WELLPOINT®

Building a sustainable health care system

WHEN IT COMES TO HEALTH CARE REFORM, WE SHOULD NOT JUST GET IT DONE, WE SHOULD GET IT RIGHT.

AWPBR60330 (2/09)

The urgency of the health care crisis in today's economy calls for thoughtful, sustainable solutions. As the nation's leading health benefits company — covering 1 in 9 Americans[1] through WellPoint, Inc.'s affiliated health plans (WellPoint) — WellPoint has real-world, proven solutions to share. We not only know how to get health care reform done, but how to get it done right. WellPoint is currently advancing strategies to improve health care quality, which can help better manage costs and improve insurance coverage, and by working together with the government, employers, and providers, we can build a health care system that is accessible to all and provides quality care for those who need it most.

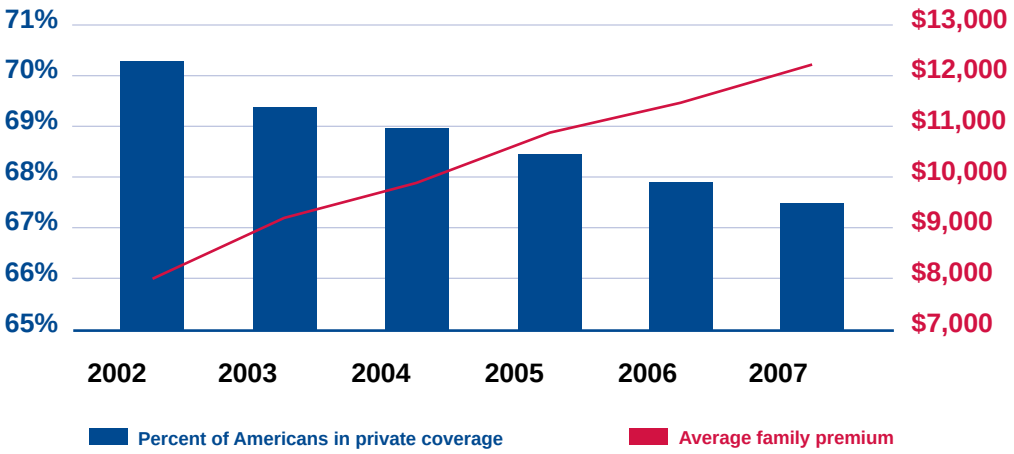
The strength of any health care reform plan will be measured by the sum of its parts. We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which can help manage costs. And while WellPoint believes improving quality and reducing costs is the key to a better system, we believe we must also get our country on a sustainable path to covering everyone.

America's health care system

In many ways, the U.S. health care system is the envy of the world. It is the home of the best facilities for life-saving treatments and premier medical research facilities that pioneer medical breakthroughs that are exported throughout the world. In contrast to most industrialized countries that have chosen a path of nationalized health care, the public-private U.S. health care system, built on robust competition, delivers timely, necessary specialty care and is a magnet for those traveling internationally who demand the best medical treatment.[2] When Italian Prime Minister Silvio Berlusconi needed heart surgery in 2006, he could have had the procedure done in his own or any one of many European countries with nationalized and/or private health care. Instead, he traveled 5,000 miles to the renowned Cleveland Clinic Heart Center in Ohio for a successful operation.[3]

Despite these areas of leadership, the U.S. health care system exhibits substantial challenges. While an impressive 250 million Americans currently have health insurance coverage[4] and the peace of mind that needed services will be attainable, far too many Americans lack both coverage and access to needed health care services. The cost of such an advanced, highly technological and disparate delivery system makes coverage much more expensive. In fact, medical costs are growing at a rate that threatens to consume other areas of the economy[5], while our medical delivery system produces inconsistent quality and suboptimal health outcomes.

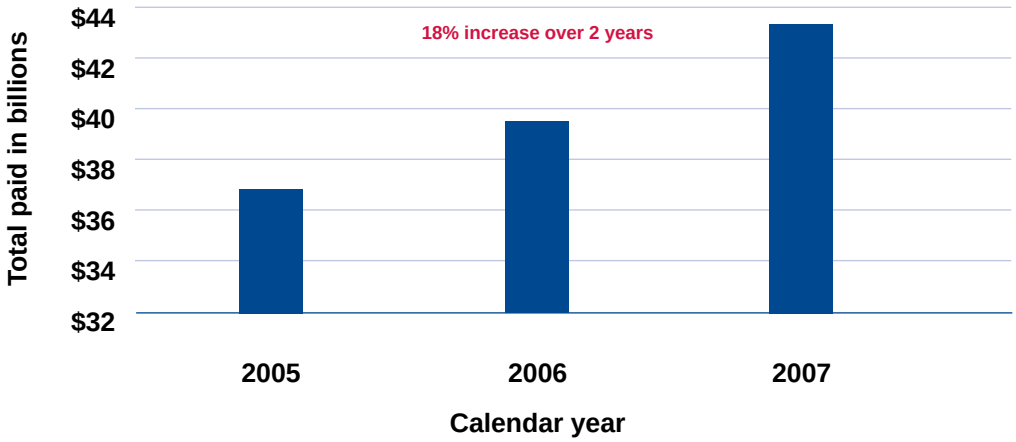
As prices rise, coverage decreases[6]



Diagnosing the problem

We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which can help manage costs. While health care reform discussions often focus on the regulation of the health insurance marketplace (e.g., guaranteed issue, rating rules, benefit mandates), many of the ills of America's health care system lie downstream in the delivery system. The crisis that is demonstrated by 45.7 million uninsured Americans — including more than six million children[7] — is driven by the fact that the rising cost of coverage has priced so many out of the market. The typical family health insurance premium now costs more than $12,000 per year[8], about the same as the entire annual income of an individual earning the federal minimum wage.[9] These high costs are, to a large degree, a function of provider prices and utilization, which escalate each year due to quickly increasing provider costs and a lack of consistent quality in the delivery system, both of which too often result in over- and mis-utilization of services. There are many opportunities to improve health care in this country, and we are far from having a system that provides the right care at the right place at the right time. Failure to do so will only leave more and more Americans without coverage and access to affordable, quality care. Therefore, the path to a sustainable health care system begins with improving health care quality, which can help manage costs.

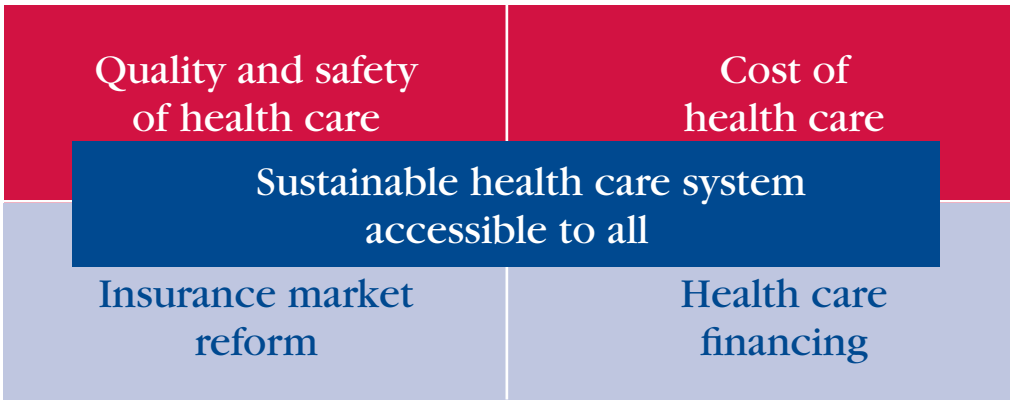
WellPoint affiliated health plan payments to hospitals & physicians (Includes all affiliated health plan markets except NY, CO, and NV)[10]



Examples of opportunities to improve patient care include the following:

- Medical errors and drug safety events contribute to up to 2.4 million extra hospital days per year, 32,000 annual deaths, and $9 billion in costs annually.[11] Additionally, an estimated 1.5 million preventable adverse drug events occur each year.[12]
- Geographic areas with higher costs may exhibit lower quality.[13]
- Children get recommended care from their doctors less than half of the time.[14] Adults fail to get recommended care nearly half the time.[15]
- Approximately 30 percent of health care spending goes toward redundant or inappropriate care.[16]
- Health care fraud accounts for more than $100 billion of America's $2 trillion health care system.[17]
- Medical liability and defensive medicine could account for as much as 10 percent of premium costs.[18]
- Even though the average charge for a hospital day is now about $10,000 — nearly the full price of an annual family premium — hospitals are often demanding rate increases in excess of 10 percent per year, many times higher than the general rate of inflation.[19]

Building a sustainable health care system



Improving quality, helping manage costs

We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which can help manage costs. There are many opportunities to improve health care in this country, as we are far from having a system that provides the right care at the right place at the right time. Building on six principles, WellPoint has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence based medicine; determine real-world outcomes
- Advance health care quality by disseminating information throughout the system
- Focus on prevention and manage chronic illness
- Improve effective use of drug therapies to prevent and manage illness
- Promote strategies to reduce medical errors and adverse drug events
- Reduce costs through eliminating fraud, reducing costs related to litigation, and improving administration

WellPoint has already initiated strategies in many of these areas to help improve quality and manage costs, and with the government's assistance, there is even more that can be done to help consumers get the right care at the right place at the right time.

Promote evidence-based medicine; determine real-world outcomes

The Problem: Despite the availability of world-class technology and innovative treatment options in America's health care system, there is insufficient information concerning which medical treatments are most effective. The result is suboptimal quality and over-utilization, where 30 percent of health care spending goes toward redundant or inappropriate care.[20]

What WellPoint is Doing	What the Government Should Do
• Maintaining rigorous, transparent medical policy and technology assessment in collaboration with medical specialty societies • Ensuring delivery system buy-in of effective treatments through establishment of Integrated Research Network • Promoting comparative effectiveness research to determine comparative medical benefit, risk and cost impact of treatments, devices, drugs and procedures • Educating and informing clinicians, consumers, and national health policy through publication and dissemination of comparative effectiveness research results • Promoting WellPoint's health outcomes research unit, HealthCore, and advancing capabilities in outcomes research	• Should support the Institute of Medicine's recommendations for determining what works in health care • Should establish a national board to prioritize comparative evaluation of new drug, device, and treatment effectiveness • Should increase investments in comparative effectiveness research

Advance health care quality by disseminating information throughout the system

The Problem: Despite the high cost of coverage, children get recommended care from their doctors less than half of the time.[21] Adults fail to get recommended care nearly half the time.[22] Furthermore, geographic areas with higher costs may exhibit lower quality.[23] Much of this inconsistent quality is reinforced by a lack of transparency in the system that makes it difficult for consumers to identify high-quality, cost-effective providers.

What WellPoint is Doing	What the Government Should Do
• Promoting quality through clinical performance measurement, pay-for-performance incentives, and Quality Hospital Insights Programs (Q-HIP) • Expanding Blue Distinction® quality designation programs that currently identify high-quality providers in four treatment categories to cover additional treatment categories • Enabling informed decision-making through the delivery of transparent cost, quality, and physician-patient experience information to members of its affiliated health plans • Empowering consumers by developing consumer-directed health care products in every major WellPoint market • Delivering coordinated, point-of-care clinical and administrative information to providers through electronic health records • Establishing for consumers access to a one-stop shop for health care information to meet their needs • Establishing goals and tracking progress for the member health index and state health index to monitor and measure health improvement • Participating in the "patient charter" initiative that establishes guiding principles for physician performance measurement and focusing on nationally-recognized quality metrics	• Should support the establishment of consistent, national metrics and reporting requirements on cost and quality • Should work collaboratively with providers, trade associations, and regulators to ensure fair and accurate physician performance reporting • Should establish interoperable Health IT standards that will allow secure transmission of any individual's health information to any payer or provider • Should establish payment strategies in public programs that reward quality

Focus on prevention and manage chronic illness

The Problem: Utilization in the health care system is largely driven by the more than 133 million Americans who live with chronic conditions and account for more than 75 percent of the nation's $2 trillion medical care costs.[24]

What WellPoint is Doing	What the Government Should Do
• Expanding and enhancing successful health management programs to engage members of its affiliated health plans and provide them a one-stop shop for managing their condition • Integrating Health IT to deliver prevention, compliance, and care management messaging and information to affiliated health plan members, clinicians and clinical associates • Encouraging a coordinated primary care team approach through patient-centered medical home initiatives • Providing incentives for the delivery of preventive services and disease management protocols and drug regimen compliance • Working with employers to establish wellness programs that encourage employees to be healthy • Developing innovative health insurance products that emphasize and reward prevention • Deploying initiatives, such as www.NuestroBien.com, that provide health information that is targeted to improve the health of under-served communities	• Should establish interoperable Health IT standards that will allow secure transmission of any individual's health information to any payer or provider • Should enhance disease management in public programs, including Medicare, Medicaid and SCHIP • Should establish coordinated care and medical home initiatives in public programs, including Medicare, Medicaid and SCHIP

Promote strategies that improve effective use of drug therapies to prevent and manage illness

The Problem: Current utilization of drug treatments is far from optimal, with inefficient prescribing and a high prevalence of drug-related adverse events.[25]

What WellPoint is Doing	What the Government Should Do
• Maintaining a pharmacy and therapeutics committee process to establish evidence-based clinical designations and formulary tiering • Promoting appropriate generic utilization and dispensing through multiple pharmacy benefit manager and clinical pharmacy strategies • Providing incentives for appropriate generic substitution through pay-for-performance • Expanding e-prescribing programs to inform physicians and members of its affiliated health plans of generic alternatives	• Should establish generic-first strategies in publicly funded programs • Should help facilitate electronic prescribing to achieve 100 percent penetration • Should encourage generic specialty pharmaceutical development with "add-on" biologics legislation • Should allow for mail-order-only benefits to help reduce benefit costs • Should permit prior authorization to help ensure safe and appropriate use of prescription drugs while controlling costs

Promote strategies to reduce medical errors and adverse drug events

The Problem: Medical errors and drug safety events contribute to up to 2.4 million extra hospital days per year, 32,000 annual deaths, and $9 billion in costs annually.[26] Additionally, an estimated 1.5 million preventable adverse drug events occur each year.[27]

What WellPoint is Doing	What the Government Should Do
• Deploying HealthCore's Safety Sentinel System (HSSS), teaming with the Federal Drug Administration (FDA), the National Institutes of Health (NIH), and academia to help identify, verify and mitigate adverse drug events • Establishing non-payment strategies for certain preventable adverse events • Encouraging physician and hospital safety improvement through collaborative health care improvement initiatives • Deploying Health IT and e-prescribing to identify potential allergies, drug interactions and/or duplicative, unnecessary or harmful care	• Should encourage additional collaboration with FDA on HealthCore's Safety Sentinel System • Should encourage other payers to follow CMS' lead for non-payment of medical errors • Should help facilitate e-prescribing to achieve 100 percent penetration • Should provide funding for Health IT adoption and implementation costs • Should enact reporting requirements for preventable adverse events • Should permit prior authorization to help ensure safe and appropriate use of prescription drugs

Reduce costs through eliminating fraud, reducing costs related to litigation, and improving administration

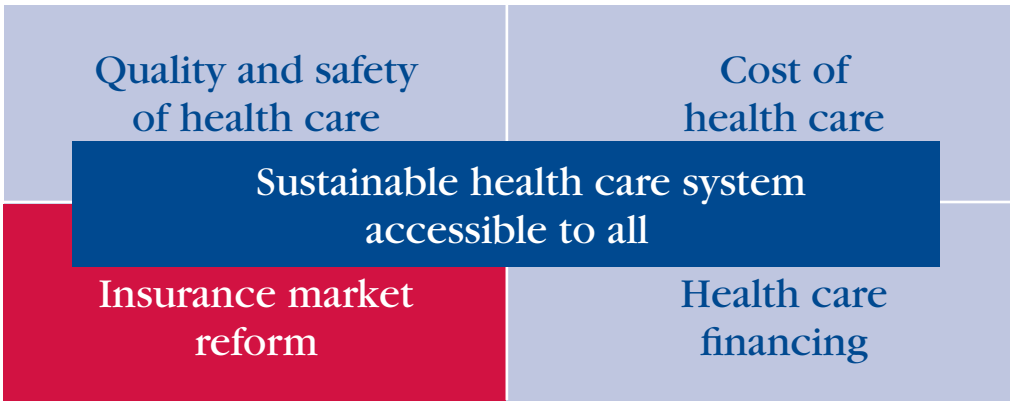
The Problem: By some estimates, health care fraud accounts for more than $100 billion of America's $2 trillion health care system.[28] Medical liability and defensive medicine could account for as much as 10 percent of premium cost.[29]

What WellPoint is Doing	What the Government Should Do
• Deploying anti-fraud initiatives, including educa tion campaigns that focus on identifying fraud and abuse in the health care system • Utilizing sophisticated utilization review tactics that can identify potentially fraudulent or abusive patterns • Introducing quality and transparency initiatives intended to help health care providers avoid the incidence of medical errors that lead to litigation • Teaming with organizations committed to the development and accelerated adoption of a much fairer, less expensive and more timely system of justice for patients injured by medical providers	• Should increase penalties for health care fraud and abuse • Should improve partnerships with other health care payers to share data on fraudulent and abusive patterns • Should support the adoption of the CAQH Committee on Operating Rules for Information Exchange (CORE) that works to facilitates provider access eligibility and benefits information of patients • Should allow insurers to communicate with their members electronically • Should enact state tort reform that establishes (1) clinical guideline "safe harbor" for physicians, (2) caps on non-economic damages, (3) caps on attorneys' fees, and (4) a preliminary evaluation of the merits of the case • Should explore alternative dispute resolution in medical malpractice cases

Covering the uninsured and improving coverage for all Americans

Enacting strategies to improve quality and control costs is essential to building a health care system that works for all Americans both now and in the future. While WellPoint believes improving health care quality and reducing costs is the key to a better system, we believe we must also get our country on a sustainable path to covering everyone.

Building a sustainable health care system



Reforming markets to better meet the needs of consumers

Health insurers must make the health insurance market work more efficiently and effectively. Additionally, much can be done to improve health insurance markets to better meet the needs of consumers. WellPoint's health care reform plan calls for reforms in the following areas to better meet the needs of consumers:

- Ensure all Americans can access affordable coverage
- Create a vibrant health insurance marketplace that facilitates competition and consumer choice and encourages insurers to create innovative products that meet the needs of consumers

Ensure all Americans can access affordable coverage

Policymakers who seek to enact a requirement for insurers to offer coverage to all applicants — "guaranteed issue" — are responding to the inability of some consumers to get coverage, which is of significant importance to Americans. However, we must address the issue in a way that does not create a dysfunctional marketplace that would disrupt coverage for the millions of insured Americans who have coverage today. Study after study has demonstrated that traditional guaranteed issue requirements result in the opposite outcome of the goals of health care reform — higher costs and more uninsured.[30] WellPoint is working to fix what is broken without breaking what works.

Traditional guaranteed issue may indeed be possible if policymakers are willing to establish an effective, enforceable mandate for all individuals to obtain coverage. Such a requirement is critical, because in a guaranteed issue environment where anyone can wait until they get sick to purchase coverage, there must be something that counteracts the incentive for healthy individuals to drop coverage. While a mandate to compel healthy individuals into the system may theoretically be possible, in reality policymakers must ensure a critical mass of individuals participate under the mandate to keep the system functional. For example, enforcing a mandate only through tax penalties will likely not be effective, because millions of American households do not file tax returns for one reason or another.[31]

If an effective, enforceable mandate is not achievable, it is still possible to meet the desire for guaranteed issue without the unintended consequences of traditional guaranteed issue in the absence of an effective, enforceable mandate. One such option is to establish improved "high risk pools" or "guaranteed access plans." These plans pool the costs of high-risk applicants who are unable to obtain coverage into a single pool of which the state subsidizes the medical costs associated with these high-risk

individuals. It is critical that the costs for these high-risk individuals are spread over a broad funding base. While 33 states have established such pools[32], they need to be improved. Many do not work well and need to be reformed to be more consumer-friendly and operate more like private coverage. Additionally, more sustainable funding sources need to be identified.

Another option to guarantee access to coverage would be a requirement for all carriers (including group-only carriers) to offer one guaranteed issue product in the individual market. The premium for this product would be capped relative to the existing underwritten market and subsidized via a broad-based funding mechanism. The state would establish insurer-specific enrollment caps based on an insurer's market share to ensure no single insurance carrier — and thus its members — carry a disproportionate amount of risk. In this way, all consumers would have the ability to purchase private coverage, while spreading the costs of high-risk individuals broadly to maintain a functional insurance pool.

Create a competitive, flexible marketplace that facilitates competition and consumer choice and encourages insurers to create innovative products that meet the needs of consumers

Most states have health insurance markets that are the result of many years of tinkering and incremental reform, leading to higher costs and reduced insurer competition. Such reforms include costly benefit mandates, access requirements, administrative mandates and rating rules that result in an increased average premium. While many of these reforms were adopted with good, consumer-friendly intentions, and few cause significant cost increases individually, the aggregate result in many states has been substantially higher insurance costs and fewer insurers willing to compete in the market. For example, due to the many rules and mandates established in Maine, WellPoint's affiliated health plan is now the only remaining major insurer continuing to offer new coverage to individuals in the commercial market, and coverage is very expensive.

WellPoint has proven that innovative products in states that allow for product flexibility can have great success in attracting the uninsured. For example, for as little as $144 per month, a 35-year old female living in Los Angeles can purchase coverage through the California affiliated health plan's new individual market product that offers a benefit package that includes up to $7 million in lifetime benefits combined with preventive care coverage outside the $500 deductible.[33] This product was recently rolled out in two states, and half, or 25,000, of the new enrollees were previously uninsured.[34] States can pave the way for insurers to offer such innovative products by enacting laws that give them more flexibility with respect to benefit and product design, allowing insurers to offer coverage at a more affordable price point.

While these reforms to the insurance marketplace will respond to the needs of consumers, they will not be effective or sustainable unless they are also paired with reforms to the delivery system to lower costs and improve quality.

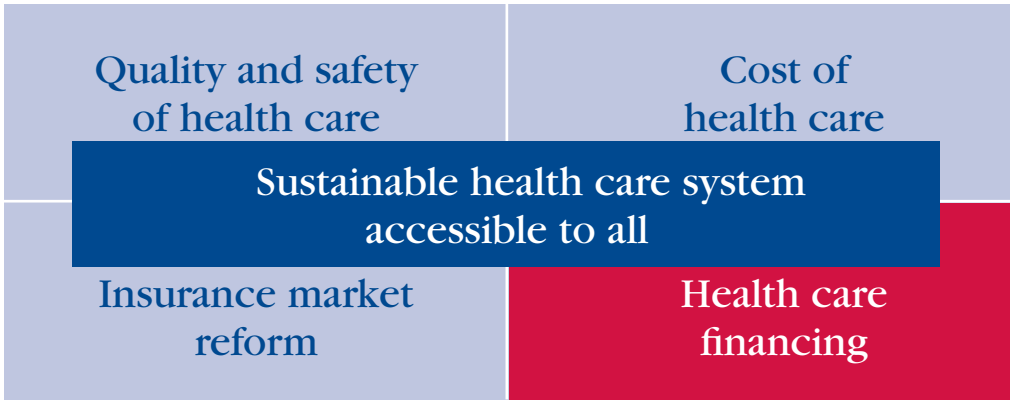
What experience has shown:

WellPoint has extensive experience witnessing first-hand how market regulations can upset the marketplace in preventable ways. After 45 insurers fled the state of Kentucky, WellPoint's affiliated health plan in Kentucky was the last carrier in the individual market before the state reversed the reforms. WellPoint's affiliated health plan in Maine is now the last major carrier actively writing in the state's individual market. The Maine Bureau of Insurance has approved premium increases of 124 percent in the last 6 years due to individuals waiting until they get sick to get coverage (WellPoint analysis of rates, January 2001 to January 2007).

In New York, studies have found that a large number of individuals dropped coverage soon after "guaranteed issue" was implemented with rating restrictions. The State Department of Insurance estimated that 44,000 individual policyholders dropped coverage within 12 months of the new law's effective date. The actuarial firm Milliman, Inc. estimated 500,000 individuals insured in the individual or small group market dropped coverage. Insurer Mutual of Omaha reported that 39,000 of its individual policies had lapsed over a 15-month period (Meier, 2005).

In Washington State, policymakers removed the requirement of "guaranteed issue" after carriers dropped out of the marketplace to such an extent that policies were not available to individuals in most counties (National Center for Policy Analysis, 1994).

Building a sustainable health care system

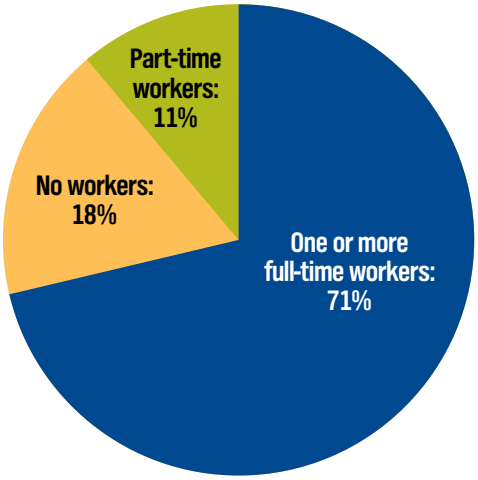


Enacting strategies to expand and finance sustainable coverage for all Americans

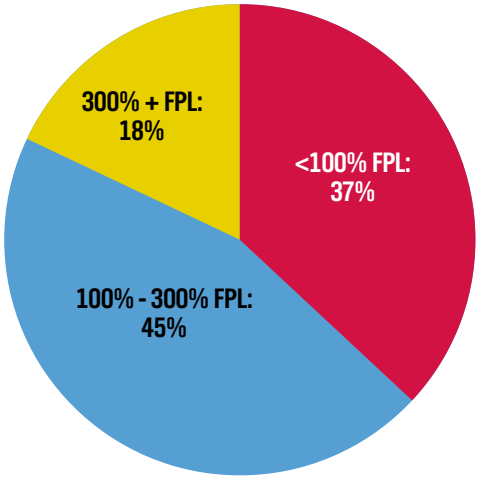
WellPoint believes that we must get our country on a sustainable path to covering everyone. With 82 percent of the uninsured having family incomes less than 300 percent of the Federal Poverty Level (FPL)[35], even with strategies to improve quality and control costs, WellPoint believes that financing must be part of any strategy to significantly expand coverage. WellPoint's health care reform plan calls for the following strategies to put America on a sustainable path to covering everyone that focuses on public-private partnerships and expanding the employer-based system:

- Improve and expand programs for the most needy
- Provide a bridge to self-sufficiency through premium assistance
- Expand the employer-based system
- Equalize tax treatment for individuals purchasing coverage on their own
- Increase funding for public-private partnerships

Uninsured by family employment status[36]



Uninsured by federal poverty level[36]



Improving and expanding public programs for the most needy

WellPoint believes that expanding public programs for the most needy is an essential element in addressing the uninsured. WellPoint encourages states and the federal government to improve and expand public programs to broaden the safety net for many who have previously been closed out of the system. We support aggressive outreach efforts to sign up those who are already eligible for public assistance but not currently enrolled, a population that represents almost 26 percent of the uninsured, or 12 million individuals.[36] However, given varying budgetary, political and other factors in each state, we do not advocate a mandate on states to expand coverage.

We do, however, support expanding public programs to cover not only children up to 300 percent of FPL, but also parents up to 200 percent of FPL and childless adults up to 100 percent of FPL. These expansions, if adopted by all states, could extend coverage to 6.5 million children, 9.3 million parents of Medicaid/SCHIP-eligible children and 5.1 million childless adults. Combined, this expansion of public programs and efforts to reach those who are already eligible for coverage could cover up to 33 million of the 45.7 million people who are currently uninsured.[36]

Providing a bridge to self-sufficiency through premium assistance

Many lower-income individuals earn too much money to be eligible for public programs but still find the cost of private coverage out-of-reach. For that reason, we support providing all individuals and families earning up to 300 percent of FPL with a bridge to self-sufficiency — that is, providing them with financial assistance to enable them to purchase private coverage that is available to them. Several states have implemented such programs, frequently referred to as premium assistance programs, and these programs are receiving renewed interest at the federal and state levels. States with successful programs could serve as a model for other initiaives.

Expanding the employer-based system

Studies demonstrate that Americans like getting their health insurance from their employer; only 17 percent of individuals enrolled in employer-sponsored coverage say that they would prefer to buy coverage on their own if it cost the same.[37] Advantages of employer-based coverage include the fact that employers are sophisticated buyers of coverage that meets the needs of their employees; employers make enrollment almost effortless; and employers can partner with insurers to develop innovative strategies that promote a healthier, more productive workforce.

The vast majority of the uninsured — approximately 82 percent — are in families with one or more workers who do not have access to employer-sponsored coverage.[36] Today, they do not even have the ability to purchase coverage with pre-tax dollars. Giving these individuals the ability to purchase coverage through their employer is a logical first step to universal coverage. If this proportion of the uninsured was enrolled in coverage through its employers, the number of uninsured Americans would drop from 45.7 million to about 8 million, or by more than 80 percent.[36]

What do employers and voters think?

Employers: Surveys show that most employers like offering **coverage, with only 32 percent saying that they would prefer to** get out of the business of offering coverage to their employees **(Newsline, 2008).**

Voters: There is broad-based support for requiring employers **to help facilitate and contribute towards the** purchasing of coverage for their employees. **A recent poll found that 73 percent of** voters support such a **requirement (Field Poll, 2008). Additionally,** 77 percent of voters **support the idea of providing state-subsidized health** insurance coverage **to low-income adults (Field Poll, 2008).**

Equalize tax treatment for individuals purchasing coverage on their own

It might seem unjust to allow those who purchase coverage through an employer to pay for coverage with before-tax income, while forcing individuals who buy coverage on their own to pay with after-tax income — yet that is the status of America's antiquated tax code. Although one strategy to ensure more Americans can purchase coverage with pre-tax dollars is to expand the employer-based system (as noted above), a way to provide many more Americans a substantial discount on coverage (and thus put coverage within reach for many of the uninsured) is to directly extend the deductibility of the cost of coverage to coverage obtained in the individual market. While many proposals under consideration would enact tax deductibility for individuals and limit or eliminate the tax deductibility of employer-based coverage, we believe that the cost of all coverage, regardless of the source, should be tax deductible.

How does WellPoint's plan address 45.7 M uninsured?[36]

Element	Eligible
Extend outreach to those already eligible for programs	12M
Kids expansion to 300 percent of FPL	6.5 M
Parents expansion to 200 percent of FPL	9.3 M
Childless adults to 100 percent of FPL	5.1 M
Premium assistance	4.6 M
Total	37.5 M

For the remaining 18 percent of uninsured who make over 300 percent of FPL ($67,000 for a family of four), focus on expanding the employer-based system and designing attractive products

Increasing funding for public-private partnerships

With 82 percent of the uninsured with family incomes less than 300 percent of the federal poverty level (FPL)[36], placing America on a path to universal coverage will no doubt require additional government funding for these additional public-private partnerships. While new funding is needed, funding can also be redistributed from existing programs. Policymakers should not lose sight of the fact that the uninsured are currently receiving some services with public funding that can potentially be freed up, and that current public programs can be made more efficient to create savings. WellPoint believes that policymakers should evaluate the following funding sources when searching for ways to expand public-private partnerships that seek to expand coverage:

- **Evaluate use of existing funding where possible.** Providers currently receive billions of dollars in uncompensated care funding for caring for the uninsured. These funds could be redistributed to fund proposals that would reduce the uninsured.
- **Expand penetration of Medicaid Managed Care in existing programs.** Currently, only 16 percent of Medicaid spending is in the form of managed care capitation payments; this creates a significant opportunity for further reforms that expand the penetration of Medicaid Managed Care, which is proven to improve care and lower costs. [38]
- **Evaluate raising tobacco tax revenue.** If additional funding is needed beyond tobacco tax revenue, policymakers should evaluate other taxes that promote healthy behavior and/or broad-based funding sources.
- **Health insurance access assessments.** The health insurance industry can be part of a broad-based funding mechanism to finance individual market access. However, it should not be the sole source of funding for such efforts.

Conclusion

By focusing on the strengths of America's health care system, and addressing its deficiencies without breaking what works, we can reposition our health care system for the 21st century. Ultimately, improving health care quality, which will help manage costs, will be the critical aspect of any approach to health care reform. This will enable us to put the health care system onto a sustainable path to covering everyone. As the nation's largest health benefits company by membership, we hope to work with policymakers to achieve these objectives.

About WellPoint, Inc.

WellPoint is **committed to improving the lives and health of the people and** communities we serve by simplifying the connection **between health, care and value. Our goal** is to help shape the impact each health **care decision has on individuals, the health care system at-large, and our communities. WellPoint's more than 42,000 associates work every day to help** create the best health care value for our **customers. Through** collaborations with **providers and with innovative programs, WellPoint's affiliated health plans reward** healthy lifestyles **and quality, safe and** effective care. As the **nation's largest health benefits company, with more than 35** million members in its **affiliated health plans,** WellPoint is at the center of the health **care system. This position provides us** with the relationships **and insights needed to help create affordable and actionable** solutions that improve health care.

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9 Based on July 2008 federal minimum wage of $6.55 per hour, or $13,624 per year for 40-hours for all 52 weeks in a year.
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