Diluted net income per share	\$ 3.94	\$ 3.05	29	NM ₄	NM ₄	NM ₄
Benefit expense ratio ⁵	80.2%	81.8%	(160)bp ⁶	80.8%		(60)bp ⁶
Selling, general and administrative expense ratio ⁷	16.6%	17.1%	(50)bp ⁶	16.7%		(10)bp ⁶
Income before income taxes as a percentage of total revenue	8.7%	7.0%	170bp ⁶	NM ₄		NM ₄
Net income as a percentage of total revenue	5.5%	4.6%	90bp ⁶	NM ₄		NM ₄

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

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¹ Financial results for 2004 include operations of the former WellPoint Health Networks Inc. for the one month period ended December 31, 2004 and the former Anthem, Inc. for the year ended December 31, 2004.

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- ² See below for discussion of comparable basis information.
- ³ For certain line items impacted by the merger of Anthem and WHN, comparable basis is not meaningful due to related capitalization and purchase accounting.
- ⁴ NM = Not meaningful.
- ⁵ Benefit expense ratio = Benefit expense ÷ Premiums.
- ⁶ bp = basis point; one hundred basis points = 1%.
- ⁷ Selling, general and administrative expense ratio = Total selling, general and administrative expense ÷ Total operating revenue.

We discuss our 2005 and 2004 operations using comparable basis information, which is presented to provide a more meaningful 2004 comparison to 2005, due to the merger with WHN. Comparable basis information is not calculated in accordance with GAAP and is not intended to represent or be indicative of the results of WellPoint, Inc. had the merger been completed as of January 1, 2004. Comparable basis information for the year ended December 31, 2004 was calculated by adding the reclassified historical statements of income for the former WHN for the 11 months ended November 30, 2004 to the reported results of WellPoint, Inc. for the year ended December 31, 2004, which includes one month of the former WHN. Comparable basis information contains no intercompany eliminations or pro forma adjustments.

	WellPoint, Inc. as Reported Year Ended December 31, 2004	WellPoint Health Networks Inc. Eleven Months Ended November 30, 2004	Reclassification Adjustments ¹	WellPoint, Inc. Comparable Basis Year Ended December 31, 2004
<i>(In millions)</i>				
Premiums	\$ 18,678.3	\$ 19,804.7	\$ (432.7)	\$ 38,050.3
Administrative fees	1,457.0	1,108.9	(72.9)	2,493.0
Other revenue	218.4	54.1	216.7	489.2
Total operating revenue	20,353.7	20,967.7	(288.9)	41,032.5
Net investment income	311.7	276.3	(24.9)	563.1
Net realized gains on investments	42.5	8.4	25.0	75.9
Total revenues	20,707.9	21,252.4	(288.8)	41,671.5
Benefit expense	15,280.6	15,925.5	(475.1)	30,731.0
Selling, general and administrative expense:				
Selling expense	537.2	820.8		1,358.0
General and administrative expense	2,940.5	2,493.4	45.4	5,479.3
Total selling, general and administrative expense	3,477.7	3,314.2	45.4	6,837.3
Cost of drugs	95.0	32.6	142.2	269.8
Interest expense	142.3	48.1		190.4
Amortization of other intangible assets	61.4	7.8	35.3	104.5
Other expenses		36.6	(36.6)	
Merger-related undertakings	61.5			61.5
Loss on repurchase of debt securities	146.1			146.1
Total expenses	19,264.6	19,364.8	(288.8)	38,340.6
Income before income tax expense	1,443.3	1,887.6		3,330.9
Income tax expense	483.2	755.1		1,238.3
Net income	\$ 960.1	\$ 1,132.5	\$	\$ 2,092.6
Benefit expense ratio ²	81.8%			80.8%
Selling, general and administrative expense ratio ³	17.1%			16.7%

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- ¹ Represents the reclassification of certain WHN historical amounts to conform to a consistent presentation with WellPoint.
² Benefit expense ratio = Benefit expense ÷ Premiums.
³ Selling, general and administrative expense ratio = Total selling, general and administrative expense ÷ Total operating revenue.

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	WellPoint, Inc. as Reported Year Ended December 31, 2004	WellPoint Health Networks Inc. Eleven Months Ended November 30, 2004	Reclassification Adjustments	WellPoint, Inc. Comparable Basis Year Ended December 31, 2004
<i>(In millions)</i>				
Operating Revenue:				
Health Care	\$ 19,427.7	\$ 20,014.8	\$ (460.3)	\$ 38,982.2
Specialty	1,447.0	976.0	423.0	2,846.0
Other:				
External customers	208.6	37.4	69.9	315.9
Elimination of intersegment revenue	(729.6)	(60.5)	(321.5)	(1,111.6)
Total Other	(521.0)	(23.1)	(251.6)	(795.7)
Total operating revenue	\$ 20,353.7	\$ 20,967.7	\$ (288.9)	\$ 41,032.5
Operating Gain (Loss)				
Health Care	\$ 1,497.4	\$ 1,507.7	\$ (9.2)	\$ 2,995.9
Specialty	105.2	226.0	6.0	337.2
Other	(102.2)	(38.3)	1.8	(138.7)

Premiums increased \$22.0 billion, or 118%, to \$40.7 billion in 2005. On a comparable basis, premium increased \$2.6 billion, or 7%, primarily due to premium rate increases in our Large Group, ISG and Senior businesses and membership gains in our ISG, State Sponsored and Senior membership types. Partially offsetting the impact of premium rate increases was the conversion of some Large Group customers from fully-insured contracts to self-funded arrangements and the non-renewal of certain fully-insured accounts.

Administrative fees increased \$1.3 billion, or 87%, to \$2.7 billion in 2005. On a comparable basis, administrative fees increased \$226.2 million, or 9%, primarily due to increased self-funded membership in our National and Large Group businesses. These membership gains are driven by the popularity of the BlueCard program, as well as successful efforts to attract large self-funded accounts and the continuing trend towards self-funded arrangements over fully-insured contracts among our Large Group customers.

Other revenue principally includes amounts from mail-order drug sales by our PBM companies, which provides services to members of our Health Care segment and third party clients. Other revenue increased \$300.8 million, or 138%, to \$519.2 million in 2005. On a comparable basis, other revenue increased \$30.0 million, or 6%, primarily due to additional mail-order prescription revenue and increased prices of prescription drugs sold by our PBM companies. Increased mail-order prescription volume resulted from both membership increases and additional utilization of our PBM's mail-order pharmacy option.

Net investment income increased \$321.4 million, or 103%, to \$633.1 million in 2005 primarily resulting from invested assets acquired with the WHN merger (net of cash used in the merger) and from growth in invested assets from reinvestment of cash generated from operations.

A summary of our net realized (losses) gains on investments for the years ended December 31, 2005 and 2004 is as follows:

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	Year Ended December 31		\$ Change
	2005	2004	
<i>(In millions)</i>			
Net realized (losses) gains from the sale of fixed maturity securities	\$ (25.3)	\$ 40.6	\$ (65.9)
Net realized gains from the sale of equity securities	22.0	3.3	18.7
Other-than-temporary impairments credit related	(14.8)	(0.8)	(14.0)
Other realized gains (losses)	7.9	(0.6)	8.5
Net realized (losses) gains	\$ (10.2)	\$ 42.5	\$ (52.7)

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In 2005, net realized gains and losses from the sale of fixed maturity and equity securities were primarily due to restructuring of our portfolio as a result of integration activities related to our merger with WHN.

During 2004, we reallocated securities in our fixed maturity portfolio, primarily to optimize future after-tax income by investing in a higher mix of tax-exempt fixed maturity securities. The sale of fixed maturity securities associated with this reallocation resulted in the majority of the net realized gains reported during the year ended December 31, 2004.

Net gains or losses on investments are influenced by market conditions when an investment is sold, and will vary from year to year.

Other-than-temporary impairments in 2005 were approximately equal between equity securities and fixed maturity securities, while in 2004, other-than-temporary impairments were substantially related to equity securities. Other-than-temporary impairments in both 2005 and 2004 are primarily due to the length of time that such securities' fair value had been less than cost.

Benefit expense increased \$17.3 billion, or 114%, to \$32.6 billion in 2005. On a comparable basis, benefit expense increased \$1.9 billion, or 6%, primarily due to increased cost of care, which was driven primarily by higher costs in outpatient and inpatient services. In addition, our benefit expense included \$35.0 million in 2005 related to the MDL settlement agreement discussed in Significant Transactions within this MD&A. On a comparable basis, our benefit expense ratio decreased 60 basis points from 80.8% in 2004 to 80.2% in 2005. The decrease in our benefit expense ratio is driven by moderating cost of care trends coupled with disciplined underwriting practices.

Selling, general and administrative expense increased \$3.8 billion, or 109%, to \$7.3 billion in 2005. On a comparable basis, selling, general and administrative expense increased \$435.4 million, or 6%, primarily due to increases in volume-sensitive costs such as higher commissions, premium taxes and other expenses associated with growth in our business; increased incentive compensation, including merger-related stay bonuses; and costs associated with the transition of information technology infrastructure services to IBM. In addition, we incurred expenses related to the MDL settlement agreement and start-up costs related to Medicare Part D. On a comparable basis, our selling, general and administrative expense ratio decreased 10 basis points to 16.6% in 2005, primarily due to growth in operating revenue and the leveraging of costs over a larger membership base, partially offset by the factors noted above.

Cost of drugs increased \$193.0 million, or 203%, to \$288.0 million in 2005. On a comparable basis cost of drugs increased \$18.2 million, or 7%, primarily due to higher mail-order prescription volume at our PBM companies.

Interest expense increased \$83.9 million, or 59%, to \$226.2 million in 2005, primarily due to additional interest expense on the debt incurred in conjunction with the WHN merger, partially offset by reduced interest expense from the repurchase of debt securities in December of 2004.

Amortization of other intangible assets increased \$177.5 million, or 289%, to \$238.9 million in 2005, primarily due to a full year of additional amortization expense related to identifiable intangible assets with finite lives resulting from the WHN merger.

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Income tax expense increased \$943.3 million, or 195%, to \$1,426.5 million in 2005. Included in 2005 was \$28.4 million in tax benefits associated with a refund claim recognizing the deductibility of capital losses on the sale of certain subsidiaries that occurred in prior years. Included in 2004 was \$44.8 million in tax benefits associated with a change in Indiana laws governing the state's high-risk health insurance pool.

Our net income as a percentage of total revenue increased 90 basis points, from 4.6% in 2004 to 5.5% in 2005. The increase in this metric reflects a combination of all factors discussed above.

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The discussion of segment results for the years ended December 31, 2005 and 2004 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies.

Health Care

Our Health Care segment's summarized results of operations for the year ended December 31, 2005 and 2004 are as follows:

	Year Ended December 31			Comparable Basis Year Ended December 31,		
	2005	2004	% Change	2004	\$ Change	% Change
<i>(In millions)</i>						
Operating revenue	\$ 41,867.0	\$ 19,427.7	116%	\$ 38,982.2	\$ 2,884.8	7%
Operating gain	\$ 3,418.0	\$ 1,497.4	128%	\$ 2,995.9	\$ 422.1	14%
Operating margin	8.2%	7.7%	50bp	7.7%		50bp

Operating revenue increased \$22.4 billion, or 116%, to \$41.9 billion. On a comparable basis, operating revenue increased \$2.9 billion, or 7%, primarily due to growth in premium income as a result of premium rate increases in our Large Group and ISG businesses resulting from underwriting discipline. Also contributing to premium revenue growth was higher membership, primarily in our ISG and State Sponsored businesses. Administrative fees also increased primarily due to additional self-funded membership in National Accounts and Large Group businesses.

Operating gain increased \$1.9 billion, or 128%, to \$3.4 billion. On a comparable basis, operating gain increased \$422.1 million, or 14%, primarily due to premium rate increases mentioned above along with membership growth and lower than expected cost of care within our ISG, Senior and Large Group businesses. Partially offsetting this increase was the impact of the \$103.0 million pre-tax expense recognized in connection with the MDL settlement agreement in 2005.

Specialty

Our Specialty segment's summarized results of operations for the years ended December 31, 2005 and 2004 are as follows:

	Year Ended December 31		% Change	Comparable Basis Year Ended December 31,	\$ Change	% Change
	2005	2004				

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<i>(In millions)</i>	2004					
Operating revenue	\$ 3,066.1	\$ 1,447.0	112%	\$ 2,846.0	\$ 220.1	8%
Operating gain	\$ 426.4	\$ 105.2	305%	\$ 337.2	\$ 89.2	26%
Operating margin	13.9%	7.3%	660bp	11.8%		210bp

Operating revenue increased \$1.6 billion, or 112%, to \$3.1 billion. On a comparable basis, operating revenue increased \$220.1 million, or 8%, primarily due to increases in PBM operating revenue driven by improved pharmaceutical contracting and increased script volume, particularly mail-order script volume. This increase was partially offset by decreases in behavioral health revenue due to the standardization in funding arrangements between Health Care and Specialty segments.

Operating gain increased \$321.2 million, or 305%, to \$426.4 million. On a comparable basis, operating gain increased \$89.2 million or 26%, primarily due to an increase in PBM, behavioral health and dental businesses.

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On a comparable basis, PBM operating gain increased due to higher script volume and improved pharmaceutical contracting. In addition, operating gain from behavioral health increased as we standardized funding arrangements between the Health Care and Specialty segments. Finally, membership growth, driven primarily by the transition of 1.9 million behavioral health members from an outside vendor, also contributed to the improved results in Specialty segment. These gains are partially offset by decreased rates on workers' compensation insurance in California driven by unfavorable legislation.

Other

Our summarized results of operations for our Other segment for the years ended December 31, 2005 and 2004 are as follows:

	Year Ended December 31			Comparable Basis Year Ended December 31,		
	2005	2004	% Change	2004	\$ Change	% Change
<i>(In millions)</i>						
Operating revenue from external customers	\$ 333.6	\$ 208.6	60%	\$ 315.9	\$ 17.7	6%
Elimination of intersegment revenue	(1,348.3)	(729.6)	85%	(1,111.6)	(236.7)	21%
Total operating revenue	\$ (1,014.7)	\$ (521.0)	95%	\$ (795.7)	\$ (219.0)	28%
Operating loss	\$ (111.9)	\$ (102.2)	9%	\$ (138.7)	\$ 26.8	(19)%

Operating revenue from external customers increased \$125.0 million, or 60%, to \$333.6 million. On a comparable basis, operating revenue from external customers increased \$17.7 million, or 6%. The elimination of intersegment revenue increased \$618.7 million, or 85%. On a comparable basis, the elimination of intersegment revenue increased \$236.7 million, or 21%, reflecting additional sales by our PBM companies to our Health Care segment.

Operating loss increased \$9.7 million, or 9%, to \$111.9 million. On a comparable basis, operating loss decreased \$26.8 million or 19%, primarily due to expenses not allocated to the Health Care or Specialty segments.

IX. Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with U.S. generally accepted accounting principles, or GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider some of our most important accounting policies that require estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our significant accounting policies are summarized in Note 2 to our audited consolidated financial statements for the year ended December 31, 2006 included in this Form 10-K.

Medical Claims Payable

The most judgmental accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2006, this liability was \$5.3 billion and represented 19% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims including the estimated costs of processing such claims. Incurred but not paid claims include (1) an

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estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 95%, or \$5.1 billion, of our total medical claims liability as of December 31, 2006; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 5%, or \$239.3 million, of the total medical claims liability as of December 31, 2006. The level of claims payable processed through our systems but not yet paid may fluctuate from one period end to the next, from 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be adequate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical data of paid claims is formatted into claim triangles, which compare claim incurred dates to the dates of claim payments. This information is analyzed to create completion factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (generally the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or trend factors.

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated, rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

In addition to incurred but not paid claims, the liability for medical claims payable includes reserves for premium deficiencies, if appropriate. Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts, which are reported with reserves for future policy benefits, includes consideration of investment income. For purposes of premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to

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claim liabilities occur each quarter and are sometimes significant as compared to the net income recorded in that quarter. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid liability as of December 31, 2006 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by other operational variables including system changes, provider submission patterns and business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through 12 months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. At December 31, 2006, the variability in months three to five was estimated to be between 20 and 70 basis points, while months six through twelve have much lower variability ranging from 10 to 20 basis points.

Over the period from December 31, 2005 to December 31, 2006, completion factors have increased. With consideration of claim payments through December 31, 2006, the completion factors used to determine the incurred but not paid claim liability estimate for the December 31, 2005 valuation period have developed higher than those used at December 31, 2005, primarily because we are receiving claims information from our providers more timely as a result of increased electronic submissions. In addition, we are paying claims more quickly once they have been received. This resulted in approximately \$113.6 million of redundancy in the December 31, 2005 estimate and is included in the statement of income for the year ended December 31, 2006. This continued increase has been taken into consideration when determining the completion factors used in establishing the December 31, 2006 incurred but not paid claim liability by choosing factors that reflect the more recent experience. The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately \$101.0 million, in the December 31, 2006 incurred but not paid claim liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

Over the period from December 31, 2004 to December 31, 2005, completion factors increased. With consideration of claims payment through December 31, 2005, the completion factors used to determine the incurred but not paid claim liability estimate for the December 31, 2004 valuation period have developed higher than those used at December 31, 2004, primarily because we are receiving claims information from our providers more timely as a result of increased electronic submissions. This resulted in approximately \$194.3 million of redundancy in the December 31, 2004 estimate and included in the statement of income for the year ended December 31, 2005. In 2003, results presented represent the former Anthem, Inc. on a stand alone basis. Due to the acquisition of WHN at the end of 2004, these periods are not on a comparable basis. Therefore, changes in assumptions from 2003 to 2004 are not meaningful in comparing these periods.

The other major assumption used in the establishment of the December 31, 2006 incurred but not paid claim liability was the trend factors used in determining the claims expense per member per month for the most recent two incurrence months. At December 31, 2006, there was a 740 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 10%, or approximately \$504.0 million, in the incurred but not paid claims liability, depending upon the trend factor used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken

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into consideration in establishing the incurred but not paid claim liability at December 31, 2006. As we look at the year-over-year claim trend for the prior period (November and December 2005) compared to the current period (November and December 2006), the trend used in our reserve models have increased moderately due to mix changes resulting from the introduction of Part D drug plans and other product changes. However, claim trends observed as of December 31, 2005 based upon subsequent claim runout were lower than anticipated in the assumptions used to estimate medical claims payable at December 31, 2005. This decline was due to moderating outpatient service trends and declines in pharmacy benefit cost trend. This difference between the trends assumed in establishing the December 31, 2005 medical claims payable, and the trend observed based upon subsequent claims runout through the twelve months ended December 31, 2006, resulted in approximately \$504.1 million of redundancy in the December 31, 2005 estimate and included in the statement of income for the year ended December 31, 2006.

Over the period from 2004 to 2005, claim trends declined. Claim trends observed based upon subsequent claim runout were lower than anticipated in the assumptions used to estimate medical claims payable at December 31, 2004. This decline was due to moderating outpatient service trends and declines in pharmacy benefit cost trend. This difference between the trends assumed in establishing the December 31, 2004 medical claims payable, and the trend observed based upon subsequent claims runout, resulted in approximately \$450.6 million of redundancy in the December 31, 2004 estimate and included in the statement of income for the year ended December 31, 2005.

As summarized below, Note 10 to our audited consolidated financial statements for the year ended December 31, 2006 included in this Annual Report on Form 10-K provides historical information regarding the accrual and payment of our medical claims liability. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 10 to our audited consolidated financial statements, the line labeled Net incurred medical claims: Prior years (redundancies) accounts for those adjustments made to prior year estimates. The impact of any reduction of Net incurred medical claims: Prior years (redundancies) claims may be offset as we establish the estimate of Net incurred medical claims: Current year. Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material. We believe we have consistently applied our methodology in determining our best estimate for unpaid claims liability at each reporting date.

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A reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2006, 2005 and 2004 is as follows:

<i>(In millions)</i>	Years Ended December 31		
	2006	2005	2004
Gross medical claims payable, beginning of period	\$ 4,853.4	\$ 4,134.0	\$ 1,836.0
Ceded medical claims payable, beginning of period	(27.7)	(31.9)	(8.7)
Net medical claims payable, beginning of period	4,825.7	4,102.1	1,827.3
Business combinations and purchase adjustments	(6.4)	784.5	2,331.0
Net incurred medical claims:			
Current year	42,613.2	32,865.6	15,344.9
Prior years (redundancies)	(617.7)	(644.9)	(171.9)
Total net incurred medical claims	41,995.5	32,220.7	15,173.0
Net payments attributable to:			
Current year medical claims	37,486.0	28,997.1	12,453.2
Prior years medical claims	4,089.5	3,284.5	2,776.0
Total net payments	41,575.5	32,281.6	15,229.2
Net medical claims payable, end of period	5,239.3	4,825.7	4,102.1
Ceded medical claims payable, end of period	51.0	27.7	31.9
Gross medical claims payable, end of period	\$ 5,290.3	\$ 4,853.4	\$ 4,134.0
Current year medical claims paid as a percent of current year net incurred medical claims	88.0%	88.2%	81.2%
Prior year redundancies in the current period as a percent of prior year net medical claims payable less prior year redundancies in the current period	14.7%	18.7%	10.4%
Prior year redundancies in the current period as a percent of prior year net incurred medical claims	1.9%	4.2%	1.4%

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of \$617.7 million shown above for the year ended December 31, 2006 represents an estimate based on paid claim activity from January 1, 2006 to December 31, 2006. Medical claim liabilities are usually described as having a short tail, which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 82%, of the \$617.7 million redundancy relates to claims incurred in calendar year 2005, with the remaining 18% related to claims incurred in 2004 and prior.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 88.0% for 2006, 88.2% for 2005 and 81.2% for 2004. The 2004 ratio was impacted by having only one month of medical claims incurred and paid during 2004 for the former WHN. If the former WHN had not been included during 2004, current year medical claims payments would have been \$12,057.7 million, current year

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net incurred medical claims would have been \$13,835.1 million and the adjusted ratio would have been approximately 87.2% for 2004. Comparison of the 2006 ratio of 88.0% and the 2005 ratio of 88.2% reflect a moderate decline due to system conversions and integration activity that impacted the 2006 ratio. Comparison of the 2005 ratio of 88.2% and the adjusted 2004 ratio of 87.2% indicate that we paid claims faster between those periods. The increase was primarily attributable to improved processes and our provider networks submitting claims information to us more timely as a result of increased electronic submissions. The result of these changes is an enhanced ability to adjudicate and pay claims more quickly.

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We calculate the percentage of prior year redundancies in the current period as a percent of prior year net incurred claims payable less prior year redundancies in the current period in order to demonstrate the development of the prior year reserves. This metric was 14.7% for 2006, 18.7% for 2005 and 10.4% for 2004. As discussed previously, the 400 basis point decrease in this metric for 2006 was caused by actual completion factors and claim trends differing from the assumptions used to support our best estimate of the incurred but not paid claim liability of the prior period.

We calculate the percentage of prior year redundancies in the current period as a percent of prior year net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation indicates the reasonableness of our prior year estimation of incurred medical claims and the consistency of our methodology. This metric was 1.9% for 2006, 4.2% for 2005 and 1.4% for 2004. This ratio is calculated using the redundancy of \$617.7 million, shown above, which represents an estimate based on paid claim activity from January 1, 2006 to December 31, 2006. The 2006 ratio is impacted by having no net incurred medical claims for the former WellChoice, Inc. in 2005. If the former Wellchoice, Inc. had been included for the full year 2005, this ratio would have been approximately 1.6%. The 2005 ratio is impacted by having only one month of net incurred medical claims for WHN in 2004. If WHN had been included for the full year 2004, estimated prior year net incurred medical claims would have been \$30,819.1 million, and the adjusted ratio would have been approximately 2.1% for the year ended December 31, 2005.

The following table shows the variance between total net incurred medical claims as reported in the above table for each of 2005 and 2004 and the incurred claims for such years had it been determined retrospectively (computed as the difference between net incurred medical claims current year for the year shown and net incurred medical claims prior years (redundancies) for the immediately following year):

	Years Ended December 31	
	2005	2004
<i>(In millions)</i>		
Total net incurred medical claims, as reported	\$ 32,220.7	\$ 15,173.0
Retrospective basis, as described above	32,247.9	14,700.0
Variance	\$ (27.2)	\$ 473.0
Variance to total net incurred medical claims, as reported	(0.1)%	3.1%

Given that our business is primarily short tailed, the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2006 estimate of medical claims payable will be known during 2007.

The 2005 variance of \$(27.2) million and variance to total incurred medical claims, as reported of (0.1)% are impacted by having no WellChoice, Inc. activity in the total incurred as reported during 2005 and full development of activity from the former WellChoice, Inc. in the retrospective basis amount. The adjusted variance would be approximately \$(175.2) million and the variance to total incurred would be approximately (0.5)% if the impact of WellChoice is removed.

The 2004 variance of \$473.0 million and variance to total incurred medical claims, as reported of 3.1% are impacted by having only one month of total incurred as reported for WHN during 2004 and a full development of WHN activity in the retrospective basis amount. The adjusted variance would be approximately \$136.5 million and the variance to total incurred would be approximately 1.0% if the impact of WHN is removed.

These small variances to total net incurred medical claims, adjusted for the impacts of WellChoice, Inc. and WHN, shows that our estimates of this liability have approximated the actual experience for the years depicted.

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Income Taxes

We account for income taxes in accordance with Statement of Financial Accounting Standards No. 109, *Accounting for Income Taxes*. This standard requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is more likely than not that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

the types of temporary differences that created the deferred tax asset;

the amount of taxes paid in prior periods and available for a carry-back claim;

the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and

any significant other issues impacting the likely realization of the benefit of the temporary differences.

During 2006 the valuation allowance increased by \$0.5 million. This resulted from realized and unrealized capital losses of subsidiaries, which are not included in our consolidated tax return. During 2004 and 2003, the valuation allowance decreased by \$33.8 million and \$81.9 million, respectively. The 2004 and 2003 reductions resulted from utilizing alternative minimum tax, or AMT, credits and net operating losses on our federal income tax return for which we had a deferred tax asset with a corresponding valuation allowance. As deferred tax assets related to those deductions are available for use in the tax return, a valuation was no longer required and was reduced. The decrease in the valuation allowance in 2004 was partially offset by an additional \$5.6 million related to Indiana state taxes, as discussed below.

During 2004 and 2003, we recorded additional tax liabilities of \$44.1 million and \$81.9 million, respectively, offsetting the reduction in valuation allowances discussed above. These additional liabilities were recorded for uncertainty on several tax issues, including the lack of clear guidance from the Internal Revenue Service, or IRS, on various tax issues relating to our conversion in 1986 from tax-exempt to tax-paying status.

During the third quarter of 2006, we decreased our state deferred tax liability by \$43.0 million, resulting in a tax benefit, net of federal taxes, of \$28.0 million, or \$0.04 per basic and diluted share, for the year ended December 31, 2006. This resulted from a lower effective tax rate due to changes in our state apportionment factors following the WellChoice acquisition.

During 2005, a refund claim we filed in 2003 was approved by the Congressional Joint Committee on Taxation. The claim related to initially disallowed losses on the sale of certain subsidiaries in the late 1990s. A tax benefit of \$28.4 million related to this claim was recorded in the first quarter of 2005. Net income related to this claim was \$0.04 per basic and diluted share for the year ended December 31, 2005.

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As a result of legislation enacted in Indiana on March 16, 2004, we recorded deferred tax assets and liabilities, with a corresponding net tax benefit in our income statement of \$44.8 million, or \$0.15 per basic share and \$0.14 per diluted share, for the year ended December 31, 2004. The legislation eliminated the creation of tax credits resulting from the payment of future assessments to the Indiana Comprehensive Health Insurance Association, or ICHIA. ICHIA is Indiana's high-risk health insurance pool. Our historical ICHIA assessment payments far exceeded our Indiana income tax liability. Thus, the recognition of a state deferred tax asset was not warranted, as a future Indiana tax liability was unlikely. Under the new legislation, ICHIA tax credits are limited to any unused ICHIA assessment paid prior to December 31, 2004. FAS 109 requires that deferred assets or liabilities be established in the period a change in law is enacted. These deferred tax assets and liabilities reflect

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temporary differences, net operating loss carryforwards and tax credits relating to our Indiana income tax filings. Following guidance in FAS 109, a valuation allowance of \$5.6 million was established for the portion of the deferred tax asset, which we believe will likely not be utilized. There is no carryforward limitation on the tax credits and the net operating loss carryforwards do not begin to expire until 2018. We believe we will have sufficient taxable income in future years to offset these carryforwards; therefore, no additional valuation allowance was recorded.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional tax liability for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for tax exposures. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and state authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and intend to defend our positions vigorously through the IRS appeals process. We believe we have adequately provided for any reasonable foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact to earnings from these matters. As of December 31, 2006, the IRS was nearing completion of its examination of our 2003 tax year. The IRS will continue auditing our 2004 tax year and will initiate a review of the 2005 and 2006 tax years during 2007. In addition, the IRS has invited us to join the Compliance Assurance Program, or CAP, for 2007. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations. Various tax examinations and proceedings also continue for certain subsidiaries for tax years prior to being included in our consolidated tax return.

For additional information, see Note 14 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K. See also *New Accounting Pronouncements* disclosure included in this Critical Accounting Policies and Estimates section of our MD&A for discussion of new accounting guidance related to uncertain tax positions.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2006 was \$13.4 billion and other intangible assets were \$9.4 billion. The sum of goodwill and intangible assets represents 44% of our total consolidated assets and 93% of our consolidated shareholders' equity at December 31, 2006.

We follow Statement of Financial Accounting Standards No. 141, *Business Combinations*, and Statement of Accounting Standards No. 142, *Goodwill and Other Intangible Assets*. FAS 141 specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under FAS 142, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. We completed our annual impairment tests of existing goodwill and other intangible assets (with indefinite lives) for each of the years ended December 31, 2006, 2005 and 2004 and based upon these tests we have not incurred any impairment losses related to any goodwill and other intangible assets (with indefinite lives).

On December 28, 2005, we purchased 100% of the outstanding common stock of WellChoice, Inc. In accordance with FAS 141, we allocated the purchase price to the fair value of assets acquired, including intangible assets, and liabilities assumed. This allocation process included the review of relevant information

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about the assets and liabilities, independent appraisals and other valuations to determine the fair value of assets acquired and liabilities assumed. The allocation resulted in \$3.5 billion of non-tax deductible goodwill and \$1.7 billion of identifiable intangible assets.

On November 30, 2004, we completed our merger with WHN and purchased 100% of the outstanding common stock of WHN. In accordance with FAS 141, we allocated the purchase price to the fair value of assets acquired, including intangible assets, and liabilities assumed. This allocation process included the review of relevant information about the assets and liabilities, independent appraisals and other valuations to determine the fair value of assets acquired and liabilities assumed. The allocation resulted in \$7.6 billion of non-tax deductible goodwill and \$7.0 billion of identifiable intangible assets.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, the annual impairment testing required under FAS 142 requires us to make assumptions and judgments regarding the estimated fair value of our goodwill and intangibles. Such assumptions include the discount factor used to determine the fair value of a reporting unit, which is ultimately used to identify potential goodwill impairment. Such estimated fair values might produce significantly different results if other reasonable assumptions and estimates were to be used. If we are unable to support a fair value estimate in future annual goodwill impairment tests or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 4 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

Investments

Current and long term available-for-sale investment securities were \$17.5 billion at December 31, 2006 and represented 34% of our total consolidated assets at December 31, 2006. In accordance with Statement of Financial Accounting Standards No. 115, *Accounting for Certain Investments in Debt and Equity Securities*, our fixed maturity and equity securities are classified as available-for-sale securities and are reported at fair value. We classify our investments in available-for-sale fixed maturity securities as either current or noncurrent assets based on their contractual maturity. Investment income is recorded when earned, and realized gains or losses, determined by specific identification of investments sold, are included in income when the securities are sold.

WellPoint maintains various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. Rabbi trust assets were previously classified as noncurrent available-for-sale investments. Effective January 1, 2006 and in connection with a restructuring of the plans, WellPoint changed its classification for the majority of such securities from available-for-sale to trading, which are reported in Other invested assets, current in the consolidated balance sheet. The change in the fair value of the trading portfolio rabbi trust assets during 2006 resulted in \$35.6 million of realized gains, which, together with net investment income from trading portfolio rabbi trust assets of \$8.6 million, is classified in general and administrative expense in the consolidated statement of income, consistent with the related increase in compensation expense.

During December 2006, WellPoint initiated a program whereby it generally purchases corporate-owned life insurance policies on participants in the deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in Other invested assets, long-term in the consolidated balance sheets. The change in cash surrender value is reported as an offset to premium expense classified as general and administrative expense.

In addition to available-for-sale investment securities, we held other long-term investments of \$628.8 million, or 1% of total consolidated assets, at December 31, 2006. These long-term investments consist primarily

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of real estate, cash surrender value of corporate-owned life insurance policies and certain other investments. Due to their less liquid nature, these investments are classified as long-term.

An impairment review of securities to determine if declines in fair value below cost are other-than-temporary is subjective and requires a high degree of judgment. We evaluate our investment securities on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security's market value has been less than its cost, financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. If any declines are determined to be other-than-temporary, we charge the losses to income when that determination is made. We have a committee made up of certain accounting and investment associates and management responsible for managing the impairment review process. The current economic environment and recent volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We recorded charges for other-than-temporary impairment of securities of \$56.2 million, \$14.8 million and \$0.8 million, respectively, for the years ended December 31, 2006, 2005 and 2004. The \$56.2 million impairment for the year ended December 31, 2006 primarily related to our intent to hold fixed maturity securities that were in an unrealized loss position due to the prevailing interest rate environment, as well as other-than-temporary impairments of equity securities that had been in an unrealized loss position for an extended period of time. Impairments recorded in 2005 and 2004 were primarily the result of the continued credit deterioration on specific issuers in the bond and equity markets.

We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines being charged against future income.

A summary of available-for-sale investments with unrealized losses as of December 31, 2006 along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

	Less than		Twelve Months		Total	
	Twelve Months		or More		Gross	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
<i>(In millions)</i>						
Fixed maturity securities	\$ 3,884.1	\$ (28.8)	\$ 5,306.4	\$ (103.3)	\$ 9,190.5	\$ (132.1)
Equity securities	234.6	(15.3)	21.0	(0.6)	255.6	(15.9)
Total	\$ 4,118.7	\$ (44.1)	\$ 5,327.4	\$ (103.9)	\$ 9,446.1	\$ (148.0)

Our fixed maturity investment portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses reported above were primarily caused by the effect of a rising interest rate environment on certain securities with stated interest rates currently below market rates. We currently have the ability and intent to hold these securities until their full cost can be recovered. Therefore, we do not believe the unrealized losses represent an other-than-temporary impairment as of December 31, 2006.

During the year ended December 31, 2006, we sold \$5.9 billion of fixed maturity and equity securities resulting in gross realized losses of \$95.7 million. Subsequent to the acquisition of WellChoice, during 2006, we restructured our investment portfolios to align the merged portfolios with our overall investment guidelines. The majority of the sales of fixed maturity securities resulted in realized losses due to the prevailing interest

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rate environment. For equity securities, the 2006 sales to restructure the merged portfolios primarily resulted in realized gains. Similarly, subsequent to the merger with WHN, during 2005, we restructured our investment

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portfolios to align the merged portfolios with our overall investment guidelines. The majority of the sales of fixed maturity securities resulted in realized losses due to the prevailing interest rate environment. For equity securities, the 2005 sales to restructure the merged portfolios primarily resulted in realized gains.

A primary objective in the management of the fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses.

In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectation that the fair value could deteriorate further; (iii) desire to reduce our exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers based on, among other things, their creditworthiness in exchange for collateral initially equal to at least 102% of the value of the securities on loan and is thereafter maintained at a minimum of 100% of the market value of the securities loaned. The market value of the securities on loan to each borrower is monitored daily and the borrower is required to deliver additional collateral if the market value of the collateral falls below 100% of the market value of the securities on loan. The fair value of the collateral amounted to \$904.7 million and \$1,389.9 million, which represented 103% and 102% of the carrying value at December 31, 2006 and 2005, respectively. Under guidance provided in FAS 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, we recognize the collateral as an asset, which is reported as securities lending collateral on our balance sheet and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as securities lending payable. The securities on loan are reported in the applicable investment category on the balance sheet.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage the market risks through our investment policy, which establishes credit quality limits and limits of investments in individual issuers. Ineffective management of these risks could have an impact on our future earnings and financial position.

We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$619.0 million decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$583.0 million increase in fair value. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of \$207.1 million. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of \$207.1 million.

For additional information, see Part II, Item 7A, Quantitative and Qualitative Disclosures about Market Risk, of this Form 10-K, and Note 5 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for our employees, including plans sponsored by the former WellChoice and WHN prior to the related mergers. These plans are accounted for in accordance with FAS 87, *Employers' Accounting for Pensions*, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by FAS 87, we calculate the value of plan assets described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

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An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our September 30, 2006 measurement date, we selected a long-term rate of return on plan assets of 8.00% for all plans. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and historical returns are also reviewed for appropriateness of the selected assumption. The expected long-term rate of return is calculated by the geometric averaging method, which calculates an expected multi-period return, reflecting volatility drag on compound returns. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

The assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. The difference between this expected return and the actual return on plan assets is deferred and amortized over the average remaining service of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

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 September 30, 2006 measurement date. The selected discount rate for all plans is 5.90% (compared to a weighted average discount rate of 5.31% for 2006 expense recognition), which was developed using a yield curve approach. Using yields available on high-quality fixed maturity securities with various maturity dates, the yield curve approach provides a customized rate, which is meant to match the expected cash flows of our specific benefit plans. The net effect of 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.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities and equity securities across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in the Company's expense and cash flow. As of our September 30, 2006 measurement date, we had approximately 67% of plan assets invested in equity securities, 27% in fixed maturity securities and 6% in other assets. No plan assets were invested in WellPoint common stock as of the measurement date.

For the year ended December 31, 2006, there were no contributions required under the Employee Retirement Income Securities Act of 1974, as amended, or ERISA; however we elected to make discretionary contributions totaling \$108.6 million during the three months ended September 30, 2006. For the year ending December 31, 2007, we do not expect any required contributions under ERISA; however, we may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes.

At December 31, 2006, our consolidated net prepaid pension asset was \$274.1 million. For the years ended December 31, 2006, 2005 and 2004, we recognized consolidated pretax pension expense of \$32.6 million, \$48.6 million and \$40.8 million, respectively.

Effective January 1, 2006, we curtailed the benefits under the WellPoint Cash Balance Pension Plan, or the Plan, which name changed from the Anthem Cash Balance Pension Plan effective January 1, 2006. Most participants will no longer have pay credits added to their accounts, but continue to earn interest on existing account balances. Employees hired on or after January 1, 2006, are not eligible to participate in the Plan. Certain participants will be grandfathered into the Plan based on age and years of service in previously merged plans. Grandfathered participants continue to receive pay credits under the Plan formula. We recorded a curtailment

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gain of \$4.6 million in the first quarter of 2006. We increased our matching contributions to certain defined contribution plans during 2006 at amounts equal to or greater than the curtailment gain amount.

The Empire Blue Cross Blue Shield Cash Balance Pension Plan, or the Empire Plan, was merged into the Plan on December 31, 2006. Effective January 1, 2007, we curtailed the benefits under the Empire Plan. Most participants will no longer have pay credits added to their accounts, but will continue to earn interest on existing account balances. Participants will continue to earn years of service for vesting. Employees hired on or after January 1, 2007 will not be able to participate in the Plan. Certain participants will be grandfathered into the Plan based on age and years of service in the Empire Plan. Grandfathered participants will continue to receive pay credits under the Plan formula. There will be no curtailment gain or loss associated with the curtailment of benefits under the Empire Plan.

Other Postretirement Benefits

We provide most associates with certain life, medical, vision and dental benefits upon retirement. We use various actuarial assumptions including a discount rate and the expected trend in health care costs to estimate the costs and benefit obligations for our retiree benefits. We recognized a postretirement benefit liability of \$554.4 million at December 31, 2006.

At our September 30, 2006 measurement date, the selected discount rate for all plans was 5.90% (compared to a weighted average discount rate of 5.29% for 2006 expense recognition). We developed this rate using a yield curve approach as described above.

The assumed health care cost trend rates used to measure the expected cost of other benefits at our September 30, 2006 measurement dates was 9.00% for 2007 with a gradual decline to 5.00% by the year 2012. These estimated trend rates are subject to change in the future. The health care cost trend assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2006 by \$44.3 million and would increase service and interest costs by \$2.9 million. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation by \$38.1 million as of December 31, 2006 and would decrease service and interest costs by \$2.6 million.

For additional information regarding retirement benefits, see Note 17 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K. See also *New Accounting Pronouncements* disclosure included in this Critical Accounting Policies and Estimates section of our MD&A for discussion of new accounting guidance related to retirement benefits.

New Accounting Pronouncements

We maintain a share-based employee compensation plan. Prior to January 1, 2006, we accounted for the plan under the recognition and measurement provisions of Accounting Principles Board Opinion No. 25, *Accounting for Stock Issued to Employees* (APB 25). Effective January 1, 2006, we adopted the fair value recognition provisions of FAS 123R under the modified prospective method of adoption for which compensation expense related to stock options is recognized on a prospective basis. Also in accordance with the prospective method of adoption, prior period results have not been restated. See Note 2, Basis of Presentation and Significant Accounting Policies, and Note 12, Capital Stock, to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

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In July 2006, FASB issued FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes-an interpretation of FASB Statement 109* (FIN 48). Among other things, FIN 48 creates a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold which all income tax positions must achieve before being recognized in the financial statements. In

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addition, FIN 48 requires expanded annual disclosures, including a rollforward of the beginning and ending aggregate unrecognized tax benefits as well as specific detail related to tax uncertainties for which it is reasonably possible the amount of unrecognized tax benefit will significantly increase or decrease within twelve months. FIN 48 was effective for us on January 1, 2007. Any differences between the amounts recognized in the statements of financial position prior to the adoption of FIN 48 and the amounts reported after adoption are generally accounted for as a cumulative-effect adjustment recorded to the beginning balance of retained earnings. We do not expect the adoption of FIN 48 to have a material impact on our beginning retained earnings at January 1, 2007. See Note 2 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

In September 2006, FASB issued Statement of Financial Accounting Standards No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans - an amendment of FASB Statements No. 87, 88, 106, and 132(R)* (FAS 158). FAS 158 retains the previous measurement and disclosure requirements of prior accounting guidance. In addition, FAS 158 requires the recognition of the funded status of pension and other postretirement benefit plans on the balance sheet (recognition provisions). Furthermore, for fiscal years ending after December 15, 2008, FAS 158 requires fiscal-year-end measurements of plan assets and benefit obligations, eliminating the use of earlier measurement dates which are currently permissible. The recognition provisions of FAS 158 were effective for us on December 31, 2006. The adoption of FAS 158 decreased our accumulated other comprehensive income by \$99.5 million at December 31, 2006. See Note 2 to our audited consolidated financial statements as of and for the year ended December 31, 2006 included in this Form 10-K.

There were no other new accounting pronouncements issued during 2006 that had a material impact on our financial position, operating results or disclosures.

X. Liquidity and Capital Resources***Introduction***

Our cash receipts result primarily from premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from exercise of stock options and our employee stock purchase plan. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on long-term borrowings, capital expenditures and repurchases of our common stock. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have some negative impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities, to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Excess capital at our subsidiaries is paid annually by subsidiaries in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

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The availability of financing in the form of debt or equity is influenced by many factors including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. We have access to a \$2.5 billion commercial paper program supported by a \$2.5 billion senior credit facility, which allows us to maintain further operating and financial flexibility.

Table of Contents***Liquidity Year Ended December 31, 2006 Compared to Year Ended December 31, 2005***

During 2006, net cash flow provided by operating activities was \$4,044.2 million, compared to \$3,135.5 million in 2005, an increase of \$908.7 million. This increase resulted from improved premium collections, and higher net income, including the impact of the acquisition of WellChoice, partially offset by higher tax payments.

Net cash flow used in investing activities was \$457.3 million in 2006, compared to \$5,151.6 million of cash used in 2005. The table below outlines the decrease in cash flow used in investing activities of \$4,694.3 million between the two periods:

<i>(In millions)</i>	Change in Cash Used in Investing Activities
Decrease in net purchases of investments	\$ 1,441.8
Decrease in securities lending collateral	1,216.6
Decrease in net purchases of subsidiaries	2,471.5
Increase in net purchases of property and equipment	(35.9)
Increase in other, net	(399.7)
Net decrease in cash used in investing activities	\$ 4,694.3

The decrease in net purchases of investments resulted from the portfolio restructure in 2005 following the WHN merger, with lower amounts of restructuring in 2006 following the WellChoice acquisition. The decrease in securities lending collateral is consistent with the decrease in amounts outstanding under this program. The offset to the reduction of securities lending collateral is a reduction of securities lending payable, which is reported with cash used in financing activities. The decrease in net purchase of subsidiaries resulted from the WellChoice acquisition in 2005, with no corresponding acquisition during 2006. The increase in other, net includes the purchase of corporate-owned life insurance policies on participants in our deferred compensation plans.