WELLPOINT INC
Form 10-K
February 21, 2008
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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, 2007**

OR

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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)

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 x 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 x

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 x 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, a non-accelerated filer or a smaller reporting company. See definitions of large accelerated filer , accelerated filer , and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer x	Accelerated filer ¨
Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

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, 2007 was approximately $48,112,776,548.

As of February 12, 2008, 541,939,848 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 21, 2008.

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WELLPOINT, INC.

Indianapolis, Indiana

Annual Report to Securities and Exchange Commission

December 31, 2007

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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, bel predict, project , potential, intend and similar expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. 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, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

References in this Annual Report on Form 10-K to the terms we , our , us , WellPoint or the Company refer to WellPoint, Inc., an Indiana corporation, which name changed from Anthem, Inc., or Anthem, effective November 30, 2004, and its direct and indirect subsidiaries, as the context requires.

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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 34.8 million medical members as of December 31, 2007. 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, or PBM, 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 2007 operating revenue was derived from premium income, while approximately 7% was derived from administrative fees and other revenues.

Through December 31, 2007, our customer base primarily included Local Groups with less than 1,000 eligible employees (48% of our medical members at December 31, 2007) and Individuals under age 65 (7% of our medical members as of December 31, 2007). Other major customer types included National Accounts (generally multi-state employer groups with 1,000 or more employees, accounting for 18% of our medical members at December 31, 2007), BlueCard Host (enrollees of non-owned BCBS plans who receive benefits in our BCBS markets, accounting for 13% of our medical members at December 31, 2007), Senior (over age 65 individuals enrolled in Medicare Supplement or Medicare Advantage policies, accounting for 4% of our medical members at December 31, 2007), State Sponsored Programs (primarily Medicaid and State Children s Health Insurance Plans, accounting for 6% of our medical members at December 31, 2007) and Federal Employee Program, or FEP (United States government employees and covered family members, accounting for 4% of our medical members at December 31, 2007).

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

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 adequate product pricing, 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.

In January 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. In furtherance of our plan, we recently launched an interactive website for the uninsured and opened community resource centers to assist the uninsured obtain health insurance coverage.

We also announced the launch of *360º 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 have collaborated with 19 other Blue Cross and Blue Shield plans to launch the nation s largest private database of health care information. Blue Health Intelligence℠, or BHI, is a unique resource that is designed to 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.

In addition, we continue to supplement 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.

WellPoint is a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) 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 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 amended, 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

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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. is an Indiana corporation incorporated on July 17, 2001.

As required by NYSE Rule 303A.12, in 2007 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.

Significant Transactions

We intend to continue our expansion and earnings per share, or EPS, growth through organic membership growth, strategic acquisitions and capital transactions. Listed below are the more significant transactions over the last five years:

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. The repurchases are effected from time to time in the open market, through negotiated transactions and through plans designed to comply with Rule 10b5-1(c) under the Exchange Act. During the year ended December 31, 2007, our Board of Directors authorized increases of $9.5 billion in our stock repurchase program, resulting in a total amount available for repurchases in 2007 and thereafter of $10.4 billion, which included $0.95 billion of authorization remaining unused at December 31, 2006. During the year ended December 31, 2007, we repurchased and retired approximately 76.9 million shares at an average price of $79.99, for an aggregate cost of $6.2 billion. Therefore, as of December 31, 2007, $4.3 billion remained authorized by our Board of Directors for future repurchases. Subsequent to December 31, 2007, we repurchased and retired approximately 15.0 million shares for an aggregate cost of approximately $1.2 billion, leaving approximately $3.1 billion for authorized future repurchases at February 12, 2008. 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 August 1, 2007, we completed our acquisition of Imaging Management Holdings, LLC, or IMH, whose sole business is the holding company parent of American Imaging Management, Inc., or AIM. AIM is a leading radiology benefit management and technology company and provides services to us as well as other customers nationwide, including nine other Blue Cross and Blue Shield licensees. The acquisition supports our strategy to become the leader in affordable quality care by incorporating AIM s services and technology for more effective and efficient use of radiology services by our members. The purchase price for the acquisition was approximately $300.0 million in cash.

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, we

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paid $61.3 million in legal fees, including interest, on October 6, 2007. 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 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 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 been developed. 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, such as 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

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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, 2007, 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.

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, including health information;
- 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, care management, product value and brand recognition.

To build our provider networks, we compete with other health benefits plans for the best 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.

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At the sales and distribution level, we compete for qualified agents and brokers to recommend and 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 quality and price of our products, support services, reputation, prior relationships, along with a reasonable commission structure 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. Typically we are the lead competitor in each of our markets and thus a closely watched target by other insurance competitors.

Reportable Segments

We revised our reportable segments during the first quarter of 2007 consistent with changes made to our organizational structure, which reflected how the chief operating decision maker evaluated the performance of the business beginning January 1, 2007. Segment disclosures for 2006 and 2005 have been reclassified to conform to the 2007 presentation.

Through December 31, 2007, we managed our operations through three reportable segments: Consumer and Commercial Business, or CCB; Specialty, Senior and State Sponsored Business, or 4SB; and Other.

Our CCB segment includes business units which offer similar products and services, including commercial accounts and individual programs. CCB offers a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans. CCB also offers a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products. Additionally, CCB provides 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.

Our 4SB segment is comprised of businesses providing health and specialty products and services such as Medicare Part D, Medicare Advantage, Medicare Supplement, Medicaid, life and disability insurance benefits, PBM, specialty pharmacy, dental, vision, behavioral health benefit services and long-term care insurance. 4SB also provides network rental and medical management services to workers compensation carriers.

The Other segment includes results from our Federal Government Solutions, or FGS, business and other businesses that do not meet the quantitative thresholds for an operating segment as defined in Statement of Financial Accounting Standards (FAS) No. 131, *Disclosures about Segments of an Enterprise and Related Information*, or FAS 131, as well as intersegment sales and expense eliminations and corporate expenses not allocated to the other reportable segments. FGS business includes FEP and National Government Services, Inc. (which name changed from AdminaStar Federal, Inc. effective November 17, 2006), or NGS, which acts as a Medicare contractor in several regions across the nation.

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 as of and for the year ended December 31, 2007 included in this Form 10-K.

On October 2, 2007, we announced a new organizational structure with new strategic business units: a Commercial Business unit and a Consumer Business unit that service different customer types. The Commercial Business unit includes Local Group customers, National

Accounts, UniCare and Specialty business operations (dental, vision, life and disability and workers compensation). The Consumer Business unit includes Senior, State Sponsored and Individual business. In addition, a new Comprehensive Health Solutions Business unit brings together our resources focused on optimizing the quality of health care and the cost of care management. The Comprehensive Health Solutions Business unit includes provider relations, care and disease management, behavioral health, employee assistance programs and our PBM business, which includes NextRx, and our specialty pharmacy, PrecisionRx Specialty Solutions. Our FGS business includes FEP and NGS, which acts as a

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Medicare contractor. This simplified, customer-focused structure builds on the strength of our commercial and consumer businesses, and will create additional opportunities for cross-selling medical and specialty products. These changes also emphasize our comprehensive approach to improving the quality, transparency and cost of health care for all of our customers. Our chief operating decision maker will assess performance under this new structure effective January 1, 2008 and, accordingly, we expect to revise our reportable segments in the first quarter of 2008.

Products and Services

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

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.

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.

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

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from the BlueCard members home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Senior Plans. We offer a wide variety of senior plans, products and options such as Medicare supplement plans, Medicare Advantage (including private fee-for-service plans) and Medicare Part D Prescription Drug Plans, or Medicare Part D. Medicare supplement 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 and often include a Medicare Part D benefit. Medicare Part D offers a prescription drug plan to Medicare and dual eligible (Medicare and Medicaid) beneficiaries nationwide. We served as the exclusive point of sale facilitated enrollment provider as defined by the Centers for Medicare & Medicaid Services, or CMS, for 2007 and 2006, and have been awarded that role again for the 2008 plan year.

Individual Plans. We offer a full range of health insurance plans with a variety of options and deductibles for individuals under age 65 who are not covered by employer-sponsored coverage. Some of our products target certain demographic populations such as the uninsured, young invincibles, (individuals between the ages of 19 and 29), or early retirees. Our products are offered in 14 states and are distributed by independent brokers and agents, WellPoint sales representatives and via the Internet.

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 Hampshire, New York, Ohio, Texas, Virginia, West Virginia and Wisconsin. We expect to begin providing services in South Carolina sometime during the second quarter of 2008.

Pharmacy Products. We offer pharmacy services and PBM services to our members. Our pharmacy services incorporate features such as drug formularies (where we develop lists of preferred, cost effective drugs), a pharmacy network and maintenance of a prescription drug database and mail order capabilities. PBM 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 PBM 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 PBM companies on January 1, 2006.

Life Insurance. We offer an array of competitive individual and 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.

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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.

Medicare Fiscal Intermediary Operations. Through our National Government Services, Inc. subsidiary, 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 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 primarily on a cost reimbursement basis.

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, employers, seniors and Medicaid recipients, as well as the unique needs of educational and public entities, labor groups, 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, which better enables us to develop benefit plans and services that meet the unique needs of the distinct markets.

Overall, we seek to establish pricing and product designs to achieve an appropriate level of profitability for each of our customer categories. Our customer definitions were revised in the first quarter of 2007 to be consistent with how we manage our business effective January 1, 2007. Prior periods have been reclassified to conform to the 2007 presentation. As of December 31, 2007, our customer types included the following categories:

Local Group includes employer customers with less than 1,000 employees eligible to participate as a member in one of our health plans. In addition, Local Group includes customers with 1,000 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. Local 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. Local Group accounted for 48% of our medical members at December 31, 2007.

Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, our in-house sales force or via the

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Internet. Individual business is sold on a fully-insured basis and is usually medically underwritten at the point of initial issuance. Individual 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 as compared to local groups. Individuals accounted for 7% of our medical members at December 31, 2007.

National Accounts are defined as generally multi-state employer groups primarily headquartered in a WellPoint service area with 1,000 or more eligible employees, with at least 5% or more eligible employees located in a service area outside of the headquarter s state. Some exceptions are allowed based on broker relationships. 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 the size and breadth of our networks and 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 18% of our medical members at December 31, 2007.

BlueCard host customers are defined as 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 month. BlueCard host membership accounted for 13% of our medical members at December 31, 2007.

Senior customers are defined as 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. 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. 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, primarily through independent agents and brokers. Senior business accounted for 4% of our medical members at December 31, 2007.

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 6% of our medical members at December 31, 2007.

FEP members consist of 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. FEP business accounted for 4% of our medical members at December 31, 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.

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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	
	2007	2006
(In thousands)		
Customer Type:		
Local Group	16,663	16,766
Individual	2,390	2,488
National:		
National Accounts	6,389	6,136
BlueCard	4,563	4,279
Total National	10,952	10,415
Senior	1,250	1,193
State Sponsored	2,174	1,882
FEP	1,380	1,357
Total medical membership by customer type	34,809	34,101
Funding Arrangement:		
Self-Funded	17,737	16,745
Fully-Insured	17,072	17,356
Total medical membership by funding arrangement	34,809	34,101

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. Physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including CMS resource-based relative value system, or RBRVS, changes, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed and is maintained by CMS, and is used by the Medicare program and other

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major payers. In addition, we have implemented and continue to expand physician incentive contracting, which recognizes clinical quality and performance as a basis for reimbursement.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or per case for inpatient covered services. Some hospitals, primarily sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our per case reimbursement methods utilize many of the same attributes contained in Medicare s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. 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.

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. As described in Significant Transactions above, on August 1, 2007, we completed our acquisition of AIM. We intend to incorporate AIM s services and technology for more effective and efficient use of radiology services by our members.

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 medical technologies and treatments.

Quality programs. We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incent hospitals and physicians to support national initiatives to improve the quality of clinical care, patient

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

ConditionCare and *FutureMoms* are care management and maternity management programs that 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.

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.

ComplexCare is an advanced care management program that 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. *ComplexCare* 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*.

MyHealth Advantage 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.

MyHealth Coach provides our members with a professional guide who helps them navigate the health care system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for serious health issues or have complex health care needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer s financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity and diet and nutrition.

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MyHealth@Anthem is our secure web-based solution, complementing other programs by reinforcing telephonic coaching and mail campaigns. The website 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 and our communities receive through our proprietary Member Health Index, or MHI and State Health Index, or SHI. The MHI is comprised of 20 clinically relevant measures for our health plan members and combines prevention, care management, clinical outcome and patient safety metrics. The SHI measures the health of all the residents in our states, not just our members, using public data from the Centers for Disease Control and Prevention.

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.

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.

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

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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.

Our license agreements require an annual fee to be paid to the BCBSA. For historical years up to and including the 2007 calendar year, the fee was based upon enrollment and net revenue as defined by BCBSA. Beginning in 2008, the fee will be based on enrollment only. 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 licenses to use the BCBS names and marks in those 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;
- 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, federal and international regulation throughout 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

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;

underwriting and pricing;

benefits;

eligibility requirements;

service areas;

market conduct;

sales and marketing activities;

quality assurance procedures;

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plan design and disclosures, including mandated benefits;

underwriting, marketing and rating restrictions for small group products;

utilization review activities;

prompt payment of claims;

requirements that pharmacy benefit managers pass manufacturers rebates to customers;

member rights and responsibilities;

collection, access or use of protected health information;

data reporting, including financial data;

provider rates of payment;

surcharges on provider payments;

provider contract forms;

provider access standards;

premium taxes and assessments for the uninsured and/or underinsured;

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;

assessments for state run immunization programs;

member and provider complaints and appeals;

financial arrangements;

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

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 Medicare 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 jurisdiction 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 jurisdiction to jurisdiction. 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.

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

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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 insurance company and HMO 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 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 of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, 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

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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 and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company 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 company s business. In general, under these laws, an insurance company or HMO 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 a 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 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 a company to be placed under regulatory control in a rehabilitation or liquidation proceeding. As of December 31, 2007, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

Employees

At December 31, 2007, we had approximately 41,700 persons employed on a full-time basis. As of December 31, 2007, a small portion of employees were covered by collective bargaining agreements: 145 employees in the Sacramento, California area with the Office and Professional Employees International Union, Local 29; 110 employees in the greater Detroit, Michigan area with the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Local No. 614; 12 employees in the New York city metropolitan area with the Office and Professional Employees International Union, Local 153; and 51 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.

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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 or federal regulatory 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, and eligibility requirements, 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.

Congress and state legislatures continue to focus on health care issues. In addition, the candidates for the 2008 presidential election have focused on health care issues and several of them have proposed significant reform to the health care system. A number of states, including California, Colorado, Connecticut, New York, 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. In particular, if Governor Schwarzenegger s proposal for universal coverage in California had been enacted in the format as passed by the California Assembly in December 2007, such proposal could have had a material adverse effect on our business, operations and financial condition. In addition, several states are considering legislative proposals to require prior regulatory approval of premium rate increases or establish minimum loss ratio thresholds. If enacted, these proposals could have a material adverse 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

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e-business initiatives, uncertainty surrounding the regulatory authority and requirements in this area may make it difficult to ensure compliance.

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. 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 adversely affected.

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; state and federal regulatory changes; and general economic downturn that results in business failures.

There are risks associated with contracting with the Centers for Medicare & Medicaid Services to provide Medicare Part C and Medicare Part D Prescription Drug benefits.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or 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. We offer Medicare approved prescription drug plans and Medicare Advantage plans to Medicare eligible individuals nationwide. In addition, we provide various administrative services for other entities offering medical and/or prescription drug plans to their Medicare eligible employees and retirees through our PBM companies and/or 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. Risks associated with the Medicare Advantage and 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 correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, increased medical or pharmaceutical costs, and the underlying seasonality of this business. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Part C and D, including those related to collectability of receivables and establishment of liabilities, the actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations.

As a participant in Medicare and Medicaid programs, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant penalties.

We participate as a payer or fiscal intermediary for the Medicare and Medicaid programs. The laws and regulations governing participation in Medicare and Medicaid programs are complex, subject to interpretation and can expose us 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 which could have a material adverse effect on our business, financial condition and results of operations. In addition, legislative or regulatory changes to these programs could have a material adverse effect on our business, financial condition and results of operations.

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

We participate in Medicare Part C (Medicare Advantage), Medicare Part D, Medicare fiscal intermediary and Medicaid programs and receive revenues from the Medicare and Medicaid programs to provide benefits under these programs. Revenues for these programs are dependent, in whole or in part, 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.

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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 BCBSA or other BCBSA licensees may 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.

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 the employer groups assume the underwriting risks. 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 PBM 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

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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;

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;

changes in the average wholesale price industry pricing benchmark for prescription drugs, as a consequence of potential court approval of a proposed class action settlement involving the two defendant companies that report data on prescription drug prices;

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 for, among other things, rebates, discounts and administrative fees.

The failure to adhere to these or other relevant laws and regulations could expose our PBM 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 BCBSA 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

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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 PBM 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.

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 BCBSA 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 BCBSA. Our license agreements with the BCBSA 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 BCBSA; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA 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, as defined by the BCBSA, 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, as defined by the BCBSA, 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 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. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

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The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA 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 BCBSA 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 BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA 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 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 BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a Blue Cross and/or Blue Shield presence in the vacated service area. Through December 31, 2007 the fee was set at $86.18 per licensed enrollee. As of December 31, 2007 we reported 28.3 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 BCBSA.

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.

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.

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, federal and state law enforcement officials have issued warnings about potential terrorist activity

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involving biological and other weapons. In addition, natural disasters such as hurricanes 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.

As of December 31, 2007, we had indebtedness outstanding of approximately $9.0 billion and had available borrowing capacity of approximately $0.7 billion under our revolving credit facility, which 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, 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

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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 past mergers and acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately $22.7 billion as of December 31, 2007, 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. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our goodwill and intangibles (with indefinite lives). 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 used.

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, state and international 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

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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 upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of 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.

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. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively, we could have a decrease in membership, have problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, have regulatory problems, have increases in operating expenses or suffer other adverse consequences. 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.

We are working towards 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. We cannot assure you that we will be able to fully realize our e-business vision. 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 significant portion of our core applications development as well as a component of our data center operations to IBM. We are dependent upon IBM for these support functions. If our relationship with IBM is significantly disrupted 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

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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.

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 BCBSA. 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 BCBSA, 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 (which is required by our license agreement with the BCBSA); restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose 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

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shareholders; impose restrictions on shareholders ability to amend our articles of incorporation and bylaws; and prohibit shareholders from amending our bylaws.

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 our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal polices, 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.

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ITEM 2. PROPERTIES

We have set forth below a summary of our principal office space (locations greater than 100,000 square feet).

Location	Amount (Square Feet) of Building Owned or Leased and Occupied by WellPoint	Principal Usage
220 Virginia Ave., Indianapolis, IN[1]	557,000	Operations
21555 Oxnard St., Woodland Hills, CA[1]	421,000	Operations
370 Basset Rd., North Haven, CT[1]	418,000	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
2221 Edward Holland Drive, Richmond, VA[1]	193,000	Operations
8115-8125 Knue Road, Indianapolis, IN[1]	184,000	Operations
3000 Goff Falls Rd., Manchester, NH[1]	180,000	Operations
6740 N. High St., Worthington, OH	178,000	Operations
85 Crystal Run, Middletown, NY[1]	173,000	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]	143,000	Operations
602 S. Jefferson St., Roanoke, VA	131,000	Operations
2825 West Perimeter Road, Indianapolis, IN[1]	126,000	Operations
4553 La Tienda Drive, Thousand Oaks, CA[1]	120,000	Operations
3 Huntington Quadrangle, Melville, NY[1]	110,000	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 as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

Litigation

In July 2005, we entered into a settlement agreement with representatives of more than 700,000 physicians nationwide to resolve certain cases brought by physicians. The cases resolved were known as the CMA Litigation, the Shane Litigation, the Thomas Litigation *(Kenneth Thomas, M.D., et al. vs. Blue Cross Blue Shield*

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Association, et al.) and certain other similar cases brought by physicians. Final monetary payments were made in October 2006. Following its acquisition in 2005, WellChoice was merged with and into a wholly-owned subsidiary of WellPoint. Since the WellChoice transaction closed on December 28, 2005, after we reached settlement with the plaintiffs, WellChoice continues to be a defendant in the Thomas (now known as Love) Litigation and is not affected by the prior settlement between us and plaintiffs. The Love Litigation alleges that the BCBSA and the Blue Cross and Blue Shield plans violated the Racketeer Influenced and Corrupt Organizations Act, or RICO. On April 27, 2007, we, along with 22 other Blue Cross and Blue Shield plans and the BCBSA, announced a settlement of the Love Litigation. The Court granted preliminary approval on May 31, 2007. A hearing was held on November 14, 2007 to consider final approval. The settlement will not have a material effect on our consolidated financial position or results of operations.

Prior to WHN s acquisition of the group benefit operations, or GBO of John Hancock Mutual Life Insurance Company, or 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 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. We are currently in arbitration with John Hancock regarding these arrangements. The arbitration panel s Phase I ruling addressed liability. On April 23, 2007, the arbitration panel issued a Phase II ruling stating the amount we owe to John Hancock for losses and expenses John Hancock paid through June 30, 2006. The panel further outlined a process for determining our liability for losses and expenses paid after June 30, 2006, which liability has not yet been determined. We filed a Petition to Confirm and John Hancock filed an Application to Vacate the arbitration rulings, which are currently pending in federal court. We believe that the liability that may result from this matter is unlikely to have a material adverse effect on our consolidated financial condition or results of operations.

In various California state courts, we are defending a number of individual lawsuits and four purported class actions alleging the wrongful rescission of individual insurance policies. The suits name WellPoint as well as Blue Cross of California, or BCC, and BC Life & Health Insurance Company, or BCL&H, both WellPoint 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. The parties have agreed to mediate most of these lawsuits and the mediation has resulted in the resolution of some of these lawsuits. In addition, the California Department of Managed Health Care and California Department of Insurance are conducting investigations of the allegations. In February 2007, the California Department of Managed Health Care issued its final report in which it indicated its intention to impose a monetary penalty against BCC of $1.0 million. In June 2007, the California Department of Insurance issued its final report in which it issued a number of citations alleging violations of fair-claims handling laws. While the outcome is currently unknown, we believe that any liability that may result from this matter is unlikely to have a material adverse effect on our consolidated financial condition or results of operations.

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 mediation or arbitration. In addition, a purported class action has been filed against BCC, BCL&H and WHN in a California state court on behalf of hospitals. This suit also seeks to recover for payment of claims denied where the member was rescinded. An amended complaint was recently filed adding the California Medical Association along with the California Hospital Association as new plaintiffs in the suit. We deny any wrongdoing and intend to vigorously defend these proceedings. While the outcome is currently unknown, we believe that any liability that may result from this matter is unlikely to have a material adverse effect on our consolidated financial condition or results of operations.

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Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain health care services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. 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, we are also involved in other pending and threatened litigation of the character incidental to our 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 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 financial position or results of operations.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS.

We did not submit any matters to a vote of security holders during the fourth quarter of 2007.

PART II

ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER

MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Prices

Our common stock, par value $0.01 per share, is listed on the NYSE under the symbol WLP . On February 12, 2008, the closing price on the NYSE was $75.88. As of February 12, 2008, there were 124,373 shareholders of record of our common stock. The following table presents high and low sales prices for our common stock on the NYSE for the periods indicated.

	High	Low
2007		
First Quarter	$ 84.15	$ 73.88
Second Quarter	86.25	77.98
Third Quarter	83.55	72.90

Fourth Quarter	89.95	75.08
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

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

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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., ATH Holding Company, LLC and Arcus Financial Holding Corp. 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 our equity compensation plans is set forth in or incorporated by reference into Part III Item 12 of this Form 10-K.

Issuer Purchases of Equity Securities

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

Period *(In millions, except share and per share data)*	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
October 1, 2007 to October 31, 2007	7,766,644	$ 78.85	7,764,775	$ 1,512.3
November 1, 2007 to November 30, 2007	8,121,478	79.85	8,120,149	863.9
December 1, 2007 to December 31, 2007	6,654,295	85.88	6,583,933	4,298.4
	22,542,417		22,468,857	

1 Total number of shares purchased includes 73,560 shares delivered to or withheld by us 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, 2007, our Board of Directors authorized increases of $9.5 billion in our stock repurchase program, resulting in a total amount available for repurchases in 2007 and thereafter of $10.4 billion, which includes $949.8 million of authorization remaining unused at December 31, 2006. During the year ended December 31, 2007, we repurchased approximately 76.9 million shares at a cost of $6.2 billion under the program. Therefore, remaining authorization under the program was $4.3 billion as of December 31, 2007.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2002 through December 31, 2007, with the cumulative total return over such period of (i) the Standard & Poor s 500 Stock Index (the S&P 500 Index) (ii) the Morgan Stanley Healthcare Payor Index (the MS Healthcare Payor Index) and (iii) the Standard & Poor s Managed Health Care Index (the S&P Managed Health Care Index). The graph assumes an investment of $100 on December 31, 2002 in each of our common stock, the S&P 500 Index, the MS Healthcare Payor

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Index and the S&P Managed Health Care 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 we caution 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 we are 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 SEC, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933 or the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.

	December 31,					
	2002	**2003**	**2004**	**2005**	**2006**	**2007**
WelPoint, Inc.	$ 100	$ 119	$ 183	$ 254	$ 250	$ 279
S&P 500 Index	$ 100	$ 129	$ 143	$ 150	$ 173	$ 183
MS Healthcare Payor Index[1]	$ 100	$ 144	$ 218	$ 311	$ 292	$ 335
S&P Managed Health Care Index[1]	$ 100	$ 141	$ 216	$ 308	$ 288	$ 333

* Based upon an initial investment of $100 on December 31, 2002 with dividends reinvested

1 We have selected the S&P Managed Health Care Index to replace the MS Healthcare Payor Index because the new index is more readily available. We have included both the new and old index in the chart above.

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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, 2007. 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.

	As of and for the Years Ended December 31				
	2007[1]	2006	2005[1]	2004[1]	2003
(In millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue[2,3]	$ 60,122.0	$ 56,160.4	$ 43,991.2	$ 20,398.3	$ 16,457.0
Total revenue[3]	61,134.3	57,038.8	44,614.1	20,752.5	16,751.3
Net income	3,345.4	3,094.9	2,463.8	960.1	774.3
Per Share Data					
Basic net income per share	$ 5.64	$ 4.93	$ 4.03	$ 3.15	$ 2.80
Diluted net income per share	5.56	4.82	3.94	3.05	2.73
Other Data (unaudited)					
Benefit expense ratio[3,4]	82.4%	81.2%	80.1%	81.6%	80.5%
Selling, general and administrative expense ratio[3,4]	14.5%	15.7%	16.5%	17.0%	18.8%
Income before income taxes as a percentage of total revenue	8.6%	8.6%	8.7%	7.0%	7.2%
Net income as a percentage of total revenue	5.5%	5.4%	5.5%	4.6%	4.6%
Medical membership *(In thousands)*	34,809	34,101	33,856	27,728	11,927
Balance Sheet Data					
Cash and investments[3]	$ 21,249.8	$ 20,812.2	$ 20,336.0	$ 15,792.2	$ 7,478.2
Total assets[3]	52,060.0	51,574.9	51,123.9	39,663.3	13,408.9
Long-term debt[3]	9,023.5	6,493.2	6,324.7	4,289.5	1,662.8
Total liabilities[3]	29,069.6	26,999.1	26,130.8	20,204.3	7,409.0
Total shareholders equity	22,990.4	24,575.8	24,993.1	19,459.0	5,999.9

1 The net assets for WellChoice, Inc. and the net assets of and results of operations for Imaging Management Holdings, LLC; Lumenos, Inc.; and WellPoint Health Networks Inc. are included from their respective acquisition dates of December 28, 2005 (effective December 31, 2005 for accounting purposes), August 1, 2007, June 9, 2005, and November 30, 2004.

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 corporation, 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 MD&A is as follows:

I. Executive Summary

We are the largest health benefits company in terms of commercial membership in the United States, serving 34.8 million medical members as of December 31, 2007. 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.

Operating revenue for the year ended December 31, 2007 was $60.1 billion, an increase of $4.0 billion, or 7%, over the year ended December 31, 2006. Operating revenue increases were primarily driven by premium rate increases in Local Group, growth in our State Sponsored business primarily due to the addition of five new states between the third quarter of 2006 and the first quarter of 2007, growth of our Medicare Advantage products and increased reimbursement in the Federal Employee Program, or FEP.

Our fully-diluted earnings per share, or EPS, was $5.56 for the year ended December 31, 2007, which included $0.01 per share from net realized investment gains, and was a 15% increase over the EPS of $4.82 for the year ended December 31, 2006, which included $0.04 per share in tax benefits resulting from a change in state tax apportionment factors. Net income for the year ended December 31, 2007 was $3.3 billion, an 8% increase over the year ended December 31, 2006.

Operating cash flow for the year ended December 31, 2007 was $4.3 billion, or 1.3 times net income. Operating cash flow for the year ended December 31, 2006 was $4.0 billion, or 1.3 times net income. The increase in operating cash flow from 2006 was driven primarily by higher net income in 2007.

We have successfully executed our strategy to deliver on our long-term goal of achieving at least 15% growth in EPS. We have accomplished this by focusing on profitable enrollment growth with innovative product

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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, including share repurchases.

We intend to continue expanding through a combination of organic growth, strategic acquisitions and capital 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.

II. Overview

We revised our reportable segments during the first quarter of 2007 consistent with changes made to our organizational structure, which reflected how the chief operating decision maker evaluated the performance of the business beginning January 1, 2007. Segment disclosures for 2006 and 2005 have been reclassified to conform to the 2007 presentation.

Through December 31, 2007, we managed our operations through three reportable segments: Consumer and Commercial Business, or CCB; Specialty, Senior and State Sponsored Business, or 4SB; and Other.

Our CCB segment includes business units which offer similar products and services, including commercial accounts and individual programs. CCB offers a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans. CCB also offers a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products. Additionally, CCB provides 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.

Our 4SB segment is comprised of businesses providing health and specialty products and services such as Medicare Part D, Medicare Advantage, Medicare Supplement, Medicaid, life and disability insurance benefits, pharmacy benefit management, or PBM, specialty pharmacy, dental, vision, behavioral health benefit services and long-term care insurance. 4SB also provides network rental and medical management services to workers compensation carriers.

The Other segment includes results from our Federal Government Solutions, or FGS, business and other businesses that do not meet the quantitative thresholds for an operating segment as defined in Statement of Financial Accounting Standards No. 131, *Disclosures about Segments of an Enterprise and Related Information*, or FAS 131, as well as intersegment sales and expense eliminations and corporate expenses not allocated to the other reportable segments. FGS business includes FEP and National Government Services, Inc. (which name changed from AdminaStar Federal, Inc. effective November 17, 2006), or NGS, which acts as a Medicare contractor in several regions across the nation.

On October 2, 2007, we announced a new organizational structure with new strategic business units: a Commercial Business unit and a Consumer Business unit that service different customer types (see *Membership* in this MD&A for a definition of our customer types discussed below). The Commercial Business unit includes Local Group customers, National Accounts, UniCare and Specialty business operations (dental,

vision, life and disability and workers compensation). The Consumer Business unit includes Senior, State Sponsored and Individual business. In addition, a new Comprehensive Health Solutions Business unit brings together our resources focused on optimizing the quality of health care and the cost of care management. The Comprehensive Health Solutions Business unit includes provider relations, care and disease management, behavioral health,

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employee assistance programs and our PBM business, which includes NextRx, and our specialty pharmacy, PrecisionRx Specialty Solutions. Our FGS business includes FEP and NGS, which acts as a Medicare contractor. This simplified, customer-focused structure builds on the strength of our commercial and consumer businesses, and will create additional opportunities for cross-selling medical and specialty products. These changes also emphasize our comprehensive approach to improving the quality, transparency and cost of health care for all of our customers. Our chief operating decision maker will assess performance under this new structure effective January 1, 2008 and, accordingly, we expect to revise our reportable segments in the first quarter of 2008. See Note 19 to our audited consolidated financial statements as of and for the year ended December 31, 2007 included in this Form 10-K.

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 disease 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 prices. 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 associate compensation expense. Examples of 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 and specialty pharmacy companies. 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 companies, 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 management programs. Several economic factors related to health care costs, such as regulatory mandates of coverage, technological advancements and the advancement in the delivery of medical services, as well as 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.

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This MD&A should be read in conjunction with our audited consolidated financial statements for the year ended December 31, 2007 included in this Form 10-K.

III. Significant Transactions

Stock Repurchase Program

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. The repurchases are effected from time to time in the open market, through negotiated transactions and through plans designed to comply with Rule 10b5-1(c) under the Exchange Act, as amended. During the year ended December 31, 2007, our Board of Directors authorized increases of $9.5 billion in our stock repurchase program, resulting in a total amount available for repurchases in 2007 and thereafter of $10.4 billion, which included $0.95 billion of authorization remaining unused at December 31, 2006. During the year ended December 31, 2007, we repurchased and retired approximately 76.9 million shares at an average share price of $79.99, for an aggregate cost of $6.2 billion. Therefore, as of December 31, 2007, $4.3 billion remained authorized for future repurchases. Subsequent to December 31, 2007, we repurchased and retired approximately 15.0 million shares for an aggregate cost of approximately $1.2 billion, leaving approximately $3.1 billion for authorized future repurchases at February 12, 2008. 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 Imaging Management Holdings, LLC

On August 1, 2007, we completed our acquisition of Imaging Management Holdings, LLC, or IMH, whose sole business is the holding company parent of American Imaging Management, Inc., or AIM. AIM is a leading radiology benefit management and technology company and provides services to us as well as other customers nationwide, including nine other Blue Cross and Blue Shield licensees. The acquisition supports our strategy to become the leader in affordable quality care by incorporating AIM s services and technology for more effective and efficient use of radiology services by our members. The purchase price for the acquisition was approximately $300.0 million in cash.

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 MDL 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, we paid $61.3 million in legal fees, including interest, on October 6, 2006. As a result of the MDL

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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 MDL 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 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, 2007 Compared to December 31, 2006

Our customer type definitions were revised in the first quarter of 2007 to be consistent with how we managed our business effective January 1, 2007. Prior periods have been reclassified to conform to the 2007 presentation. As of December 31, 2007, our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard, Senior, State Sponsored and FEP.

Local Group consists of those employer customers with less than 1,000 employees eligible to participate as a member in one of our health plans. In addition, Local Group includes customers with 1,000 or more eligible employees with less than 5% of eligible

employees located outside of the headquarter s state.

Individual consists of individual customers under age 65 and their covered dependents.

National Accounts customers are generally multi-state employer groups primarily headquartered in a WellPoint service area with 1,000 or more eligible employees, with at least 5% of eligible employees located outside of the headquarter s state. Some exceptions are allowed based on broker relationships. 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

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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 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.

FEP members consist of 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.

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 elect to retain most or all of the financial risk associated with their employees health care costs. Some self-funded customers choose to purchase stop-loss coverage to limit their retained risk.

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The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2007 and 2006. Also included below are key metrics from our Specialty business, 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.

(In thousands)	December 31 2007	2006	Change	% Change
Medical Membership				
Customer Type				
Local Group	16,663	16,766	(103)	(1)%
Individual	2,390	2,488	(98)	(4)
National Accounts[1]	6,389	6,136	253	4
BlueCard	4,563	4,279	284	7
Total National	10,952	10,415	537	5
Senior	1,250	1,193	57	5
State Sponsored	2,174	1,882	292	16
FEP	1,380	1,357	23	2
Total medical membership by customer type	34,809	34,101	708	2
Funding Arrangement				
Self-Funded	17,737	16,745	992	6
Fully-Insured	17,072	17,356	(284)	(2)
Total medical membership by funding arrangement	34,809	34,101	708	2
Reportable Segment				
Commercial and Consumer Business	30,005	29,669	336	1
Specialty, Senior and State Sponsored	3,424	3,075	349	11
Other	1,380	1,357	23	2
Total medical membership by reportable segment	34,809	34,101	708	2
Specialty Metrics				
PBM prescription volume[2]	391,480	392,668	(1,188)	
Behavioral health membership	20,230	16,937	3,293	19
Life and disability membership	5,598	5,970	(372)	(6)
Dental membership	5,014	5,270	(256)	(5)
Vision membership	2,401	1,536	865	56
Medicare Part D membership[3]	1,614	1,568	46	3

1 Effective January 1, 2007, we revised our definition of a National Account to include multi-state employers primarily headquartered in our service area with 1,000 or more eligible employees, of which at least 5% or more are located in a service area outside of the headquarter state. Previously a National Account was defined as a multi-state employer with 5,000 or more eligible employees.

2 Represents prescription volume for the years ended December 31, 2007 and 2006.

3 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, 2007, total medical membership increased approximately 708,000, or 2%, primarily due to increases in National, including BlueCard, and State Sponsored business partially offset by declines in Local Group and Individual membership.

Self-funded medical membership increased 992,000, or 6%, primarily due to an increase in self-funded National Accounts membership resulting from additional sales and in-group growth, BlueCard growth and the conversion of 144,000 members from the Connecticut Medicaid managed care program from fully-insured to self-funded during the fourth quarter of 2007.

Fully-insured membership decreased 284,000, or 2%, primarily due to Local Group decreases, including conversions to self-funded arrangements and in-group changes, as well as due to the conversion of the Connecticut Medicaid managed care program from fully-insured to self-funded. These decreases were partially offset by increases in State Sponsored business, whose growth was driven by the addition of two new states during 2007 and growth in existing markets.

Local Group membership decreased 103,000, or 1%, primarily driven by lapses and unfavorable in-group change in our non-BCBSA branded business.

Individual membership decreased 98,000, or 4%, due to decreases in certain BCBSA-branded regions as well as in UniCare due to competitive pricing pressures and competitive broker compensation programs in certain regions.

National Accounts membership increased 253,000, or 4%, primarily driven by in-group growth and additional sales as employers are increasingly attracted to the benefits of our distinctive value proposition, which includes extensive and cost-effective provider networks, wellness and care management programs and a broad and innovative product portfolio.

BlueCard membership increased 284,000, or 7%, representing increased sales and corresponding claims by non-affiliated BCBSA licensees accounts with members who reside in or travel to our licensed area.

Senior membership increased 57,000, or 5%, driven by growth in Medicare Advantage membership, partially offset by a slight decline in Medicare Supplement membership.

State Sponsored membership increased 292,000, or 16%, primarily due to the addition of 172,000 new members in two new states during 2007, as well as growth in existing programs.

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 decreased slightly by 1,188,000, primarily due to lower non-Part D utilization in our retail and mail-order PBM, partially offset by higher Part D utilization.

Behavioral health membership increased 3,293,000, or 19%, primarily due to the conversion of 2,882,000 members from a third-party vendor in April 2007 and growth in membership due to new sales of our behavioral health products.

Life and disability membership decreased 372,000, or 6%, primarily due to a general decrease in both life and accidental death and disability membership, as well as membership changes at a large automotive customer.

Dental membership decreased 256,000, or 5%, primarily due to the loss of the dental component within one of our State Sponsored plans and lapses due to a very competitive environment.

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Vision membership increased 865,000, or 56%, primarily due to the conversion of members over the last twelve months from a competing plan in Virginia to our Blue View Vision product as well as general growth of this new product.

Medicare Part D membership increased 46,000, or 3%, primarily due to growth in the Medicare Part D benefit component of our Medicare Advantage products.

V. Cost of Care

The following discussion summarizes our aggregate cost of care trends for the rolling 12 months ended December 31, 2007 for our Local Group and Individual fully-insured businesses only.

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, based on medical cost trends during the twelve months ended December 31, 2007, our aggregate 2007 cost of care trend was less than 8%.

Overall, our medical cost trend continues to be driven by unit costs. Inpatient hospital trend is in the mid-single digit range and is related to increases in cost per admission. Cost per admission is higher, due in part to the greater intensity of inpatient services as less intensive services are performed outpatient. Other drivers include negotiated rate increases with hospitals. However, we have noticed a slowing of the cost per admission trend in the latter part of 2007 due to our re-contracting and clinical management efforts. Utilization (admissions per 1,000 members) has been flat, while average length of hospital stay and hospital days per 1,000 members have both decreased slightly. Cost trend increases for outpatient services are in the upper-single digit range. Outpatient costs are a collection of different types of expenses, such as outpatient facilities, labs, x-rays, emergency room, and occupational and physical therapy. The increases are 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. We are continuing to develop plan designs to encourage appropriate utilization of outpatient services and 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. On August 1, 2007, we completed our acquisition of AIM. Incorporating their technology will allow us to achieve even greater efficiencies in this high trend area while ensuring that consumers receive the quality tests they need. Physician services trend is in the mid-single digit range and is about 65% cost driven and 35% utilization. Fee schedule changes are one of the drivers of these trends. We are collaborating with physicians to improve quality of care through pay-for-performance programs.

Pharmacy trend is in the upper-single digit range and is 60% unit cost (cost per prescription) related and 40% utilization (prescriptions per member per year) driven. The increased use of specialty drugs and higher mail order volume by our members were primary drivers of the higher unit cost trend. Specialty drugs, also known as biotech drugs, are generally higher cost and are being utilized more frequently. In October 2007, we announced the opening of our new PrecisionRx Specialty Solutions pharmacy in Indianapolis, Indiana, which manages over 1,000 different drugs for 14 diseases including hemophilia, multiple sclerosis, rheumatoid arthritis, psoriasis, hepatitis C and cancer. We have built a technologically advanced specialty pharmacy staffed with certified pharmacy technicians, registered nurses and clinical pharmacists to better manage both the quality and cost of care for our members. Higher mail order volume contributes to higher cost per prescription as mail order prescriptions are filled for a 90 day supply versus a 30 day supply for retail pharmacy prescriptions. These increases in unit costs were offset by increases in our generic usage rates, lower utilization resulting from higher mail order volume, benefit plan design changes, and improved pharmaceutical contracting. Higher mail order volume contributes to a lower number of prescriptions as one mail order prescription is filled for a 90 day supply versus three 30 day retail prescriptions.

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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 continue to expand *360º Health*, the industry s first 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.

VI. Results of Operations Year Ended December 31, 2007 Compared to the Year Ended December 31, 2006

Our consolidated results of operations for the years ended December 31, 2007 and 2006 are discussed in the following section.

	Year Ended December 31			
	2007	2006	$ Change	% Change
(In millions, except per share data)				
Premiums	$ 55,865.0	$ 51,971.9	$ 3,893.1	7%
Administrative fees	3,674.6	3,595.4	79.2	2
Other revenue	582.4	593.1	(10.7)	(2)
Total operating revenue	60,122.0	56,160.4	3,961.6	7
Net investment income	1,001.1	878.7	122.4	14
Net realized gains (losses) on investments	11.2	(0.3)	11.5	NM[1]
Total revenues	61,134.3	57,038.8	4,095.5	7
Benefit expense	46,036.1	42,191.4	3,844.7	9
Selling, general and administrative expense:				
Selling expense	1,716.8	1,654.5	62.3	4
General and administrative expense	6,984.7	7,163.2	(178.5)	(2)
Total selling, general and administrative expense	8,701.5	8,817.7	(116.2)	(1)
Cost of drugs	400.2	414.4	(14.2)	(3)
Interest expense	447.9	403.5	44.4	11
Amortization of other intangible assets	290.7	297.4	(6.7)	(2)
Total expenses	55,876.4	52,124.4	3,752.0	7
Income before income tax expense	5,257.9	4,914.4	343.5	7
Income tax expense	1,912.5	1,819.5	93.0	5
Net income	$ 3,345.4	$ 3,094.9	$ 250.5	8
Average diluted shares outstanding	602.0	642.1	(40.1)	(6)%
Diluted net income per share	$ 5.56	$ 4.82	$ 0.74	15%
Benefit expense ratio[2]	82.4%	81.2%		120bp[3]
Selling, general and administrative expense ratio[4]	14.5%	15.7%		(120)bp[3]
Income before income taxes as a percentage of total revenue	8.6%	8.6%		0bp[3]
Net income as a percentage of total revenue	5.5%	5.4%		10bp[3]

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

[1] NM = Not meaningful
[2] Benefit expense ratio = Benefit expense ÷ Premiums.
[3] bp = basis point; one hundred basis points = 1%.
[4] Selling, general and administrative expense ratio = Total selling, general and administrative expense ÷ Total operating revenue.

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Premiums increased $3.9 billion, or 7%, to $55.9 billion in 2007, driven by premium rate increases in Local Group, growth in our State Sponsored business primarily due to the addition of five new states between the third quarter of 2006 and the first quarter of 2007, growth in Medicare Advantage business and increased reimbursement in FEP.

Administrative fees increased $79.2 million, or 2%, to $3.7 billion in 2007, primarily due to self-funded membership growth in National, including BlueCard, and Local Group. 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 success of the BlueCard program.

Other revenue is comprised principally of co-payments and deductibles associated with the sale of mail-order prescription drugs by our PBM companies, which provide services to members of our CCB and 4SB segments and third party clients. Other revenue decreased $10.7 million, or 2%, to $582.4 million in 2007, primarily due to decreased prescription volume from third party customers in our mail-order PBM business, partially offset by continued growth in specialty pharmacy prescription volume.

Net investment income increased $122.4 million, or 14%, to $1.0 billion in 2007 primarily resulting from higher yields and growth in invested assets driven by reinvestments of cash generated from operations. This growth was partially offset by the use of cash for repurchases of our common stock.

A summary of our net realized gains (losses) on investments for the years ended December 31, 2007 and 2006 is as follows:

	Years Ended December 31		
(In millions)	**2007**	**2006**	**$ Change**
Net realized gains (losses) from the sale of fixed maturity securities	$ 11.5	$ (47.9)	$ 59.4
Net realized gains from the sale of equity securities	254.2	98.5	155.7
Other-than-temporary impairments credit related	(113.4)	(32.5)	(80.9)
Other-than-temporary impairments interest rate related	(146.3)	(23.7)	(122.6)
Other realized gains	5.2	5.3	(0.1)
Net realized gains (losses)	$ 11.2	$ (0.3)	$ 11.5

Net realized gains on investments in 2007 were primarily driven by sales of equity securities at a gain, partially offset by other-than-temporary impairments of fixed maturity securities due to rising interest rates and impairments of equity securities. See *Critical Accounting Policies and Estimates* in this MD&A for a discussion of our investment impairment review process.

Net realized losses on investments in 2006 related primarily to the sale of fixed maturity securities at a loss and other-than-temporary impairments, partially offset by the sale of equity securities at a gain.

Benefit expense increased $3.8 billion, or 9%, to $46.0 billion in 2007, primarily due to higher cost in the 4SB segment and medical cost trend in the CCB segment. Benefit expense for the 4SB segment increased primarily due to growth in State Sponsored business with the addition of five new states between the third quarter of 2006 and the first quarter of 2007, as well as growth in our Medicare Advantage business. Benefit expense in the CCB segment increased primarily due to medical cost trend in Local Group business. Lastly, continued increased trend in FEP business resulted in higher benefit expense, for which we are reimbursed for the cost plus a fee.

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Our benefit expense ratio increased 120 basis points to 82.4% in 2007, primarily related to the medical business of the 4SB segment and, to a lesser extent, the CCB segment, including a business mix shift resulting from a decline in Individual membership. The increase in 4SB s benefit expense ratio resulted from higher trend in State Sponsored business and Medicare Advantage. The benefit expense ratio of State Sponsored business was unfavorably impacted by a higher benefit expense ratio in the Ohio Covered Families & Children s Medicaid program and the Connecticut Medicaid program in 2007 compared to the prior year. In January 2008, we notified the state of Ohio that we will terminate participation in the Ohio Medicaid program by March 31, 2008 as we were unable to reach an agreement to service these members in a financially responsible manner. In addition, the Connecticut Medicaid program was fully-insured through November 30, 2007 and converted to self-funded business effective December 1, 2007. The current self-funded arrangement with the Connecticut Medicaid program will expire on March 31, 2008 and we are in negotiations with the state on extending the contract.

Selling, general and administrative expense decreased $116.2 million, or 1%, to $8.7 billion, primarily due to lower salary and benefit costs including performance-based incentive compensation, partially offset by higher costs associated with growth of our business. Our selling, general and administrative expense ratio decreased 120 basis points to 14.5%. This decrease in our selling, general and administrative expense ratio was primarily due to growth in operating revenue and further leveraging of general and administrative costs over a larger membership base.

Cost of drugs decreased $14.2 million, or 3%, to $400.2 million in 2007. This decrease was primarily attributable to decreased PBM mail-order prescription volume from our third party customers and higher utilization of generic prescription drugs, partially offset by higher specialty pharmacy prescription volume.

Interest expense increased $44.4 million, or 11%, to $447.9 million in 2007, primarily due to the issuance of approximately $2.0 billion of long-term debt in 2007.

Amortization of other intangible assets decreased $6.7 million, or 2%, to $290.7 million in 2007, primarily due to certain intangibles amortizing on an accelerated amortization schedule over their estimated life, which resulted in greater expense in earlier periods.

Income tax expense increased $93.0 million, or 5%, to $1.9 billion in 2007. The effective tax rate declined 60 basis points to 36.4% in 2007. The 2006 effective tax rate of 37.0% included a reduction of 60 basis points due to a $28.0 million tax benefit that was recognized in 2006 resulting from lower effective state tax rates. In addition, the 2007 effective tax rate was favorably impacted by various tax settlements.

Our net income as a percentage of total revenue was 5.5% in 2007 compared to 5.4% in 2006, which reflects a combination of all of the factors discussed above.

Reportable Segments

We use operating gain to evaluate the performance of our reportable segments. Effective January 1, 2007 through December 31, 2007, and in accordance with FAS 131, our reportable segments were CCB, 4SB 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, 2007

and 2006 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. Our reportable segments results of operations for 2006 have been reclassified to conform to the 2007 presentation.

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CCB

Our CCB segment s summarized results of operations for the year ended December 31, 2007 and 2006 are as follows:

	Year Ended December 31			
	2007	2006	$ Change	% Change
(In millions)				
Operating revenue	$ 42,122.0	$ 40,602.6	$ 1,519.4	4%
Operating gain	$ 3,999.7	$ 3,679.5	$ 320.2	9%
Operating margin	9.5%	9.1%		40bp

Operating revenue increased $1.5 billion, or 4%, to $42.1 billion in 2007, primarily due to premium rate increases across all lines of business, partially offset by membership declines in Local Group and a shift in the mix of business from fully-insured to self-funded.

Operating gain increased $320.2 million, or 9%, to $4.0 billion in 2007 driven by disciplined pricing as operating revenue growth outpaced increased benefit expense, primarily in Local Group. In addition, selling, general and administrative expense decreased in 2007 driven by lower performance-based incentive compensation.

The operating margin in 2007 was 9.5%, a 40 basis point increase primarily due to the factors discussed in the preceding two paragraphs.

4SB

Our 4SB segment s summarized results of operations for the year ended December 31, 2007 and 2006 are as follows:

	Year Ended December 31	
	2007	2006