WELLPOINT, INC
Form 10-K
February 20, 2014

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, 2013
OR

o 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	35-2145715
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
120 MONUMENT CIRCLE INDIANAPOLIS, INDIANA	46204
(Address of principal executive offices)	(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 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 whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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. x
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 the 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 28, 2013 was approximately $24,439,366,963.

As of February 7, 2014, 282,459,121 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 14, 2014.

WellPoint, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2013

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words "may," "will," "should," "anticipate," "estimate," "expect," "plan," "believe," "feel," "predict," "project," "potential 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 that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. 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, and its direct and indirect subsidiaries, as the context requires.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 35.7 million medical members through our affiliated health plans and more than 67.8 million individuals through all subsidiaries as of December 31, 2013. 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. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New York, Tennessee, Texas and Washington. Amerigroup also provided services in the state of Ohio through June 30, 2013 and in the state of New Mexico through December 31, 2013. We also serve customers throughout the country as HealthLink, UniCare and in certain Arizona, California, Nevada, New York and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

We have a vision of becoming America's valued health partner. Together we are transforming health care with trusted and caring solutions and as a result, we focus on delivering quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

•Accountable
•Caring
•Easy to do business with
•Innovative
•Trustworthy

We offer a broad spectrum of network-based managed care health benefit plans to the large and small employer, individual, Medicaid and Medicare 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; and 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, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as behavioral health benefit services, dental, vision, life and disability insurance benefits, radiology benefit management, analytics-driven personal health care guidance and long-term care insurance. We also provide services to the Federal Government in connection with the Federal Employee Program, or FEP, and various Medicare programs. Finally, prior to January 31, 2014, we sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business. In preparation for the coming changes to the health care system and to focus on our core growth opportunities across our Commercial and Specialty Business and Government Business segments, we entered into a definitive agreement in December 2013 to sell our 1-800 CONTACTS subsidiary to the private equity firm Thomas H. Lee Partners, L.P. Concurrently, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets. The divestitures were completed on January 31, 2014.

The increased focus on health care costs by employers, the government and consumers has continued to drive 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 high quality 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 health care system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may 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, prepaid premiums and generally pay co-payments, coinsurance and/or 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, but often offer more generous benefit coverage. 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.

Economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger, more extensive networks, more member choice related to coverage, physicians and hospitals, and a desire for greater flexibility for customers to assume larger deductibles and co-payments in return for lower premiums. CDHPs, which are relatively high deductible PPO products and are often paired with some type of member tax-advantaged 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.

For our fully-insured products, we charge a premium and assume all 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. In addition, we charge a premium to provide administrative services to large group employers that maintain self-funded health plans and we underwrite stop loss insurance for self-funded plans.

Our medical membership includes seven different customer types:

- Local Group
- Individual
- National Accounts
- BlueCard®
- Medicare
- Medicaid
- FEP

BCBS-branded business generally refers to members in our service areas licensed by the BCBSA.

Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup and CareMore plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, 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 types. Overall, we seek to establish pricing and product designs to achieve an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the individual and small group markets we offer on-exchange products through state or federally facilitated marketplaces and off-exchange products. Federal premium subsidies are available only for certain on-exchange individual products.

Each of the BCBS member companies, of which there were 37 independent primary licensees as of December 31, 2013, 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 member company is able to take advantage of other BCBS licensees' substantial provider networks and discounts when any BCBS 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 when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Form 10-K.

Our results of operations depend in large part on accurately predicting health care costs and our ability to manage future health care costs through adequate product pricing, 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. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs 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. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the U.S. Congress passed and the President signed into law the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, which represents significant changes to the U.S. health care system. The legislation is far-reaching and is intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States and the continuing modification and interpretation of Health Care Reform's rules, we continue to analyze the impact and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. A list of certain material changes resulting from Health Care Reform include:

- Requirements to modify our products to cover essential health benefits and comply with other defined criteria;
- Requirement to cancel existing products and enroll new and renewing members in the new ACA-compliant products;
- Introduction of exchanges, subsidies and mandates to require and allow previously uninsured customers to enter the market; and
- Significant new taxes and fees which will be paid by health insurers, and which may or may not be passed through to customers.

The above changes resulting from Health Care Reform will provide growth opportunities for health insurers, but also introduce new risks and uncertainties, and require changes in the way products are designed, underwritten, priced, distributed

and administered.

For additional discussion, see “Regulation,” herein and Part I, Item 1A “Risk Factors” in this Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership. In recent years, we experienced significant membership declines due to unfavorable economic conditions driving increased unemployment. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. These membership trends could have a material adverse effect on our future results of operations. See Part I, Item 1A “Risk Factors” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Form 10-K.

We continue to believe health care is local and feel that we have the strong local presence required to understand and meet local customer needs. We believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has 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. We believe that an essential ingredient for practical and sustainable improvements in health care is raising health care quality while managing costs for total cost affordability. We have identified initiatives that we believe will deliver better health care while reducing costs. These include driving innovation in paying and partnering with providers to compel improved cost, quality and health along with finding new, effective ways to manage risk and engage the member as a consumer. In addition, we seek to achieve efficiencies from our national scale while optimizing service performance for our customers. Finally, we seek to continue to rationalize our portfolio of businesses and products, and align our investments to capitalize on new opportunities to drive growth in both our existing and new markets in the future.

We continue to enhance interactions with customers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementation of advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

We intend to continue pursuing our vision of becoming America's valued health partner by transforming health care with trusted and caring solutions and by delivering quality products and services that give members access to the care they need. At the same time, we will focus on earnings per share, or EPS, growth through organic membership gains, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

The more significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Use of Capital—Board of Directors declaration of dividends on common stock (2013, 2012 and 2011) and a 16.7% increase in the quarterly dividend to $0.4375 per share (2014); authorization for repurchases of our common stock (2013 and prior); and debt repurchases and new debt issuance (2013 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012);
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014);
- Acquisition of CareMore (2011);
- Sale of our pharmacy benefits management, or PBM, business to Express Scripts, Inc., or Express Scripts (2009); and
- Acquisition of DeCare Dental, LLC, or DeCare (2009).

For additional information regarding certain of these transactions, see Note 3, “Business Acquisitions and Divestitures,” Note 13, “Debt,” and Note 15, “Capital Stock,” to our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

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, the impact of Health Care Reform, and increased quality awareness and price sensitivity among customers.

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

- quality of service;
- price;
- 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 and we have made significant investments in technology to enhance our electronic interaction with providers, 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. Our provider networks in our markets enable us to achieve efficiencies and distinctive 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.

Pricing in our Commercial and Specialty Business segment (defined below), including our individual and small group lines of business, remains highly competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. The ultimate level of exchange enrollment cannot be predicted and although it is not yet clear whether our products sold on the exchanges will be more or less profitable products, we believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

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.

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 the quality and price of our products, support services, reputation and 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 those of our competitors in all of our markets. Typically, we are the largest competitor in each of our Blue-branded markets and, thus, are a closely watched target by other insurance competitors.

Reportable Segments

On May 20, 2013, we announced certain organizational and executive leadership changes to align with how our new Chief Executive Officer is managing our operations. Beginning with the three months ended June 30, 2013, our organizational structure is comprised of three reportable segments: Commercial and Specialty Business; Government Business; and Other. Prior period segment information has been reclassified to conform to the new segment reporting structure.

Our Commercial and Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial and Specialty Business segment includes Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured products; 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, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as behavioral health benefit services, dental, vision, life and disability insurance benefits, radiology benefit management, analytics-driven personal health care guidance and long-term care insurance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the Federal Government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement, while Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid, state Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Through our participation in various federal government programs, we generated approximately 20.3%, 23.7% and 23.5% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2013, 2012 and 2011, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues are derived from activities outside of the U.S.

For additional information regarding the operating results of our segments, see Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 20, "Segment Information," to our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

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, which may result in tax benefits to the employee. 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, PPO 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.

ACA On- and Off-Exchange Products: ACA requires the modification of existing products and development of new products to meet the requirements of the legislation. Individual and small group products must cover essential health benefits as defined in ACA along with many other requirements and cost sharing changes. Individual and small group products offered on and off the exchanges must meet the definition of the “metal” product requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating on exchanges must offer at least one silver and one gold product.

In our individual markets we offer bronze, silver and gold products, both on and off the exchanges, in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the exchanges, in the states of California and New York.

In our small group markets, we offer bronze, silver and gold products, both on and off the exchanges, in the states of Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia and we offer bronze, silver and gold products, off the exchanges, in the states of California, New York and Wisconsin. Additionally, we offer platinum products, off the exchanges, in the states of California, Connecticut, Georgia, Maine and Virginia.

Administrative 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 cost management, disease management, wellness programs, claims processing and other 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 from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare 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 special needs 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. In addition, our Medicare Advantage special needs plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual eligible customers, who are low-income seniors and persons under age 65 with disabilities who are enrolled in both Medicare and Medicaid plans. Medicare Part D offers a prescription drug plan to Medicare and dual eligible (Medicare and Medicaid) beneficiaries. We offer these plans to customers through our health benefit subsidiaries throughout the country, including Amerigroup and CareMore.

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 uninsured younger individuals between the ages of 19 and 29, families, those

transitioning between jobs or early retirees. Individual policies are generally sold through independent agents and brokers, retail

partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through state or federally facilitated marketplaces and off-exchange products. Federal premium subsidies are available only for certain on-exchange products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded health care programs, including Medicaid, CHIP, and Medicaid expansion programs. The Medicaid program makes federal matching funds available to all states for the delivery of health care benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. CHIP is a state and federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. Our Medicaid plans also cover certain dual eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other State-Sponsored services in California, Florida, Georgia, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin and began providing Medicaid services in Kentucky on January 1, 2014. Amerigroup also provided services in the state of Ohio through June 30, 2013 and in the state of New Mexico through December 31, 2013.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug products to Express Scripts under a ten year contract, excluding Amerigroup and certain self-insured members, which have exclusive agreements with different PBM service providers, provided however that Amerigroup will be transitioning to the Express Scripts agreement during 2014. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions and set drug benefit design strategy and provide front line member support.

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 and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, 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.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer leading evidence-based and analytics-driven personal health care guidance. These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs.

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 a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other health care plans to assist those plans in providing dental benefits to their customers.

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

basis. In addition to vision plans, we sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS subsidiary which we divested on January 31, 2014.

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 Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor 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.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead and transform our health care system from our current fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish “market-based” hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care received by our members. Increasingly, we are supplementing our broad based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as health care exchange customers.

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, but as noted above, and more fully described below, we are transitioning to a value-based payment program. More traditional physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including the Centers for Medicare & Medicaid Services, or CMS, resource-based relative value system, or RBRVS, 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 major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay for performance”, which ties physician payment levels to performance on clinical measures.

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.

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 reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, 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 include a “pay for performance” component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Fee-for-service currently remains our predominant reimbursement methodology for physicians, but as noted above, we are rapidly transitioning to value-based payment programs. Though fee-for-service or fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost. We launched the most significant of these efforts, our Enhanced Personal Health Care program, in the fourth quarter of 2012. This program augments traditional fee-for-service with a shared savings program that allows participating providers to share in any achieved savings, when actual health care costs are below projected costs, provided that they meet threshold performance on quality measures. The quality measures are based on nationally accepted, credible standards (e.g. NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We combine this payment model with a highly collaborative relationship approach under which we give participating providers the tools and information they need to proactively manage the health of their patient population, improve health outcomes and reduce the cost associated with preventable medical events. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit, fostering a move away from episodic visit-based interventions to a proactive patient engagement and coordinated care model. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering nearly 25% of our primary care physicians and have rolled this program out in all 14 of our Commercial and Specialty Business markets. Thereafter, through 2015, we intend to continue to expand the breadth of our programs in each market by adding additional physicians until the majority of physicians participate in a value-based payment program.

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. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate location.

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. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic testing, addressing an area of historically significant cost trends. Through our American Imaging Management Specialty Health subsidiary we promote appropriate, safe and affordable member care in imaging as well as oncology, sleep management and specialty pharmacy benefits. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient’s hospital stay are reviewed, at times 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. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their health care needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home.

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 Prevention 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 and patient 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, evidence-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.

Estimate Your Cost & Anthem Care Comparison: These health care provider comparison tools disclose typical cost estimates and quality data for common services at contracted providers, with cost estimates accounting for facility, professional and ancillary services. The cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 350 procedures in 49 states. The Estimate Your Cost tool also includes member out-of-pocket cost estimates based on a member's own benefit coverage, deductible, and out of pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based health care decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a transparency and consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include member and physician messaging, providing access to evidence-based medical guidelines, physician quality profiling, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of health care services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for health care support and we have been unable to reach them. This caring team of professionals also supports our members with our shared decision making support portfolio.

Care Management Programs

We continue to expand our 360º Health suite of integrated care management programs and tools. 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 adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, 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. We also offer members infertility consultation through our SpecialOffers@Anthem program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

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 also includes a referral process to the nearest urgent care facility, a robust audiotape library, accessible by phone, with more than 400 health and wellness 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 help our members 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. Key opportunities are also shared with physicians through Availity® at the time of membership eligibility verification. Availity® is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

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.

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.

Employee Assistance Programs provide many resources that allow members to balance work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available in person as well as via telephone or internet are counseling for child care, health and wellness, financial issues, legal issues, adoption and daily living.

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 Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into the NCQA's accreditation processes. 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 health plans, NCQA's highest accreditation status of Excellent 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. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

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 23 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 BCBSA licensed 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. In addition, HealthCore works closely with government entities, including the Food and Drug Administration and the Centers for Disease Control and Prevention, on initiatives aimed at improving healthcare safety and enhancing national safety surveillance capabilities.

Our wholly-owned specialty benefit management subsidiary, AIM Specialty Health, or AIM, has supported quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals and oncology, including drugs covered under medical benefit and radiation therapy. These programs, based on widely accepted clinical guidelines, promote the most appropriate use of diagnostic and therapeutic services to improve the quality of overall health care delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physicians at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost effective medical care. In addition, AIM radiology, cardiology, sleep medicine, radiation therapy, network assessment and member engagement solutions have been evaluated as quality improvement expenses under the National Association of Insurance Commissioners, or NAIC, medical loss ratio, or MLR, regulations. Fees for these programs can be included in calculations of a health plan's MLR.

Our wholly-owned analytics-driven personal health care guidance subsidiary, Resolution Health, Inc., has supported quality by helping our members take action to get healthy, stay healthy and better manage chronic illness. Our analysis of an individual member's health data identifies opportunities to improve health care quality and safety; we then send personalized messages to the member, their doctor and care manager to take action. For example, our drug safety messages inform a member's doctor, pharmacist or care manager of potentially dangerous drug-drug, drug-condition, drug-age, or drug-dose interactions identified in our Drug Safety Scan. This helps improve safety, drug effectiveness and medication adherence.

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, including charges for new ACA taxes and fees. 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, disciplined underwriting standards. We employ our proprietary accumulated actuarial data in determining underwriting and pricing parameters. Where allowed by law and regulation, we underwrite 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. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA Licenses

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 assigned geographic territories. 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 are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational and financial standards set forth in the licenses. 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. See Part I, Item 1A “Risk Factors” in this Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. health care system have been and will continue to be significantly affected by Health Care Reform. 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;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

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

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, Health Care Reform has resulted in increased federal regulation that is likely to have a significant impact on our business. These laws and regulations, which vary significantly from state to state and on the federal level, 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:

- medical loss ratios;
- tax deductibility of certain compensation and Health Care Reform related fees;
- licensure;
- premium rates;
- benefits;
- eligibility requirements;
- guaranteed availability and renewability;
- service areas;
- market conduct;
- sales and marketing activities, including use and compensation of brokers and other distribution channels;
- quality assurance procedures;
- plan design and disclosures, including mandated benefits;
- underwriting, marketing, pricing and rating restrictions for insurance products;

- utilization review activities;
- prompt payment of claims;
- member rights and responsibilities;
- collection, access or use of protected health information;
- data reporting, including financial data and standards for electronic transactions;
- payment of dividends;
- provider rates of payment;
- surcharges on provider payments;
- provider contract forms;
- provider access standards;
- premium taxes, assessments for the uninsured and/or underinsured and insolvency guaranty payments;
- member and provider complaints and appeals;
- 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 state and federal laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

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. See Part I, Item 1A “Risk Factors” in this Form 10-K.

Patient Protection and Affordable Care Act

The ACA, signed into law on March 23, 2010, has created significant changes and will continue to create significant changes for health insurance markets for the next several years. Specifically, many of the near-term changes were effective for certain groups and individuals on their first renewal on or after September 23, 2010, including a prohibition on lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits, pre-existing condition exclusions for children, increased restrictions on rescinding coverage and extension of coverage of dependents to the age of 26. Certain requirements for insurers were also effective in 2011, including changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of new insurance exchanges for individuals and small groups, the availability of premium subsidies for certain individual products, and substantial expansions in eligibility for Medicaid.

Despite significant preparation for the advent of the new federal and state health insurance exchanges, there have been many technical difficulties in the implementation of the exchanges, which entail uncertainties associated with mix and volume of business. In November 2013, CMS notified the various state Insurance Commissioners that, under a transitional policy, health insurance coverage in the individual or small group market that is renewed for a policy year starting between

January 1, 2014 and October 1, 2014 that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform will nonetheless not be considered by CMS to be out of compliance with respect to such market reforms provided certain conditions are met. CMS further encouraged state agencies responsible for enforcing the specified market reforms to adopt the same transitional policy with respect to this coverage. Some states have adopted the transitional policy, some have not adopted it and yet others have not taken a position.

Due to the impact of the transitional policy, we may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants in the exchange markets. In addition, the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform, or Health Care Reform Premium Stabilization Programs, established to apportion risk amongst insurers, may not be effective in appropriately mitigating the financial risks related to our exchange products. These factors, along with the limited information about the individuals who have access to these newly established exchanges that was available when we established premiums, may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, there have been other material changes and delays in the implementation of ACA that could have a material adverse effect on our results of operations, financial position, and cash flows. These include:

- Delay in the effective date of the employer mandate from 2014 to 2015;
- Extension of the 2013 open enrollment period to December 23, 2013 for a January 1, 2014 effective date;
- Delay of the commencement of the 2014 open enrollment period from October 15 to November 15 through January 15, 2015;
- Changes to the annual fees on health insurance companies;
- Deferral of the online Small Business Health Options Program (SHOP) enrollment capabilities; and
- Other yet to be announced changes and delays.

These delays and changes may have a material and significant impact on anticipated enrollment in on- and off-exchange products, thus affecting the risk pools and premium rates. The technical difficulties in implementing exchanges have impacted the sharing of enrollment information between the federal government and health insurers and will significantly delay payment and subsidies to insurers. Finally, implementation of ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

ACA continues to require additional guidance and specificity to be provided by the Department of Health and Human Services, or HHS, the Department of Labor, CMS and the Department of the Treasury. These regulatory agencies continue to consider recommendations from external groups, such as the NAIC. Many provisions have final rules available for review while some proposed regulations have been released for comment or have yet to be released and others are in-process. Of particular note is the yet to be issued regulation pertaining to administrative simplification to create uniformity in implementing electronic standards. We continue to carefully evaluate each rule as it is issued; and, therefore, it continues to be too early to fully understand the impacts of the legislation on our overall business.

Some of the more significant considerations of ACA are described below:

- MLR regulations were issued by HHS in December 2011; however, significant changes could still occur to the MLR requirements through additional regulatory guidance and/or modification of the regulation. The minimum MLR thresholds by line of business, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. Certain other states have received approval from HHS to phase-in the MLR requirements in the Individual markets in those states and, as a result, are currently using lower thresholds for determination of potential rebates. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various state and federal regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Significant changes to the MLR requirements may occur through additional regulatory action by HHS.

Approximately 63.1% and 27.3% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2013. Approximately 74.4% and 28.5% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2012. Beginning with rebates paid in 2014 for the 2013 benefit year, MLR rebates will be based on a three year average. This calculation will determine an average MLR for each market segment within each state for the previous three calendar years. Additionally, insurers will be able to adjust experience to account for prior MLR rebates refunded to groups or individuals. Once the three year average MLR is calculated and compared to the minimum MLR threshold, the rebate percentage will be applied to current year premiums as defined by Health Care Reform. Beginning with MLR rebates paid in 2015 for the 2014 benefit year, insurers will adjust for the Health Care Reform Premium Stabilization Programs.

Health Care Reform also imposes a separate minimum MLR threshold of 85% for Medicare Advantage plans beginning in 2014. Medicare Advantage plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

- ACA required states to establish health insurance exchanges by January 1, 2014 through which qualified individuals and qualified small employers may access coverage. If a state failed to establish a health insurance exchange, the federal government established a health insurance exchange in that state. To date sixteen states plus the District of Columbia have elected to operate state-based exchanges. The remaining states have either a federal partnership exchange (seven states) or a federally operated exchange (twenty-seven states). In the states in which we offer products on exchanges, six states have passed legislation or executive orders establishing state-based health insurance exchanges (California, Colorado, Connecticut, Kentucky, Nevada and New York).

- ACA requires the modification of existing products and development of new products to meet the requirements of the legislation. Products must cover essential health benefits as defined in ACA along with many other requirements and cost sharing changes. Health insurers must offer individual and small group products that meet the definition of the "metal" requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating in exchanges must offer at least one silver and one gold product. Additionally, effective January 1, 2014, health insurers were required to cancel or discontinue the sale of existing non-ACA-compliant individual and small group products, subject to the conditions of the November 2013 CMS transitional policy discussed above.

- Regulations became effective in September 2011 that require filings for premium rate increases for small group and individual products above specified thresholds, generally 10%, to be reviewed. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program, in which case HHS will conduct the reviews for any rate increase filed.

- The Health Care Reform Premium Stabilization Programs introduce new requirements to the MLR calculation, beginning with the 2014 benefit year for the individual and small group markets. The risk adjustment program is a permanent program that transfers dollars from insurers who enroll individuals with lower relative health risk to insurers who enroll individuals with higher relative health risk. Risk adjustment payments/receipts will be determined separately for each state and for individual and small group. The second premium stabilization program is the transitional reinsurance program, a temporary program that runs from 2014 through 2016. The transitional

reinsurance program is intended to help stabilize premiums by reimbursing issuers of ACA-compliant non-grandfathered individual market plans for eligible claims between a defined attachment point and ceiling, at a coinsurance rate defined by HHS. The program will be funded through assessments per covered enrollee upon the commercial health insurance market and sponsors of self-funded health benefit plans of approximately $12.0 billion, $8.0 billion and $5.0 billion in 2014, 2015 and 2016, respectively. The final premium stabilization program is the temporary risk corridors program, also a three year program through 2016, that protects insurers from inaccurate pricing of individual and small group qualified health plans and substantially similar off-exchange products.

Beginning in 2014, MLR rebate calculations will be adjusted to reflect the Health Care Reform Premium Stabilization Programs. To determine an insurer's MLR, the numerator of the MLR will be reduced by receipts from the risk adjustment, reinsurance, and risk corridors programs, or increased by payments from the risk adjustment and risk corridors programs. The denominator of the MLR formula will be reduced by reinsurance contributions. This adjusted insurer-specific MLR will then be compared to the minimum MLR threshold for each line of business. The Health Care Reform Premium Stabilization Programs are not applicable to Large Group business.

- Through December 31, 2013 and depending on the laws in each state, health insurers were allowed to consider factors such as health status, gender and age in determining the appropriate premium for products in the individual and small group markets. Some states have adopted rules that limit the variation between the highest and lowest premium for the identical insurance policy. The differential in pricing is commonly referred to as "rating bands". The process of using these rating bands allows health insurers to appropriately price for products and to spread the risk more broadly across all policyholders. Except for policies issued under the CMS transitional policy, beginning in 2014, ACA precludes health insurers from using health status and gender in the determination of the appropriate insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and the rating bands for tobacco use cannot vary by more than 1.5 to 1. This change will likely have a significant impact on the majority of individual and small group customers and could lead to adverse selection in the market.
- In 2014 significant new taxes and fees will be paid by health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual fee on health insurance companies. For 2014, a total of $8.0 billion will be collected from all health insurance companies to which the annual fee is assessed. The annual fee is $11.3 billion for 2015 and 2016, $13.9 billion for 2017 and $14.3 billion for 2018. For 2019 and beyond, the annual fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year. The annual fee will be allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business during the preceding calendar year.
- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to a new payment formula promulgated by ACA that is expected to significantly reduce reimbursements in the future. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, including the Medicare Advantage MLR, evolving methodology for ratings and quality bonus payments and potential action on an audit methodology to review data submitted under "risk adjuster" programs.

In June 2012, the U.S. Supreme Court issued a decision affirming that the majority of the provisions of the ACA were constitutional. However, the provision of the ACA related to the mandatory expansion of state Medicaid programs was declared unconstitutional. Several cases pertaining to the constitutionality of the contraceptive mandate are currently pending before the U.S. Supreme Court and will likely be heard and decided during the coming year. Other pending cases pertain to challenges to the premium tax subsidies and whether the subsidies are available for eligible residents in all states or only those residents in states which have established state-based exchanges. In January 2014, the D.C. District Court upheld the subsidies for both state-based and federal exchanges and an appeal is anticipated.

Dodd-Frank Wall Street Reform and Consumer Protection Act

During 2010, the U.S. Congress passed and the President signed into law the Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act. The Dodd-Frank Act represents a far-reaching overhaul of the framework for the U.S. financial services industry. Even though we are primarily a health benefits company, our business has been impacted by the Dodd-Frank Act. Many of its provisions require the adoption of rules for implementation, including those that govern which non-bank financial companies may become subject to the oversight of the Federal Reserve. These non-bank financial companies are defined as those that could pose a threat to

the economy’s financial stability either due to the

potential of material financial distress at the company or due to the company's ongoing activities. While we are not currently considered a non-bank financial company for purposes of Federal Reserve oversight, future regulations or interpretations could change that result. Further, our investments in derivative instruments are subject to new rules regarding the reporting and clearing of transactions and new margin requirements.

In addition, the Dodd-Frank Act creates a Federal Insurance Office, with limited powers that include information-gathering and subpoena authority. Although the Federal Insurance Office does not have authority over health insurance, it may have authority over other parts of our business, such as life insurance.

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 renewability of health care coverage for most group health plans and certain individuals. Also, the law limits exclusions based on preexisting medical conditions.

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. Additional federal privacy and security requirements, including breach notification, improved enforcement and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations.

CMS posted the Interim Final Rule with Comment, or IFC, adopting operating rules for two electronic transactions: eligibility for a health plan and health care claims status. Based on the comments received on the IFC, CMS has decided not to change any of the policies established in the rule. Thus, the interim final rule became the final rule. The rule had a January 1, 2013 compliance date and we believe we have effectively complied with the requirements of the new rule.

In addition, there are proposed regulations on the HIPAA Privacy Accounting of Disclosures provisions and the HIPAA Security Rule that will greatly increase our administrative costs if they are enacted as proposed.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires 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. In addition, a number of states have adopted data security laws and/or regulations, regulating data security and/or requiring security breach notification, which may apply to us in certain circumstances.

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 that 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 and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

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 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.

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. 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. As of December 31, 2013, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

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. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder assessments.

States' adoption of the revised NAIC Model Guaranty Fund Act will tend to decrease our liability for insolvent insurers. The revised act reduces the premium base on which assessments are calculated, by omitting Medicare Parts C and D premium from the assessment base.

While the amount and timing of any future assessments 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 with the exception of potential exposure related to the Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company insolvency as discussed in Note 14, "Commitments and Contingencies", to our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

Employees

At December 31, 2013, we had approximately 48,200 employees. 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.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.wellpoint.com. We have included our Internet website address throughout this Annual Report on Form 10-K as textual reference only. The information contained on our Internet website is not incorporated into

this Annual Report on Form 10-K. We make available, free of charge, by mail 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 Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. WellPoint, Inc. is an Indiana corporation incorporated on July 17, 2001.

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.

Federal Health Care Reform legislation, together with the changes in federal and state regulations that have been enacted to implement Health Care Reform, could adversely affect our business, cash flows, financial condition and results of operations.

The passage of Health Care Reform during 2010 and subsequent regulations represent significant changes to the U.S. health care system. The legislation is far-reaching and is intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. The legislation includes a requirement that most individuals obtain health insurance coverage beginning in 2014. In addition, the new laws impose significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants. Health Care Reform imposes an annual industry-wide $8.0 billion health insurer fee beginning in 2014 and growing to $14.3 billion by 2018 and increasing annually thereafter. This health insurance fee is not deductible for income tax purposes and will be allocated pro rata among us and other industry participants based on net premiums written. Health Care Reform also imposes industry-wide reinsurance assessments of $12.0 billion, $8.0 billion and $5.0 billion in 2014, 2015 and 2016, respectively. Insurance companies will pay the fees based upon insured members whereas self-insured entities will pay them directly to HHS. As we are one of the nation's largest health benefits companies, we expect our share of the Health Care Reform fees, assessments and taxes to be significant. There is some uncertainty whether we will be able to include all or a portion of these fees, assessments and taxes in our premium rates.

Health Care Reform also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements, prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members, increased restrictions on rescinding coverage, establishment of minimum MLR and customer rebate requirements, creation of a federal rate review process, a requirement to cover preventive services on a first dollar basis, the establishment of insurance exchanges and essential benefit packages and greater limitations on how we price certain of our products. The legislation also reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time. There are also limitations on the amount of compensation that is deductible for income tax purposes.

The legislation also contains risk adjustment provisions applicable to the individual and small group markets that take effect in 2014. These risk adjustment provisions will effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against adverse selection. Effectively adapting to these risk adjustment provisions may require us to modify our operational and strategic initiatives to focus on and manage different populations of potential members than we have in the past. If we are not able to successfully design and implement operational and strategic initiatives to adapt to these changes in certain of our markets, our financial condition and results of operations may be adversely affected.

Some of the provisions of Health Care Reform became effective immediately upon enactment, while most of the other provisions became effective in January 2014, with the remaining provisions to be phased in over the next several years. These

changes could impact us through potential disruption to the employer-based market, potential cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. We have dedicated, and will continue to dedicate, material resources and incurred, and will continue to incur, material expenses to implement and comply with Health Care Reform at both the state and federal levels, including implementing and complying with future regulations that provide guidance on and clarification of significant portions of the legislation. The Health Care Reform law and regulations are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. Difficulties and delays with regard to implementation of provisions of Health Care Reform at the end of 2013, including with regard to the functionality of the federal and state health insurance exchanges and the lack of full cooperation and coordination between federal and state authorities as to implementation of Health Care Reform, have increased uncertainties and made our planning relating to Health Care Reform more difficult and unpredictable, which increases the risk that we will experience unanticipated adverse consequences arising out of Heath Care Reform.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

Changes in the regulation of our business by state and federal regulators may adversely affect our business, cash flows, financial condition and results of operations.

Our insurance, managed health care and 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 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, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements and additional governmental participation which could also adversely affect our business, financial condition and results of operations. In addition, we cannot ensure that application of the federal and/or state tax regulatory regime that currently applies to us will not, or future tax regulation by either federal and/or state governmental authorities concerning us could not, have a material adverse effect on our business, operations or financial condition.

State legislatures will continue to focus on health care delivery and financing issues. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate costs. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating enacting, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. 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 addition, California has enacted legislation to establish minimum benefit expense ratio thresholds and continues to consider legislative proposals to require prior regulatory approval of premium rate increases. California also has a November 2014 ballot initiative requiring prior regulatory approval of rate increases for the individual and small group products, which, if passed, could prevent us from securing necessary rate and benefit changes. If enacted, these state proposals could have a material adverse impact on our business, cash flows, financial condition or results of operations.

The U.S. Supreme Court has determined that significant portions of the ACA, including the provisions regarding health care exchanges, are constitutional. As a result, some states have developed their own exchanges, while other states are relying on HHS to operate the exchange in their states or are implementing partnership exchanges with the Federal government. These multiple exchange options have led to increased uncertainties and made our planning for these health insurance exchanges more difficult. The Supreme Court decision also permitted states to opt out of the elements of Health Care Reform that require expansion of Medicaid coverage in January 2014 without losing their current federal Medicaid funding. A number of states, including Florida, Georgia, Indiana, Maine, Tennessee, Texas, Virginia and Wisconsin, have indicated their current decision to opt out of Medicaid expansion, at least for the present

time. If states allow certain programs to expire or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities.

Additionally, from time to time, Congress has considered, or may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. 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.

Our inability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits or maintain our current provider agreements 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. Last minute changes in the implementation of Health Care Reform at the end of 2013, in particular those relating to difficulties with the functionality of federal and state health insurance exchanges, may increase the likelihood that our assumptions underlying the pricing and design of our exchange products prove to be inaccurate in a way that materially adversely affects the expected profitability of those products. 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, demographic characteristics, 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, particularly with respect to our products sold through the federal and state health insurance exchanges, as neither we nor our competitors have any prior experience with pricing such products or the utilization rates for medical or other covered services by members who purchase our products through such exchanges. The exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these exchange products. Therefore, health care benefit costs in excess of our cost projections reflected in our exchange product pricing cannot be recovered in the current premium period through higher premiums; however, in certain circumstances, Federal risk adjustment mechanisms, including risk adjustment payments, risk corridors and reinsurance, could help offset health care benefit costs in excess of our projections. If it is determined that our assumptions regarding cost trends, utilization, enrollment, adverse selection, acuity and other assumptions utilized in setting our premium rates are significantly different than actual results, even with these risk adjustment mechanisms, 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 customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and beginning in 2014, our plans may be excluded from participating in the health insurance exchanges if they are deemed to have a history of "unreasonable" rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, delays in premium payments 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, cash flows, 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. 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.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians and other

health care providers. The failure to maintain or to secure cost-effective health care provider contracts may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, accountable care organizations, or ACO, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our results of operations, financial position and cash flow could be adversely affected. Further, our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, do not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings.

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

A significant 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: reductions in workforce by existing customers; general economic downturn that results in business failures; employers no longer offering certain health care coverage as an employee benefit or electing to offer this coverage on a voluntary, employee-funded basis; state and federal regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; implementation of federal and state exchanges and underwriting changes in 2014; and failure to attain or maintain nationally recognized accreditations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding, compliance with government contracts and increased regulatory oversight.

We contract with various state and federal agencies, including CMS, to provide managed health care services, including Medicare Advantage plans, Medicare Supplement plans, Medicare approved prescription drug plans, Medicaid programs and CHIP. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicare eligible members through our affiliated companies and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in Medicare and Medicaid dual eligible programs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including Health Care Reform, which are still in the process of being implemented. It is difficult to predict the future impact of Health Care Reform on our Government Business segment due to Health Care Reform’s complexity, gradual and delayed implementation, and possible amendment. Health Care Reform, other regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member’s health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future levels of Medicare and Medicaid rates may be affected by continued government efforts to contain costs and may be further affected by state and federal budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our business, financial condition and results of operations. Further, certain of our contracts with the states are subject to cancellation in the event of the unavailability of state funds. In addition, the various states’ new Medicare and Medicaid dual eligible programs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these new programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our

revenues and financial results.

A portion of our premium revenue comes from CMS through our Medicare Advantage and Medicare Part D contracts. As a consequence, our Medicare Advantage and Medicare Part D plans are dependent on federal government funding levels. The

premium rates paid to Medicare plans are established based on benchmarks which are now tied to a percentage of Medicare fee for service, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and risk scores. Beginning in 2014, Medicare Advantage and Medicare Part D plans will be subject to MLR rules. Continuing government efforts to contain health care related expenditures, including prescription drug cost, and other federal budgetary constraints that result in changes in the Medicare program, including changes with respect to funding, could lead to reductions in the amount of reimbursement, or other changes that could have a material adverse effect on our business, financial condition and results of operations.

Risks associated with the Medicare Advantage and Medicare Part D plans include potential uncollectability of receivables resulting from processing and/or verifying 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 limited enrollment periods in this business. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Parts 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.

Our contracts with the various state governmental agencies and CMS contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements specific to state and federal program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans, that could impact our profitability. Additionally, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process, and if our existing contracts are not renewed or if we are not awarded new contracts as a result of this competitive procurement process, this could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs. Failure to comply with these laws and regulations could result in investigations or litigation, with the imposition of fines, restrictions or exclusions from program participation or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

Further, CMS has been conducting audits of our Medicare Advantage health plans to validate the diagnostic data and patient claims that are submitted to CMS. These audits may result in retrospective adjustments in payments made to our health plans. In addition, if we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations. The ACA also established recovery audit programs for Medicare Parts C and D. The Medicare Part D Recovery Audit Contractor, or RAC, has been auditing Medicare Part D claims and recouping overpayments since 2012, and CMS expects to award a Medicare Part C RAC contract in fiscal year 2014, which could increase the amount of audits and subsequent recoupments by the federal government.

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, Maryland, Missouri, Nevada, New Hampshire, New York, Ohio, Tennessee, Texas, Virginia and Wisconsin. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state specific or regional economic downturns impacting these states. If such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

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, which can arise from, among other things, the ongoing debate over Health Care Reform. 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, cash flows, 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 legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, beginning in 2014, we have started to compete for sales on insurance exchanges, which has required, and will continue to require, us to develop or acquire the tools (including social media tools) necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve our consumer-focused marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on the profitability of health benefits companies.
We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure 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, cash flows, financial condition and results of operations.
We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.
We are dependent on retaining existing employees, attracting additional qualified employees to meet current and future needs and achieving productivity gains from our investment 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, cash flows, financial condition and results of operations.
We would be adversely affected if we fail to adequately plan for succession of our Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.
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. It is not yet clear whether our products sold on the federal and state health insurance exchanges will be more or less profitable 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.

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

We are a holding company whose assets include all of the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. 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. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. 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, cash flows, 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 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.

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.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

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.

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 agreement. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement 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.

A downgrade in our credit ratings could have an adverse effect on our business, financial condition and results of operations.

Claims-paying ability and financial strength ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. Each of the credit rating agencies reviews its ratings periodically and there can be no assurance that our current credit ratings will be maintained in the future. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used throughout the industry. If our credit ratings are downgraded or placed under review, with possible negative implications, such actions could adversely affect our business, financial condition and results of operations. These credit ratings reflect each credit 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.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits and administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include claims relating to the denial of health care benefits; the rescission of health insurance policies; development or application of medical policy; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over compensation; provider tiering programs; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business or corporate governance practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted, arising out of our operations or our 2001 demutualization, including, but not limited to, breaches of security and violations of privacy requirements, shareholder actions, compliance with federal and state laws and regulations (including qui tam or "whistleblower" actions), or sales and acquisitions of businesses or assets, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. 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. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations or financial position.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), 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.

Our future obligations for state guaranty association assessments could increase in the event that Health Care Reform and its implementation result in increased insolvencies of health plans.

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 provide for assessments based upon the amount of premiums received on insurance underwritten within such state. While in the past, health insurance company insolvencies have been

infrequent, the changes to the U.S. health care system and markets and related uncertainties from implementation of Health Care Reform may result in increased

insolvencies of health insurance companies covered by these state insolvency or guaranty association laws. In that event, we may experience increased guaranty association assessments for health insurer insolvencies, the amount and timing of which cannot be predicted with certainty.

There are various risks associated with providing health care services.

The direct provision of health care services by our CareMore subsidiary involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of health care and related services. In addition, liability may arise from maintaining health care premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our cash flows, financial condition or results of operations.

Additionally, many states in which we operate our CareMore subsidiary limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians ("corporate practice of medicine") and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients ("anti-kickback rules"), and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity ("self-referral rules").

We believe that our health care service operations comply with applicable rules and regulations regarding the corporate practice of medicine, fee-splitting, anti-kickback, self-referral and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition or results of operations.

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 care plans and related services 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 care plans and related services 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 divide our Board of Directors into three classes serving staggered three-year terms; 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.

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. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. If we or another BCBS licensee is not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and 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 service areas. Furthermore, the BCBSA would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these service areas 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 license in the vacated service area. The fee is set at $98.33 per licensed enrollee. As of December 31, 2013 we reported 26.6 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 $2.6 billion by the BCBSA.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, 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 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 bioterrorism 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, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers and acquisitions, joint ventures and strategic alliances (collectively, “business combinations”) 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, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were under-estimated;
- we may experience difficulties in integrating acquired businesses, be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to 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;
- business combinations could disrupt our ongoing business, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards,

controls, information technology systems, policies and procedures;

- we may finance future business combinations 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 business combinations; and
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our consolidated balance sheets.

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 income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets (with indefinite lives). In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

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.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with the implementation of the various Health Care Reform regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. In some cases, the markets have exerted downward pressure on availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the exercise of stock options.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms. One of our sources of liquidity is our $2,500.0 million commercial paper program under which we had only $379.2 outstanding at December 31, 2013. Should commercial paper issuance be unavailable, we intend to use a combination of cash on hand and/or our $2,000.0 million senior revolving credit facility to redeem our commercial paper when it matures. We believe the lenders participating in our senior credit facility will be willing and able to provide financing in accordance with their legal obligations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

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. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material unrealized or realized losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns in future periods.

In accordance with FASB guidance for debt and equity investments, we classify fixed maturity and equity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2013. Also, in accordance with applicable FASB accounting guidance, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis analyzing both quantitative and qualitative factors. Such factors considered include the length of time and the extent to which market value has been less than cost, financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends.

Changes in the economic environment, including periods of increased volatility of the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We believe we have adequately reviewed our investment securities for impairment and we believe that we have appropriately estimated the fair values of our investment securities. However, over time, the economic and market environment may provide additional insight, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We may not be able to realize the value of our deferred tax assets.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded.

At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is “more likely than not” that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in the valuation allowance would result in additional income tax expense and a decrease in shareholders’ equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders’ equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

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 and provider information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, and numerous state laws governing personal information. Despite the security measures we have in place to help ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, are vulnerable to cyber-attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Noncompliance with any privacy or security laws and regulations, or any security breach, cyber-attack or cyber security breach, and any incident involving the misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member information, whether by us or by one of our vendors, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which 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, emerging cyber security risks and threats, evolving industry and regulatory standards including the minimum MLR rebates, exchanges and other aspects of Health Care Reform, compliance with legal requirements (such as a new set of standardized diagnostic codes, known as ICD-10), private insurance exchanges 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, sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. In addition, federal regulations require that we begin using ICD-10 by October 2014, which will require significant information technology investment. If we fail to adequately implement ICD-10 or comply with the operating rules, we may incur losses with respect to the resources invested and have other material adverse effects on our business and results of operations. Also, 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, cash flow, financial condition and results of operations.

We continue to implement initiatives for more effective and efficient information technology systems 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 implement all desired products or systems in a timely and effective manner. The failure to implement and maintain the most advanced technological 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 data center operations and certain core applications development. We are dependent upon IBM for these support functions. The IBM agreement includes service level agreements, or SLAs, related to issues such as performance and job disruption, with significant financial penalties if these SLAs are not met, as well as termination assistance provisions obligating IBM to provide services during periods following transitions or terminations. 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, cash flows, financial condition and results of operations may be

harmed. We may not be adequately indemnified

against all possible losses through the terms and conditions of the IBM agreement. In addition, some of our termination rights are contingent upon payment of a fee, which may be significant.

We are a party to an agreement with Express Scripts whereby Express Scripts is the exclusive provider of PBM services to certain of our members, excluding Amerigroup and certain self-insured members that have exclusive agreements with different PBM service providers, provided however that Amerigroup will be transitioning to the Express Scripts agreement during 2014. The Express Scripts PBM services include, but are not limited to, pharmacy network management, home delivery, pharmacy customer service, claims processing, rebate management, drug utilization and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. The failure of either party to meet the respective requirements could potentially serve as a basis for early termination of the contract. If this relationship was terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. In addition, our failure to meet certain minimum script volume requirements may result in financial penalties that could have a material adverse effect on our results of operations.

We have also entered into agreements with certain vendors pursuant to which we have outsourced certain back-office functions. If any of these vendor relationships were terminated for any reason, we may not be able to find an alternative partner in a timely manner or on acceptable financial terms. In addition, if for any reason there is a business continuity interruption resulting from loss of access to or availability of data, the physical location, technological resources and/or adequate human assets, we may not be able to meet the full demands of our customers and, in turn, our business, cash flow, financial conditions and results of operations may be unfavorably impacted.

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 business 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.

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: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; 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 shareholders; 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;
- our inability to convert to international financial reporting standards, if required;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this location, we have other principal operating facilities located in each of the 14 states where we operate as licensees of the BCBSA, in each of the eight additional states where Amerigroup conducts business and in the additional state of Arizona where CareMore maintains a branch office. A majority of these locations are leased properties. 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.

For information regarding our legal proceedings, see the "Litigation" and "Other Contingencies" sections of Note 14, "Commitments and Contingencies" to our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not Applicable.

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 7, 2014, the closing price on the NYSE was $84.68. As of February 7, 2014, there were 78,847 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
2013		
First Quarter	$66.62	$58.75
Second Quarter	82.33	65.82
Third Quarter	90.00	80.75
Fourth Quarter	94.36	83.13
2012		
First Quarter	$74.73	$63.34
Second Quarter	73.80	63.22
Third Quarter	64.66	52.52
Fourth Quarter	63.63	53.69

Dividends

The quarterly cash dividend declared by our Board of Directors was $0.3750, $0.2875 and $0.2500 per share in 2013, 2012 and 2011, respectively. On January 28, 2014, our Board of Directors declared a quarterly cash dividend to shareholders of $0.4375 per share.

We regularly review the appropriate use of capital, including common stock repurchases, repurchases of debt and dividends to shareholders. The declaration and payment of any dividends or repurchases of common stock or debt securities is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Further, 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 subsidiaries, including 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 SellCore, Inc. 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 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in 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	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[3]
(In millions, except share and per share data)				
October 1, 2013 to October 31, 2013	2,121,081	$ 86.10	2,114,200	$ 3,965.9
November 1, 2013 to November 30, 2013	948,874	87.62	933,809	3,876.9
December 1, 2013 to December 31, 2013	2,118,533	90.01	2,066,685	3,691.0
	5,188,488		5,114,694	

1 Total number of shares purchased includes 73,794 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 the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2013, we repurchased 20,748,394 shares at a cost of $1,645.9 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was $3,500.0 on September 25, 2013. Between January 1, 2014 and February 7, 2014, we repurchased 5.4 shares at a cost of $457.6, bringing our current availability to $2,633.4 at February 7, 2014 (see note 3 below for additional discussion of current availability). No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

3 On February 4, 2014, we entered into an accelerated share repurchase, or ASR, program with a counterparty. The agreement provides for a repurchase of a number of shares, equal to $600.0, as determined by the dollar volume weighted-average share price during a period up through at least March 14, 2014, but not to exceed March 31, 2014. At the end of the term of the ASR, the initial amount of shares will be adjusted up or down based on the dollar volume weighted-average price during the same period. On February 4, 2014, we repurchased 6.0 shares under this program. These ASR shares are not included in the shares repurchased subsequent to December 31, 2013, discussed in note 2 above, as the final shares to be repurchased will not be determined until the completion of the program in March 2014. However, the $600.0 has been removed from the authorization remaining as of February 7, 2014 discussed in note 2 above.

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, 2008 through December 31, 2013, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of $100 on December 31, 2008 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

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 S&P Capital IQ, 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, as amended, or the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.

	December 31,					
	2008	2009	2010	2011	2012	2013
WellPoint, Inc.	$100	$138	$135	$160	$149	$231
S&P 500 Index	100	126	146	149	172	228
S&P Managed Health Care Index	100	128	139	187	198	293

Based upon an initial investment of $100 on December 31, 2008 with dividends reinvested.

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, 2013. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2013 included in Part II, Item 8 “Financial Statements and Supplementary Data”, and Part II, Item 7 “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				
	2013 [1]	2012 [1,2]	2011 [2]	2010	2009 [2]
(in millions, except where indicated and except per share data)					
Income Statement Data					
Total operating revenue[3]	$70,191.4	$60,514.0	$59,865.2	$57,740.5	$60,740.0
Total revenues	71,023.5	61,497.2	60,710.7	58,698.5	64,939.5
Income from continuing operations	2,634.3	2,651.0	2,646.7	2,887.1	4,745.9
Net income	2,489.7	2,655.5	2,646.7	2,887.1	4,745.9
Per Share Data					
Basic net income per share - continuing operations	$8.83	$8.25	$7.35	$7.03	$9.96
Diluted net income per share - continuing operations	8.67	8.17	7.25	6.94	9.88
Dividends per share	1.50	1.15	1.00	—	—
Other Data (unaudited)					
Benefit expense ratio[4]	85.1 %	85.3 %	85.1 %	83.2 %	83.6 %
Selling, general and administrative expense ratio[5]	14.2 %	14.3 %	14.1 %	15.1 %	14.8 %
Income from continuing operations before income taxes as a percentage of total revenues	5.4 %	6.3 %	6.5 %	7.4 %	11.4 %
Net income as a percentage of total revenues	3.5 %	4.3 %	4.4 %	4.9 %	7.3 %
Medical membership (in thousands)	35,653	36,130	34,251	33,323	33,670
Balance Sheet Data					
Cash and investments	$22,395.9	$22,464.6	$20,696.5	$20,311.8	$22,610.9
Total assets	59,574.5	58,955.4	52,163.2	50,242.5	52,147.9
Long-term debt, less current portion	13,573.6	14,170.8	8,465.7	8,147.8	8,338.3
Total liabilities	34,809.3	35,152.7	28,875.0	26,429.9	27,284.6
Total shareholders’ equity	24,765.2	23,802.7	23,288.2	23,812.6	24,863.3

1 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2013 as a result of the pending divestiture. Included in Net income for the year ended December 31, 2013 is a loss from discontinued operations, net of tax, of $144.6. Included in Net income for the year ended December 31, 2012 is income from discontinued operations, net of tax, of $4.5.

2 The net assets of and results of operations for AMERIGROUP Corporation are included from its acquisition date of December 24, 2012. The net assets of and results of operations for CareMore Health Group, Inc. are included from its acquisition date of August 22, 2011. The net assets of and results of operations for DeCare Dental, LLC are included from its acquisition date of April 9, 2009. The results of operations for our pharmacy benefits management, or PBM, business are included until its sale on December 1, 2009. The results of operations for the year ended December 31, 2009 includes pre-tax and after-tax gains related to the sale of our PBM business of $3,792.3 and

$2,361.2, respectively.

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

4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.

5 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

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

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., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

This MD&A should be read in conjunction with our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

Overview

On May 20, 2013, we announced certain organizational and executive leadership changes to align with how our new Chief Executive Officer is managing our operations. Beginning with the three months ended June 30, 2013, our organizational structure is comprised of three reportable segments: Commercial and Specialty Business; Government Business; and Other. Prior period segment information has been reclassified to conform to the new segment reporting structure.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured products; 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, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as behavioral health benefit services, dental, vision, life and disability insurance benefits, radiology benefit management, analytics-driven personal health care guidance and long-term care insurance.

Our Government Business segment includes our Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the Federal Government in connection with the Federal Employee Program, or FEP. Our Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement, while our Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid, state Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

In preparation for the coming changes to the health care system and to focus on our core growth opportunities across our Commercial and Specialty Business and Government Business segments, we entered into a definitive agreement in December 2013 to sell our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business to the private equity firm Thomas H. Lee Partners, L.P. Concurrently, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets. The divestitures were completed on January 31, 2014. The operating results for 1-800 CONTACTS are reported as discontinued operations as a result of the pending divestiture at December 31, 2013. These results were previously reported in the Commercial and Specialty Business segment. Additionally, the assets and liabilities of 1-800-CONTACTS are reported as held for sale in the consolidated balance sheets included in this Form 10-K. Unless otherwise specified, all financial information, other than cash flows, disclosed in this MD&A is from continuing operations. In accordance with FASB guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestitures," to our audited consolidated financial statements as of and for the year ended December 31, 2013, 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 includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily 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. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. 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; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling expense consists of external broker commission expenses, and generally varies with premium or membership 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 associated 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 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 and health and wellness programs. Several economic factors related to health care costs, such as regulatory mandates of coverage 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, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in health care costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the U.S. Congress passed and the President signed into law the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, which represents significant changes to the U.S. health care system. The legislation is far-reaching and is intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impacts on health care in the United States and the continuing modification and interpretation of Health Care Reform's rules, we continue to analyze the impact and refine our estimates of the ultimate impact of Health Care Reform on our business,

cash flows, financial condition and results of operations. A list of certain material changes resulting from Health Care Reform include:

- Requirements to modify our products to cover essential health benefits and comply with other defined criteria;
- Requirement to cancel existing products and enroll new and renewing members in the new ACA-compliant “metal”

products (bronze, silver, gold and platinum);

- Introduction of exchanges, subsidies and mandates to require and allow previously uninsured customers to enter the market; and
- Significant new taxes and fees which will be paid by health insurers, and which may or may not be passed through to customers.

The above changes resulting from Health Care Reform will provide growth opportunities for health insurers, but also introduce new risks and uncertainties, and require changes in the way our products are designed, underwritten, priced, distributed and administered.

Pricing in our Commercial and Specialty Business segment, including our individual and small group lines of business, remains highly competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. While the ultimate level of exchange enrollment cannot be predicted, we have experienced a greater number of policy applications for new members through the exchanges than expected, including geographical regions with lower price competition. The exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these exchange products. However, early indications of the risk characteristics of new applicants appear to be tracking closely to the risk levels utilized in the development of our pricing assumptions. Although it is not yet clear whether our products sold on the exchanges will be more or less profitable products, we believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

In our individual markets we offer bronze, silver and gold products, both on and off the exchanges, in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the exchanges, in the states of California and New York.

In our small group markets, we offer bronze, silver and gold products, both on and off the exchanges, in the states of Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia and we offer bronze, silver and gold products, off the exchanges, in the states of California, New York and Wisconsin. Additionally, we offer platinum products, off the exchanges, in the states of California, Connecticut, Georgia, Maine and Virginia.

The legislation also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum medical loss ratio, or MLR, requirements; a requirement to cover preventive services on a first dollar basis; the establishment of state insurance exchanges and essential benefit packages; and greater limitations on how we price certain of our products. The legislation also reduces the reimbursement levels for health plans participating in the Medicare Advantage program over time.

As a result of Health Care Reform, the Department of Health and Human Services, or HHS, issued MLR regulations that require us to meet minimum MLR thresholds for large group, small group and individual lines of business. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as income tax expense or selling, general and administrative expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

Beginning with rebates paid in 2014 for the 2013 benefit year, MLR rebates will be based on a three year average. This calculation will determine an average MLR for each market segment within each state for the previous three calendar years. Additionally, insurers will be able to adjust experience to account for prior MLR rebates refunded to

groups or individuals. Once the three year average MLR is calculated and compared to the minimum MLR threshold, the rebate percentage will be applied to current year premiums as defined by Health Care Reform. Beginning with MLR rebates paid in 2015 for the 2014

benefit year, insurers will adjust for the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform.

Health Care Reform also imposes a separate minimum MLR threshold of 85% for Medicare Advantage plans beginning in 2014. Medicare Advantage plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform as key aspects go into effect and additional guidance is made available. For additional discussion regarding Health Care Reform, see Part I, Item 1 "Business—Regulation" and Part I, Item 1A "Risk Factors" in this Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guarantee association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. State life and health insurance guaranty associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner's petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation, which proposed plan was filed on April 30, 2013. The state court has ordered a hearing on the proposed plan for which a date has not yet been set. The Insurance Commissioner has filed a Notice of Appeal asking the Pennsylvania Supreme Court to reverse the order denying the liquidation petition. The Supreme Court has probable jurisdiction over the appeal and issued a schedule for filing briefs. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

In addition to external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent years, we experienced membership declines due to unfavorable economic conditions driving increased unemployment. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the exchanges, which may not be appropriately adjusted for in our premium rates. These membership trends could have a material adverse effect on our future results of operations. Also see Part I, Item 1A "Risk Factors" in this Form 10-K.

Executive Summary

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 35.7 medical members through our affiliated health plans and a total of 67.8 individuals through all subsidiaries as of December 31, 2013. 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. In a majority of these

service areas we do

business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New York, Tennessee, Texas and Washington. Amerigroup also provided services in the state of Ohio through June 30, 2013 and in the state of New Mexico through December 31, 2013. We also serve customers throughout the country as HealthLink, UniCare and in certain Arizona, California, Nevada, New York and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries. We also sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS business, which was divested on January 31, 2014.

Operating revenue for the year ended December 31, 2013 was $70,191.4, an increase of $9,677.4, or 16.0%, from the year ended December 31, 2012, primarily reflecting higher premium revenue in our Government Business segment, partially offset by lower premium revenue in our Commercial and Specialty Business segment. The higher premium revenue in our Government Business segment primarily resulted from the acquisition of Amerigroup in December 2012, growth in our FEP business resulting from both premium rate increases designed to cover overall cost trends and increases in membership as well as increased membership in our CareMore subsidiary. These increases were partially offset by lower revenues in our non-CareMore Medicare Advantage and Medicare Part D businesses primarily due to membership losses as a result of our product repositioning strategy toward HMO product offerings. The premium revenue decrease in our Commercial and Specialty Business segment was driven primarily by fully-insured membership declines in our Local Group business resulting from strategic product portfolio changes in certain states, competitive pressure in certain markets and, we believe, affordability challenges affecting healthcare consumers in general. This decrease was partially offset by premium rate increases in our Local Group, Individual and National Accounts businesses designed to cover overall cost trends as well as premium rate and membership increases in our Specialty businesses, primarily related to our dental and vision products, and increased administrative fees resulting from pricing increases for self-funded members in our Commercial businesses.

Net income for the year ended December 31, 2013 was $2,489.7, a decrease of $165.8, or 6.2%, from the year ended December 31, 2012. The decrease in net income was primarily driven by the loss on disposal of our 1-800 CONTACTS business, costs incurred in preparation for the implementation of Health Care Reform effective in 2014, realized losses on extinguishment of debt, an increase in interest expense resulting from higher outstanding debt balances associated with our acquisition of Amerigroup and lower operating results in our Commercial and Specialty Business segment. These decreases were partially offset by higher operating results in our Government Business segment, primarily from Amerigroup.

Our diluted earnings per share, or EPS, for the year ended December 31, 2013 was $8.20, an increase of $0.02, or 0.2%, from the year ended December 31, 2012. Our diluted EPS from continuing operations for the year ended December 31, 2013 was $8.67, an increase of $0.50, or 6.1%, from the year ended December 31, 2012. Our diluted shares for the year ended December 31, 2013 were 303.8 million, a decrease of 21.0 million, or 6.5%, compared to the year ended December 31, 2012. The increase in diluted EPS resulted primarily from the lower number of shares outstanding in 2013 due to share buyback activity under our share repurchase program partially offset by the decrease in net income.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate adjusted net income, adjusted EPS and operating gain, which are non-GAAP measures, to further aid investors in understanding and analyzing our core operating results and comparing them among periods. Adjusted net income and adjusted EPS exclude realized gains and losses on investments, other-than-temporary losses on investments recognized in income, impairment of other intangible assets and certain other items, if applicable, that we do not consider a part of our core operating results. Operating gain is calculated as total operating revenue less benefit expense, selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, setting incentive compensation targets and forecasting future operating periods. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or diluted EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our “Reportable Segments Results of Operations” discussion included in this MD&A.

The table below reconciles net income and diluted EPS calculated in accordance with GAAP to adjusted net income and adjusted diluted EPS for the years ended December 31, 2013 and 2012.

	Years Ended December 31			
	2013	2012	Change	% Change
Net income	$2,489.7	$2,655.5	$(165.8)	(6.2)%
Less (net of tax):				
Net realized gains on investments	176.7	217.7	(41.0)	
Other-than-temporary impairment losses on investments	(64.3)	(24.6)	(39.7)	
Loss on extinguishment of debt	(94.4)	—	(94.4)	
Tax benefit from favorable tax election	65.0	—	65.0	
Impairment of held for sale assets	(164.5)	—	(164.5)	
Acquisition and integration related costs	(16.3)	(68.4)	52.1	
Litigation related costs	—	(24.0)	24.0	
Income tax settlements	—	140.1	(140.1)	
Tax impact of non-deductible litigation related costs	—	(41.4)	41.4	
Adjusted net income	$2,587.5	$2,456.1	$131.4	5.3 %
Diluted EPS	$8.20	$8.18	$0.02	0.2 %
Less (net of tax):				
Net realized gains on investments	0.58	0.67	(0.09)	
Other-than-temporary impairment losses on investments	(0.21)	(0.07)	(0.14)	
Loss on extinguishment of debt	(0.31)	—	(0.31)	
Tax benefit from favorable tax election	0.21	—	0.21	
Impairment of held for sale assets	(0.54)	—	(0.54)	
Acquisition and integration related costs	(0.05)	(0.21)	0.16	
Litigation related costs	—	(0.07)	0.07	
Income tax settlements	—	0.43	(0.43)	
Tax impact of non-deductible litigation related costs	—	(0.13)	0.13	
Adjusted diluted EPS	$8.52	$7.56	$0.96	12.7 %

Operating cash flow for the year ended December 31, 2013 was $3,052.3, or 1.2 times net income. Operating cash flow for the year ended December 31, 2012 was $2,744.6, or 1.0 times net income. The increase in operating cash flow from 2012 of $307.7 was driven primarily by an increase in net income adjusted for non-cash items, primarily due to the loss on disposal of discontinued operations, changes in amortization expense and realized losses on extinguishment of debt. The increase was further attributable to lower payments for litigation related matters, incentive compensation and minimum MLR rebates; and a net increase in the collection of income tax refunds in 2013.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product 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 over time by providing excellent service, offering competitively priced products, access to high quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Significant Transactions

The more significant transactions that have occurred over the last three years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Use of Capital—Board of Directors declaration of dividends on common stock (2013, 2012 and 2011) and a 16.7% increase in the quarterly dividend to $0.4375 per share (2014); authorization for repurchases of our common stock (2013 and prior); and debt repurchases and new debt issuance (2013 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012);
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014); and
- Acquisition of CareMore (2011).

For additional information regarding these transactions, see Note 3, “Business Acquisitions and Divestitures,” Note 13, "Debt" and Note 15, “Capital Stock,” to our audited consolidated financial statements as of and for the year ended December 31, 2013, included in this Form 10-K.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to Amerigroup and CareMore members as well as Healthlink and UniCare members predominantly outside of our BCBSA service areas.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare local group members. These groups are generally sold through brokers or consultants working with industry specialists from our in-house sales force. Local Group insurance premiums may be based on claims incurred by the group 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 41.2%, 40.5% and 44.4% of our medical members at December 31, 2013, 2012 and 2011, respectively.
- Individual consists of individual customers under age 65 (including UniCare) and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through state or federally facilitated marketplaces and off-exchange products. Federal premium subsidies are available only for certain on-exchange individual products. 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 Group. Individual business accounted for 4.9%, 5.1% and 5.4% of our medical members at December 31, 2013, 2012 and 2011, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in a WellPoint service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. 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 an 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 at their competitive local market rates. National Accounts represented 19.0%, 19.4% and 21.6% of our medical members at December 31, 2013, 2012 and 2011, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by WellPoint who receive health care services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which a WellPoint subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-WellPoint controlled BCBSA licensee (i.e., the “home plan”). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information

and customer service, are performed by the home plan. Host members are computed using, among other things, the

average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.2%, 13.9% and 14.4% of our medical members at December 31, 2013, 2012 and 2011, respectively.

- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, who have purchased Medicare Supplement benefit coverage, some disabled under 65, or all ages with End Stage Renal Disease. 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 for Medicare Advantage 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. Medicare business accounted for 4.1%, 4.4% and 4.3% of our medical members at December 31, 2013, 2012 and 2011, respectively.
- Medicaid membership represents eligible members who receive health care benefits through publicly funded health care programs, including Medicaid, CHIP and Medicaid expansion programs. Total Medicaid program business accounted for 12.3%, 12.5% and 5.5% of our medical members at December 31, 2013, 2012 and 2011, respectively.
- 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 4.3%, 4.2% and 4.4% of our medical members at December 31, 2013, 2012 and 2011, respectively.

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 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.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2013, 2012 and 2011. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

	December 31			2013 vs. 2012		2012 vs. 2011	
(In thousands)	2013	2012	2011	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	14,690	14,634	15,212	56	0.4	(578)	(3.8)
Individual	1,755	1,855	1,846	(100)	(5.4)	9	0.5
National:							
National Accounts	6,775	6,999					