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**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549

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**FORM 10-Q/A  
(Amendment No. 1)**

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(Mark One)

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

For the quarterly period ended: **June 30, 2003**

Or

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

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission File Number: **1-12718**

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**HEALTH NET, INC.**

(Exact name of registrant as specified in its charter)

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**Delaware**  
(State or other jurisdiction  
of incorporation or organization)

**21650 Oxnard Street, Woodland Hills, CA**  
(Address of principal executive offices)

**95-4288333**  
(I.R.S. Employer  
Identification No.)

**91367**  
(Zip Code)

**(818) 676-6000**

(Registrant's telephone number, including area code)

(Former name, former address and former fiscal year, if changed since last report)

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

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Exchange Act). Yes  No

Indicate the number of shares outstanding of each of the issuer's classes of common stock as of the latest practicable date:

The number of shares outstanding of the registrant's Class A Common Stock as of March 10, 2004 was 112,743,445 (excluding 20,873,729 shares held as treasury stock) and no shares of Class B Common Stock were outstanding as of such date.

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## **EXPLANATORY NOTE**

This Amendment No. 1 on Form 10-Q/A to the Quarterly Report on Form 10-Q for the quarter ended June 30, 2003 is being filed to present restated condensed consolidated financial statements as of June 30, 2003 and for the second quarters and six months ended June 30, 2003 and 2002. A description of the adjustments that comprise the restatements is discussed in Note 2 of the Notes to Condensed Consolidated Financial Statements included in this report.

This report on Form 10-Q/A amends and restates Item 1, 2 and 4 of Part I and Item 6 of Part II of the original Form 10-Q, and no other information included in the original Form 10-Q is amended hereby. This report on Form 10-Q/A does not reflect the effect of any events subsequent to the filing of the original Form 10-Q, except for the aforementioned restatements.

**HEALTH NET, INC.  
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**PART I. FINANCIAL INFORMATION**

**Item 1. Financial Statements**

**HEALTH NET, INC.  
CONDENSED CONSOLIDATED BALANCE SHEETS  
(Amounts in thousands)  
(Unaudited)**

	<u>June 30, 2003</u>	<u>December 31, 2002</u>
	As Restated See Note 2	
<b>ASSETS</b>		
Current Assets:		
Cash and cash equivalents	\$ 788,296	\$ 832,793
Investments—available for sale	955,401	1,008,975
Premiums receivable, net	184,239	164,043
Amounts receivable under government contracts	92,982	77,969
Reinsurance and other receivables	114,327	108,147
Deferred taxes	60,081	62,930
Other assets	95,654	91,399
	<u>2,290,980</u>	<u>2,346,256</u>
Property and equipment, net	198,502	199,218
Goodwill, net	762,066	762,066
Other intangible assets, net	21,129	22,339
Deferred taxes	15,270	12,216
Other noncurrent assets	168,077	118,656
	<u>168,077</u>	<u>118,656</u>
Total Assets	<u>\$3,456,024</u>	<u>\$3,460,751</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current Liabilities:		
Reserves for claims and other settlements	\$1,079,748	\$1,025,269
Health care and other costs payable under government contracts	236,935	219,454
Unearned premiums	73,905	175,846
Accounts payable and other liabilities	281,732	282,844
	<u>1,672,320</u>	<u>1,703,413</u>
Total current liabilities	1,672,320	1,703,413
Senior notes payable	398,892	398,821
Other noncurrent liabilities	63,246	58,101
	<u>63,246</u>	<u>58,101</u>
Total Liabilities	<u>2,134,458</u>	<u>2,160,335</u>
Commitments and contingencies		
Stockholders' Equity:		
Common stock and additional paid-in capital	760,430	730,626
Restricted common stock	6,229	1,913
Unearned compensation	(5,278)	(1,441)
Treasury Class A common stock, at cost	(413,918)	(259,513)
Retained earnings	964,665	817,746
Accumulated other comprehensive income	9,438	11,085
	<u>1,321,566</u>	<u>1,300,416</u>
Total Stockholders' Equity	1,321,566	1,300,416
Total Liabilities and Stockholders' Equity	<u>\$3,456,024</u>	<u>\$3,460,751</u>

See accompanying notes to condensed consolidated financial statements.

**HEALTH NET, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
(Amounts in thousands, except per share data)  
(Unaudited)

	Second Quarter Ended June 30,	
	2003	2002
	As Restated See Note 2	As Restated See Note 2
<b>REVENUES</b>		
Health plan services premiums	\$2,259,867	\$2,106,110
Government contracts	465,727	368,660
Net investment income	14,364	15,104
Other income	12,704	15,376
	<hr/>	<hr/>
Total revenues	2,752,662	2,505,250
	<hr/>	<hr/>
<b>EXPENSES</b>		
Health plan services	1,888,966	1,769,753
Government contracts	443,549	356,885
General and administrative	219,942	205,361
Selling	56,800	46,188
Depreciation	14,453	15,132
Amortization	669	2,522
Interest	9,769	10,338
Loss on assets held for sale	—	2,600
	<hr/>	<hr/>
Total expenses	2,634,148	2,408,779
	<hr/>	<hr/>
Income before income taxes	118,514	96,471
Income tax provision	43,730	32,257
	<hr/>	<hr/>
Net income	\$ 74,784	\$ 64,214
	<hr/>	<hr/>
Basic and diluted earnings per share:		
Basic	\$ 0.64	\$ 0.51
Diluted	\$ 0.63	\$ 0.50
Weighted average shares outstanding:		
Basic	116,446	125,620
Diluted	118,631	127,800

See accompanying notes to condensed consolidated financial statements.

**HEALTH NET, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
(Amounts in thousands, except per share data)  
(Unaudited)

	Six Months Ended June 30,	
	2003	2002
	As Restated See Note 2	As Restated See Note 2
<b>REVENUES</b>		
Health plan services premiums	\$4,497,195	\$4,196,427
Government contracts	919,283	718,162
Net investment income	27,343	30,705
Other income	24,526	29,290
<b>Total revenues</b>	<b>5,468,347</b>	<b>4,974,584</b>
<b>EXPENSES</b>		
Health plan services	3,750,156	3,520,656
Government contracts	877,066	696,306
General and administrative	443,994	421,192
Selling	111,936	93,699
Depreciation	29,464	28,610
Amortization	1,338	4,983
Interest	19,531	20,527
Loss on assets held for sale	—	2,600
<b>Total expenses</b>	<b>5,233,485</b>	<b>4,788,573</b>
Income from operations before income taxes and cumulative effect of a change in accounting principle	234,862	186,011
Income tax provision	87,943	63,239
Income before cumulative effect of a change in accounting principle	146,919	122,772
Cumulative effect of a change in accounting principle, net of tax	—	(8,941)
<b>Net income</b>	<b>\$ 146,919</b>	<b>\$ 113,831</b>
<b>Basic earnings per share:</b>		
Income from operations	\$ 1.25	\$ 0.98
Cumulative effect of a change in accounting principle	—	(0.07)
<b>Net</b>	<b>\$ 1.25</b>	<b>\$ 0.91</b>
<b>Diluted earnings per share:</b>		
Income from operations	\$ 1.23	\$ 0.97
Cumulative effect of a change in accounting principle	—	(0.07)
<b>Net</b>	<b>\$ 1.23</b>	<b>\$ 0.90</b>
<b>Weighted average shares outstanding:</b>		
Basic	117,703	124,755
Diluted	119,595	126,941

See accompanying notes to condensed consolidated financial statements.

**HEALTH NET, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(Amounts in thousands)  
(Unaudited)

	Six Months Ended June 30,	
	2003	2002
	As Restated See Note 2	As Restated See Note 2
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
Net income	\$ 146,919	\$ 113,831
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Amortization and depreciation	30,802	33,593
Loss on assets held for sale	—	2,600
Cumulative effect of a change in accounting principle	—	8,941
Other changes	3,517	4,405
Changes in assets and liabilities:		
Premiums receivable and unearned premiums	(122,137)	(87,117)
Other assets	(8,971)	8,437
Amounts receivable/payable under government contracts	2,468	(83,429)
Reserves for claims and other settlements	54,998	(67,074)
Accounts payable and other liabilities	12,542	14,721
Net cash provided by (used in) operating activities	120,138	(51,092)
<b>CASH FLOWS FROM INVESTING ACTIVITIES:</b>		
Sales of investments	135,111	76,829
Maturities of investments	306,769	162,317
Purchases of investments	(410,622)	(334,315)
Purchases of property and equipment	(28,589)	(27,974)
Purchases of restricted investments and other	(30,843)	297
Net cash used in investing activities	(28,174)	(122,846)
<b>CASH FLOWS FROM FINANCING ACTIVITIES:</b>		
Proceeds from exercise of stock options and employee stock purchases	22,118	40,906
Borrowings on credit facility	—	50,000
Borrowings under term loan promissory note	5,680	—
Repurchases of common stock	(158,411)	(28,370)
Repayment of debt and other noncurrent liabilities	(5,848)	(125,214)
Net cash used in financing activities	(136,461)	(62,678)
Net decrease in cash and cash equivalents	(44,497)	(236,616)
Cash and cash equivalents, beginning of year	832,793	907,729
Cash and cash equivalents, end of period	\$ 788,296	\$ 671,113
<b>SUPPLEMENTAL SCHEDULE OF INVESTING ACTIVITIES:</b>		
Issuance of restricted stock	\$ 4,316	\$ 1,034
Securities reinvested from restricted available for sale investments to restricted cash	52,505	10,167

See accompanying notes to condensed consolidated financial statements.

**HEALTH NET, INC.**  
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
(Unaudited)

**1. BASIS OF PRESENTATION**

Health Net, Inc. (referred to hereafter as the Company, we, us or our) prepared the condensed consolidated financial statements following the rules and regulations of the Securities and Exchange Commission (SEC) for interim reporting. As permitted under those rules and regulations, certain footnotes or other financial information that are normally required by accounting principles generally accepted in the United States of America (GAAP) have been condensed or omitted if they substantially duplicate the disclosures contained in the annual audited financial statements.

We are responsible for the accompanying unaudited condensed consolidated financial statements. These condensed consolidated financial statements include all normal and recurring adjustments that are considered necessary for the fair presentation of our financial position and operating results in accordance with GAAP. In accordance with GAAP, we make certain estimates and assumptions that affect the reported amounts. Actual results could differ from estimates. As these are condensed financial statements, one should also read our 2002 consolidated financial statements and notes included in our Form 10-K/A for the year ended December 31, 2002 filed with the SEC in March 2004.

Revenues, expenses, assets and liabilities can vary during each quarter of the year. Therefore, the results and trends in these interim financial statements may not be indicative of those for the full year.

**2. RESTATEMENT**

On February 11, 2004, we announced that we would restate our consolidated financial statements for the first three quarters of 2003 and for the years ended December 31, 2002 and 2001. Subsequent to the issuance of the June 30, 2003 condensed consolidated financial statements, management determined that the correction of accounting errors, associated primarily with the period of accounting recognition, with respect to certain general and administrative (G&A) expenses was required. Additional restatements to correct certain known errors were also recorded.

The following table summarizes the various restatement adjustments and their impact on our net income and diluted earnings per share as previously reported for the second quarters and six months ended June 30, 2003 and 2002. The restatement adjustments are discussed in greater detail in the paragraphs that follow the table.

(Increases (decreases) in thousands)	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Net income as previously reported	\$74,535	\$64,735	\$142,764	\$114,549
Restatement adjustments:				
Workers' compensation expenses and liabilities	1,500	(450)	3,000	(900)
Rental expenses	(615)	(277)	(740)	(570)
Consulting costs	—	239	—	478
Deferred compensation plan	(241)	321	(233)	342
Termination benefits	(249)	—	(249)	—
Other	—	(599)	4,917	(417)
<b>Total adjustments before income tax effect</b>	<b>395</b>	<b>(766)</b>	<b>6,695</b>	<b>(1,067)</b>
Income tax effect	146	(245)	2,540	(349)
<b>Total adjustments</b>	<b>249</b>	<b>(521)</b>	<b>4,155</b>	<b>(718)</b>
<b>Net income as restated</b>	<b>\$74,784</b>	<b>\$64,214</b>	<b>\$146,919</b>	<b>\$113,831</b>
Diluted earnings per share as previously reported	\$ 0.63	\$ 0.51	\$ 1.19	\$ 0.90
Diluted earnings per share as restated	\$ 0.63	\$ 0.50	\$ 1.23	\$ 0.90

*Workers' compensation expenses and liabilities.* Changes to our workers' compensation insurance coverage beginning on January 1, 2000 resulted in our having partial coverage for certain potential claims with respect to which we had previously been fully insured. The restatement adjustments increasing (decreasing) pretax income by approximately \$1.5 million and \$(0.5) million for the second quarters ended June 30, 2003 and 2002, respectively, and \$3.0 million and \$(0.9) million for the six months ended June 30, 2003 and 2002, respectively, were made to appropriately reflect accruals associated with the self-insured portion of workers' compensation claims for those changes in our insurance coverage.



*Rental expenses.* The restatement adjustments decreasing pretax income by approximately \$0.6 million and \$0.3 million for the second quarters ended June 30, 2003 and 2002, respectively, and \$0.7 million and \$0.6 million for the six months ended June 30, 2003 and 2002, respectively, were made to correctly reflect the accrual of rent on a straight-line basis under certain leases containing rent escalation clauses.

*Consulting costs.* The restatement adjustments increasing pretax income by approximately \$0.2 million and \$0.5 million for the second quarter and six months ended June 30, 2002, respectively, reflect a correction to reverse the expensing during 2002 of consulting costs that had been incorrectly recorded as a prepaid expense during the fourth quarter of 2001.

*Deferred compensation plan.* The restatement adjustments (decreasing) increasing pretax income by approximately \$(0.2) million and \$0.3 million for the second quarter ended June 30, 2003 and 2002, respectively, and \$(0.2) million and \$0.3 million for the six months ended June 30, 2003 and 2002, respectively, reflect (losses) earnings related to one of our deferred compensation plans which became effective May 1, 1998. We had previously not properly accounted for the benefits earned by participants on their compensation deferrals nor the investment income related to the trust assets for this deferred compensation plan. Additionally, these adjustments resulted in an increase to noncurrent assets of \$10.7 million and an increase to other noncurrent liabilities of \$9.6 million as of June 30, 2003.

*Termination benefits.* The restatement adjustment decreasing pretax income by approximately \$0.2 million for the second quarter and six months ended June 30, 2003, was made to correctly reflect the accrual of termination benefits related to our Health Net One consolidation project that we had not previously recorded.

*Other pretax income adjustments:*

- a) An adjustment decreasing pretax income for the six months ended June 30, 2003 by approximately \$3.3 million related to use by our employees in December 2002 of their accrued paid time off that had not been appropriately recorded as a reduction of the related liability during the fourth quarter ended December 31, 2002;
- b) An adjustment to increase health plan premiums by approximately \$2.8 million for the six months ended June 30, 2003 reflects a correction to reverse the recording of premium adjustments that should have been recorded during the third quarter ended September 30, 2002 upon communication to us by the U.S. Office of Personnel Management related to our participation in California's federal employee health benefit program;
- c) An adjustment increasing pretax income by approximately \$2.2 million for the six months ended June 30, 2003 related to pharmacy rebates that we inadvertently recorded twice in government contracts costs during the fourth quarter of 2002;
- d) The correction of a reconciling item of \$1.9 million that increased pretax income for the six months ended June 30, 2003 that should have been expensed in government contracts costs during 2001;
- e) Various other adjustments had a net effect of (decreasing) increasing pretax income by \$(0.6) million for the second quarter ended June 30, 2002, and \$1.3 million and \$(0.4) million for the six months ended June 30, 2003 and 2002, respectively.

*Deferred tax asset and liability reclassifications.* We reclassified deferred tax asset and liability amounts, primarily related to deferred compensation and executive benefit plan liabilities, to appropriately reflect their classification as current or noncurrent. This resulted in a decrease to current deferred tax assets of \$18.4 million, an increase in noncurrent deferred tax assets of \$9.8 million, and a decrease in noncurrent deferred tax liabilities of \$8.6 million as of June 30, 2003.

*Other liabilities reclassification.* A reclassification of aged outstanding checks of \$10 million decreasing reserves for claims and other settlements and increasing accounts payable and other liabilities as of June 30, 2003 was recorded.

The following tables summarize the effects of the various restatements on our condensed consolidated statements of operations as previously reported (amounts in thousands, except per share data):

	Second Quarter Ended June 30,			
	2003		2002	
	As Previously Reported	As Restated	As Previously Reported	As Restated
Net investment income	\$ 14,004	\$ 14,364	\$ 15,318	\$ 15,104
Other income	12,704	12,704	15,876	15,376
Total revenues	2,752,302	2,752,662	2,505,964	2,505,250
General and administrative	219,977	219,942	204,484	205,361
Selling	56,800	56,800	46,688	46,188
Amortization	669	669	2,847	2,522
Total expenses	2,634,183	2,634,148	2,408,727	2,408,779
Income before income taxes	118,119	118,514	97,237	96,471
Income tax provision	43,584	43,730	32,502	32,257
Net income	74,535	74,784	64,735	64,214
Basic and diluted earnings per share:				
Basic	\$ 0.64	\$ 0.64	\$ 0.52	\$ 0.51
Diluted	\$ 0.63	\$ 0.63	\$ 0.51	\$ 0.50

	Six Months Ended June 30,			
	2003		2002	
	As Previously Reported	As Restated	As Previously Reported	As Restated
Health plan services premiums	\$4,494,435	\$4,497,195	\$4,196,427	\$4,196,427
Net investment income	27,079	27,343	30,890	30,705
Other income	24,526	24,526	30,303	29,290
Total revenues	5,465,323	5,468,347	4,975,782	4,974,584
Government contracts	881,091	877,066	696,306	696,306
General and administrative	444,140	443,994	419,660	421,192
Selling	111,436	111,936	94,712	93,699
Amortization	1,338	1,338	5,633	4,983
Total expenses	5,237,156	5,233,485	4,788,704	4,788,573
Income from operations before income taxes and cumulative effect of a change in accounting principle	228,167	234,862	187,078	186,011
Income tax provision	85,403	87,943	63,588	63,239
Income from operations before cumulative effect of a change in accounting principle	142,764	146,919	123,490	122,772
Net income	142,764	146,919	114,549	113,831
Basic earnings per share:				
Income from operations	\$ 1.21	\$ 1.25	\$ 0.99	\$ 0.98
Net	\$ 1.21	\$ 1.25	\$ 0.92	\$ 0.91
Diluted earnings per share:				
Income from operations	\$ 1.19	\$ 1.23	\$ 0.97	\$ 0.97
Net	\$ 1.19	\$ 1.23	\$ 0.90	\$ 0.90

The following table summarizes the effects of the various restatements on our condensed consolidated balance sheet as previously reported (amounts in thousands):

	June 30, 2003	
	As Previously Reported	As Restated
Deferred taxes – current	\$ 77,314	\$ 60,081
Total current assets	2,308,213	2,290,980
Deferred taxes – noncurrent	—	15,270
Other noncurrent assets	157,387	168,077
Total Assets	3,447,297	3,456,024
Reserves for claims and other settlements	1,089,717	1,079,748
Accounts payable and other liabilities	264,186	281,732
Total current liabilities	1,664,743	1,672,320
Deferred taxes – noncurrent	8,618	—
Other noncurrent liabilities	49,000	63,246
Total Liabilities	2,121,253	2,134,458
Retained earnings	969,143	964,665
Total Stockholders' Equity	1,326,044	1,321,566
Total Liabilities and Stockholders' Equity	3,447,297	3,456,024

### 3. SIGNIFICANT ACCOUNTING POLICIES

#### Comprehensive Income

Our comprehensive income is as follows (amounts in thousands):

	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Net income	\$74,784	\$64,214	\$146,919	\$113,831
Other comprehensive income (loss), net of tax:				
Net change in unrealized appreciation on investments Available for sale	147	9,607	(1,647)	4,867
Comprehensive income	\$74,931	\$73,821	\$145,272	\$118,698

## Earnings Per Share

Basic earnings per share excludes dilution and reflects net income divided by the weighted average shares of common stock outstanding during the periods presented. Diluted earnings per share is based upon the weighted average shares of common stock and dilutive common stock equivalents (stock options and restricted stock) outstanding during the periods presented. Common stock equivalents arising from dilutive stock options are computed using the treasury stock method. There were 2,185,000 and 1,892,000 shares of dilutive common stock equivalents for the second quarter and six months ended June 30, 2003, respectively, and 2,180,000 and 2,186,000 shares of dilutive common stock equivalents for the second quarter and six months ended June 30, 2002, respectively. Included in the dilutive common stock equivalents for the second quarter and six months ended June 30, 2003 are 257,000 shares of restricted common stock, and 40,000 shares of restricted common stock for the second quarter and six months ended June 30, 2002.

Options to purchase an aggregate of 1,158,000 and 1,934,000 shares of common stock during the second quarter and six months ended June 30, 2003, respectively, and 1,477,000 and 2,290,000 shares of common stock during the second quarter and six months ended June 30, 2002, respectively, were not included in the computation of diluted earnings per share because the options' exercise prices were greater than the average market price of the common stock for each respective period. These options expire through June 2013.

In April 2002, our Board of Directors authorized us to repurchase up to \$250 million (net of exercise proceeds and tax benefits from the exercise of employee stock options) of our Class A Common Stock. As of June 30, 2003, we had repurchased an aggregate of 12,569,255 shares of our Class A Common Stock under this repurchase program (see Note 6).

## Stock-Based Compensation

As permitted under Statement of Financial Accounting Standards (SFAS) No. 123, "Accounting for Stock-Based Compensation" (SFAS No. 123), we have elected to continue accounting for stock-based compensation under the intrinsic value method prescribed in Accounting Principles Board (APB) Opinion No. 25, "Accounting for Stock Issued to Employees" (APB Opinion No. 25). Under the intrinsic value method, compensation cost for stock options is measured at the date of grant as the excess, if any, of the quoted market price of our stock over the exercise price of the option. We apply APB Opinion No. 25 and related Interpretations in accounting for our plans. Accordingly, no compensation cost has been recognized for our stock option or employee stock purchase plans. Had compensation cost for our plans been determined based on the fair value at the grant dates of options and employee purchase rights consistent with the method of SFAS No. 123, our net income and earnings per share would have been reduced to the pro forma amounts indicated below (amounts in thousands, except per share data):

	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Net income, as reported	\$74,784	\$64,214	\$146,919	\$113,831
Add: Stock-based employee compensation expense included in reported net income, net of related tax effects	314	77	516	77
Deduct: Total stock-based employee compensation expense determined under fair value based method for all awards subject to SFAS No. 123, net of related tax effects	(4,525)	(4,303)	(8,202)	(8,118)
Net income, pro forma	\$70,573	\$59,988	\$139,233	\$105,790
Basic earnings per share:				
As reported	\$ 0.64	\$ 0.51	\$ 1.25	\$ 0.91
Pro forma	\$ 0.61	\$ 0.48	\$ 1.18	\$ 0.85
Diluted earnings per share:				
As reported	\$ 0.63	\$ 0.50	\$ 1.23	\$ 0.90
Pro forma	\$ 0.59	\$ 0.47	\$ 1.16	\$ 0.83

The weighted average fair value for options granted during the second quarter and six months ended June 30, 2003 was \$7.83 and \$7.96, respectively. The weighted average fair value for options granted during the second quarter and six months ended June 30, 2002 was \$11.19 and \$9.98, respectively. The fair values were estimated using the Black-Scholes option-pricing model.

The weighted average assumptions used in the fair value calculation for the following periods were:

	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Risk-free interest rate	2.07%	3.32%	2.65%	3.32%
Expected option lives (in years)	3.4	4.1	3.9	4.1
Expected volatility for options	37.4%	47.2%	38.2%	47.2%
Expected dividend yield	None	None	None	None

As fair value criteria was not applied to option grants and employee purchase rights prior to 1995, and additional awards in future years are anticipated, the effects on net income and earnings per share in this pro forma disclosure may not be indicative of future amounts.

### Goodwill and Other Intangible Assets

In July 2001, the Financial Accounting Standards Board (FASB) issued two new pronouncements: SFAS No. 141, "Business Combinations" (SFAS No. 141) and SFAS No. 142, "Goodwill and Other Intangible Assets" (SFAS No. 142). SFAS No. 141 is effective as follows: (a) use of the pooling-of-interest method is prohibited for business combinations initiated after June 30, 2001; and (b) the provisions of SFAS No. 141 also apply to all business combinations accounted for by the purchase method that are completed after June 30, 2001 (that is, the date of the acquisition is July 2001 or later).

Effective January 1, 2002, we adopted SFAS No. 142 which, among other things, eliminates amortization of goodwill and other intangibles with indefinite lives. Intangible assets, including goodwill, that are not subject to amortization will be tested for impairment annually or more frequently if events or changes in circumstances indicate that we might not recover the carrying value of these assets.

We identified the following six reporting units within our businesses: Health Plans, Government Contracts, Behavioral Health, Dental & Vision, Subacute and Employer Services Group. In accordance with the transition requirements of SFAS No. 142, we completed an evaluation of goodwill at each of our reporting units upon adoption of this Standard. We also re-assessed the useful lives of our other intangible assets and determined that the estimated useful lives of these assets properly reflect the current estimated useful lives.

We performed our annual impairment test on our goodwill and other intangible assets as of June 30, 2003 at each of our reporting units and also re-evaluated the useful lives of our other intangible assets with the assistance of the same independent third-party professional services firm that assisted us in the impairment testing and measurement process in the prior year. No goodwill impairments were identified in any of our reporting units. We also determined that the estimated useful lives of our other intangible assets properly reflected the current estimated useful lives.

The changes in the carrying amount of goodwill by reporting unit are as follows (amounts in millions):

	Health Plans	Behavioral Health	Dental/ Vision	Subacute	Employer Services Group	Total
Balance at December 31, 2001	\$716.7	\$ 3.5	\$ 0.7	\$ 5.9	\$ 37.6	\$764.4
Impairment losses	—	(3.5)	—	—	(5.4)	(8.9)
Reclassification from other intangible assets (a)	6.9	—	—	—	—	6.9
Goodwill written off related to sale of business unit	—	—	—	—	(0.3)	(0.3)
Balance at December 31, 2002	\$723.6	\$ —	\$ 0.7	\$ 5.9	\$ 31.9	\$762.1
Balance at June 30, 2003	\$723.6	\$ —	\$ 0.7	\$ 5.9	\$ 31.9	\$762.1

- (a) As part of adopting SFAS No. 142, we transferred \$6.9 million of other intangible assets to goodwill since they did not meet the new criteria for recognition apart from goodwill. These other intangible assets were acquired through our previous purchase transactions.

The intangible assets that continue to be subject to amortization using the straight-line method over their estimated lives are as follows (amounts in millions):

	<u>Gross Carrying Amount</u>	<u>Accumulated Amortization</u>	<u>Net Balance</u>	<u>Amortization Period (in years)</u>
<b>As of June 30, 2003:</b>				
Provider networks	\$ 35.7	\$ (16.8)	\$ 18.9	14-40
Employer groups	92.9	(90.7)	2.2	11-23
	<u>\$ 128.6</u>	<u>\$ (107.5)</u>	<u>\$ 21.1</u>	
<b>As of December 31, 2002:</b>				
Provider networks	\$ 35.7	\$ (15.9)	\$ 19.8	14-40
Employer groups	92.9	(90.4)	2.5	11-23
	<u>\$ 128.6</u>	<u>\$ (106.3)</u>	<u>\$ 22.3</u>	

Estimated annual pretax amortization expense for other intangible assets for each of the next five years ending December 31 is as follows (amounts in millions):

<u>Year</u>	<u>Amount</u>
2003	\$ 2.7
2004	2.7
2005	2.5
2006	2.0
2007	1.6

### Restricted Cash and Investments

We and our consolidated subsidiaries are required to set aside certain funds for restricted purposes pursuant to state regulatory requirements. We have discretion as to whether we invest such funds in cash and cash equivalents or other investments. As of June 30, 2003 and December 31, 2002, the restricted cash and cash equivalents balances totaled \$55.9 million and \$4.3 million, respectively, and are included in other noncurrent assets. Certain long-term debt investments totaled \$1.3 million as of June 30, 2003 and December 31, 2002 and are included in other noncurrent assets. Short-term investments were \$75.2 million and \$109.1 million as of June 30, 2003 and December 31, 2002, respectively, and are included in investments available for sale.

### Recently Issued Accounting Pronouncements

In January 2003, the FASB issued Interpretation No. 46 (FIN 46), "Consolidation of Variable Interest Entities." FIN 46 requires an investor with a majority of the variable interests in a variable interest entity to consolidate the entity and also requires majority and significant variable interest investors to provide certain disclosures. A variable interest entity is an entity in which the equity investors do not have a controlling interest or the equity investment at risk is insufficient to finance the entity's activities without receiving additional subordinated financial support from the other parties. The maximum exposure of any investment that may be determined to be in a variable interest entity is limited to the amount invested. FIN 46 is effective for variable interest entities created or acquired after January 31, 2003. For variable interest entities created or acquired prior to February 1, 2003, the provisions of FIN 46 must be applied in the first interim or annual period beginning after June 15, 2003. The Company believes the effect of the adoption of FIN 46 will not have any effect on its results of operations and financial position.

In May 2003, the FASB issued SFAS No. 150, "Accounting for Certain Financial Instruments with Characteristics of both Liabilities and Equity" (SFAS No. 150). SFAS No. 150 addresses the issuer's accounting for certain freestanding financial instruments. The provisions of SFAS No. 150 are effective for financial instruments entered into or modified after May 31, 2003 and pre-existing instruments as of the beginning of the first interim period that commences after June 15, 2003. The adoption of SFAS No. 150 had no impact on our financial position or results of operations as the Company has no pre-existing instruments that are impacted by SFAS No. 150.

In May 2003, the FASB issued SFAS No. 149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities" (SFAS No. 149). SFAS No. 149 amends and clarifies accounting for derivative instruments, including certain derivative instruments embedded in other contracts, and for hedging activities under SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" (SFAS No. 133). SFAS No. 149 is effective for contracts entered into or modified after June 30, 2003, except as stated as follows and for hedging relationships designated after June 30, 2003. The guidance shall be applied prospectively. The provisions of SFAS No. 149 that relate to SFAS No. 133 Implementation Issues that have been effective for fiscal quarters that began

prior to June 15, 2003, shall continue to be applied in accordance with their respective effective dates. In addition, certain provisions relating to forward purchases or sales of when-issued securities or other securities that do not yet exist, shall be applied to existing contracts as well as new contracts entered into after June 30, 2003.

In November 2002, the FASB issued Interpretation No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others" (FIN No. 45). This interpretation elaborates on the disclosures to be made by the guarantor in its interim and annual financial statements about its obligations under certain guarantees that it has issued. It also requires that a guarantor recognize, at the inception of a guarantee, a liability for the fair value of the obligation undertaken in issuing the guarantee. This interpretation's initial recognition and initial measurement provisions are applicable on a prospective basis to guarantees issued or modified after December 31, 2002, irrespective of the guarantor's fiscal year-end. See Note 5 for indemnification guarantee disclosure on pending and threatened litigation related to the sale of our Florida health plan completed on August 1, 2001. As of June 30, 2003, the adoption of FIN No. 45 had no impact on our consolidated financial position or results of operations.

In July 2002, the FASB issued SFAS No. 146, "Accounting for Costs Associated with Exit or Disposal Activities" (SFAS No. 146). SFAS No. 146 addresses financial accounting and reporting for costs associated with exit or disposal activities and nullifies EITF Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (including Certain Costs Incurred in a Restructuring)" (Issue 94-3). SFAS No. 146 requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred. Under Issue 94-3, a liability for an exit cost as generally defined in Issue 94-3 was recognized at the date of an entity's commitment to an exit plan. A fundamental conclusion reached by the FASB in SFAS No. 146 is that an entity's commitment to a plan, by itself, does not create an obligation that meets the definition of a liability. Therefore, SFAS No. 146 eliminates the definition and requirements for recognition of exit costs in Issue 94-3. SFAS No. 146 also establishes that fair value is the objective for initial measurement of any exit or disposal liability. The provisions of SFAS No. 146 are effective for exit or disposal activities that were initiated after December 31, 2002. As of June 30, 2003, the adoption of SFAS No. 146 had no impact on our consolidated financial position or results of operations.

Effective January 1, 2002, we adopted SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" (SFAS No. 144). SFAS No. 144 supersedes SFAS No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," and some provisions of APB Opinion No. 30, "Reporting the Results of Operations—Reporting the Effects of Disposal of a Segment of a Business and Extraordinary, Unusual and Infrequently Occurring Events and Transactions." SFAS No. 144 sets new criteria for determining when an asset can be classified as held-for-sale as well as modifying the financial statement presentation requirements of operating losses from discontinued operations. The adoption of SFAS No. 144 had no impact on our consolidated financial position or results of operations.

#### 4. SEGMENT INFORMATION

During the fourth quarter ended December 31, 2002, changes we made in our organizational structure, in the interrelationships of our businesses and in internal reporting resulted in changes to our reportable segments. We currently operate within two reportable segments: Health Plan Services and Government Contracts. Our Health Plan Services reportable segment includes the operations of our health plans in the states of Arizona, California, Connecticut, New Jersey, New York, Oregon and Pennsylvania, the operations of our health and life insurance companies and our behavioral health, dental, vision and pharmaceutical services subsidiaries. Our Government Contracts reportable segment includes government-sponsored multi-year managed care plans through the TRICARE programs and other government contracts.

We evaluate performance and allocate resources based on profit or loss from operations before income taxes. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies in Note 3 to the consolidated financial statements included in our Annual Report on Form 10-K/A for the year ended December 31, 2002, except that intersegment transactions are not eliminated.

Our segment information is as follows (amounts in millions):

	Health Plan Services	Government Contracts	Total
<b>Second Quarter Ended June 30, 2003</b>			
Revenues from external sources	\$ 2,259.9	\$ 465.7	\$2,725.6
Intersegment revenues	10.6	—	10.6
Segment profit	100.8	22.4	123.2
<b>Second Quarter Ended June 30, 2002</b>			
Revenues from external sources	\$ 2,106.1	\$ 368.7	\$2,474.8
Intersegment revenues	14.2	—	14.2
Segment profit	89.0	11.5	100.5
<b>Six Months Ended June 30, 2003</b>			
Revenues from external sources	\$ 4,497.2	\$ 919.3	\$5,416.5
Intersegment revenues	21.1	—	21.1
Segment profit	209.6	42.2	251.8
<b>Six Months Ended June 30, 2002</b>			
Revenues from external sources	\$ 4,196.4	\$ 718.2	\$4,914.6
Intersegment revenues	27.4	—	27.4
Segment profit	176.8	21.1	197.9

Beginning January 1, 2002, we implemented several initiatives to reduce our general and administrative (G&A) expenses. At that time, we changed our methodology from allocating budgeted costs to allocating actual expenses incurred for corporate shared services to more properly reflect segment costs. Our chief operating decision maker now uses the segment pretax profit or loss subsequent to the allocation of actual shared services expenses as the measurement of segment performance. We changed our methodology of determining segment pretax profit or loss to better reflect management's revised view of the relative costs incurred proportionally by our reportable segments. Certain 2002 balances have been reclassified to conform to our chief operating decision maker's current view of segment pretax profit or loss.

A reconciliation of the total reportable segments' measures of profit to the Company's consolidated income before income taxes and cumulative effect of a change in accounting principle is as follows (amounts in millions):

	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Total reportable segment profit	\$123.2	\$100.5	\$251.8	\$197.9
Loss from corporate and other entities	(4.7)	(1.4)	(16.9)	(9.3)
Loss on assets held for sale	—	(2.6)	—	(2.6)
Income before income taxes and cumulative effect of a change in accounting principle as reported	\$118.5	\$ 96.5	\$234.9	\$186.0

Loss from other corporate entities and our employer services group subsidiary, which are not part of our Health Plan Services and Government Contracts reportable segments, are excluded from our measurement of segment performance. Other corporate entities include our facilities, warehouse, reinsurance and surgery center subsidiaries.

## 5. DIVESTITURES AND TRANSACTIONS

### Dental and Vision Subsidiaries

On April 7, 2003, we announced the sale of our dental subsidiary to SafeGuard Health Enterprises, Inc. (SafeGuard). On June 30, 2003, we entered into definitive agreements with SafeGuard, under which SafeGuard will acquire our vision subsidiary and its California commercial membership. We expect these sales to close in the fourth quarter ended December 31, 2003 subject to regulatory approval. We will retain the Health Net Dental and Vision brands. In connection with the sale, we entered into a strategic relationship with SafeGuard under which we will offer Health Net branded (private labeled) dental HMO and dental PPO benefit products to our current and prospective members. The products will be underwritten and administered by SafeGuard Health Enterprises companies. We also entered into a similar strategic relationship with EyeMed Vision Care, LLC (EyeMed) focused on the expansion of market share and the delivery of competitive vision benefit products that will be sold in conjunction with our medical plans. The sales of our dental and vision subsidiaries closed on October 31, 2003. In connection with these sales, we received approximately \$14.8 million in cash.

Our dental and vision subsidiaries had \$14.7 million and \$29.4 million of total combined revenues for the second quarter and six months ended June 30, 2003, respectively, and had \$13.7 million and \$27.6 million of total combined revenues for the second quarter and six months ended June 30, 2002, respectively. Our dental and vision subsidiaries had \$0.3 million and \$0.9 million of income before income taxes for the second quarter and six months ended June 30, 2003, respectively, and \$(0.9) million and \$(1.0) million of (loss) before income taxes for the second quarter and six months ended June 30, 2002, respectively. As of June 30, 2003, our dental and vision subsidiaries had a combined total of \$10.3 million in net equity, which we expect to recover through the sales proceeds. Our dental and vision subsidiaries are reported as part of our Health Plan Services reportable segment.

On June 15, 2003, we entered into a strategic relationship with EyeMed Vision Care, LLC (EyeMed) focused on the expansion of market share and the delivery of competitive vision benefit products that will be sold in conjunction with our medical plans.

### Pharmacy Benefit Services Agreement

Effective April 1, 2003, we entered into an amendment to modify an existing ten-year pharmacy benefit services agreement that we had entered into in February 1999 with an external third-party service provider. The amendment provides for the termination of certain service and performance provisions of the existing pharmacy benefit services agreement and the modification of certain other service and performance provisions of the existing pharmacy benefit services agreement. In consideration for the agreements set forth in the amendment, we paid approximately \$11.5 million in May 2003 (the Amendment Payment) to the external third-party service provider. As part of the original set of transactions with this external third-party service provider, in which we sold our non-affiliate health plan pharmacy benefit management operations, we were issued a warrant to acquire 800,000 shares of common stock (as adjusted for stock splits) of the external third-party service provider. The external third-party service provider also agreed under the amendment to honor the original terms and conditions of the warrant agreement entered into as part of the consideration for the sale

of our non-affiliate pharmacy benefit management operations to them in February 1999. Of the 800,000 shares for which the warrant is exercisable, 640,000 were vested as of April 1, 2003. The remaining 160,000 are scheduled to vest on April 1, 2004. In April 2003, we

exercised the vested portion of the warrants. Following a 30-day holding period, we sold the underlying common stock for a gain of approximately \$11.5 million. We recorded the Amendment Payment as well as the gain realized on the sale of the underlying common stock in general and administrative expenses in May 2003. Under the amendment, we may terminate the pharmacy benefit services agreement on April 1, 2004, subject to certain termination provisions which include a termination fee of approximately \$3.9 million.

In April 2003, we paid \$2.9 million to this external third-party service provider for amounts previously accrued under another provision of the pharmacy benefit services agreement.

We also entered into a one-year consulting services agreement for \$5 million with this external third-party service provider to provide us with consulting services on specialty pharmacy strategic planning, benefit design strategy and e-prescribing services. This consulting services agreement ends on March 31, 2004.

### **Pennsylvania Health Plan**

In March 2003, we announced that we will withdraw our commercial health plan from the commercial market in the Commonwealth of Pennsylvania effective September 30, 2003. Coverage for our members enrolled in the Federal Employee Health Benefit Plan (FEHBP) will continue until December 31, 2003. Our Pennsylvania health plan had \$19.2 million and \$35.4 million of total revenues for the second quarters ended June 30, 2003 and 2002, respectively, and had \$39.6 million and \$72.2 million of total revenues for the six months ended June 30, 2003 and 2002, respectively. Our Pennsylvania health plan had \$(3.3) million and \$(2.2) million of (loss) before taxes for the second quarters ended June 30, 2003 and 2002, respectively, and had \$(3.9) million and \$(2.0) million of (loss) before taxes for the six months ended June 30, 2003 and 2002, respectively. As of June 30, 2003, our Pennsylvania health plan had \$15.6 million in net equity, which we believe is recoverable. As of June 30, 2003, we had approximately 28,000 members enrolled in our commercial health plan in Pennsylvania. Our Pennsylvania health plan is reported as part of our Health Plan Services reportable segment.

### **Florida Health Plan**

Effective August 1, 2001, we sold our Florida health plan, known as Foundation Health, a Florida Health Plan, Inc. (the Plan), to Florida Health Plan Holdings II, L.L.C. In connection with the sale, we received \$23 million in cash and approximately \$26 million in a secured six-year note bearing 8% interest per annum for which we recorded a full reserve. We also sold the corporate facility building used by our Florida health plan to DGE Properties, LLC for \$15 million, payable by a secured five-year note bearing 8% interest per annum.

Under the Stock Purchase Agreement that evidenced the sale (as amended, the SPA), we, through our subsidiary FH Assurance Company (FHAC), entered into a reinsurance agreement (the Reinsurance Agreement) with the Plan. Under the terms of the Reinsurance Agreement, FHAC will reimburse the Plan for certain medical and hospital expenses arising after the Florida health plan sale. The Reinsurance Agreement covers claims arising from all commercial and governmental health care contracts or other agreements in force as of July 31, 2001 and any renewals thereof up to 18 months after July 31, 2001. The Reinsurance Agreement provides that the Plan will be reimbursed for medical and hospital expenses relative to covered claims in excess of certain baseline medical loss ratios.

The maximum liability under the Reinsurance Agreement of \$28 million was reported as part of loss on assets held for sale as of June 30, 2001, since this was our best estimate of our probable obligation under this arrangement. As the reinsured claims are submitted to FHAC, the liability is reduced by the amount of claims paid. As of June 30, 2003, we have paid out \$21.9 million under this agreement.

The SPA included an indemnification obligation for all pending and threatened litigation as of the closing date and certain specific provider contract interpretation or settlement disputes. As of June 30, 2003, we have paid \$5.7 million in settlements on certain indemnified items. At this time, we believe that the estimated liability related to the remaining indemnified obligations on any pending or threatened litigation and the specific provider contract disputes will not have a material impact on the financial condition, results of operations or liquidity of the Company.

The SPA provides for the following three true-up adjustments that could result in an adjustment to the loss on the sale of the Plan:

- A retrospective post-closing settlement of statutory equity based on subsequent adjustments to the closing balance sheet for the Plan.
- A settlement of unpaid provider claims as of the closing date based on claim payments occurring during a one-year period after the closing date.

- A settlement of the reinsured claims in excess of certain baseline medical loss ratios. Final settlement is not scheduled to occur until the earlier part of 2004. The development of claims and claims related metrics and information provided by Florida Health Plan Holdings II, L.L.C. have not resulted in any revisions to the maximum \$28 million liability we originally estimated.

The true-up process has not been finalized, and we do not have sufficient information regarding the true-up adjustments to assess probability or estimate any adjustment to the recorded loss on the sale of the Plan as of June 30, 2003.

## **6. STOCK REPURCHASE PROGRAM**

In April 2002, our Board of Directors authorized us to repurchase up to \$250 million (net of exercise proceeds and tax benefits from the exercise of employee stock options) of our Class A Common Stock under our stock repurchase program. Share repurchases are made under our stock repurchase program from time to time through open market purchases or through privately negotiated transactions. As of June 30, 2003, we had repurchased 12,569,255 shares of our Class A Common Stock under our stock repurchase program for aggregate consideration of approximately \$318 million (approximately 2.4 million and 5.9 million shares of common stock were repurchased during the second quarter and six months ended June 30, 2003, respectively) before taking into account exercise proceeds and tax benefits from the exercise of employee stock options. During 2002, we received approximately \$49 million in cash and \$18 million in tax benefits as a result of option exercises. During the six months ended June 30, 2003, we received approximately \$22 million in cash and recognized \$7 million in tax benefits as a result of option exercises.

## **7. LEGAL PROCEEDINGS**

### **SUPERIOR NATIONAL INSURANCE GROUP, INC.**

We and our former wholly-owned subsidiary, Foundation Health Corporation (FHC), which merged into Health Net, Inc. in January 2001, were named in an adversary proceeding, Superior National Insurance Group, Inc. v. Foundation Health Corporation, Foundation Health Systems, Inc. and Milliman & Robertson, Inc. (M&R), filed on April 28, 2000, in the United States Bankruptcy Court for the Central District of California, case number SV00-14099GM. The lawsuit relates to the 1998 sale of Business Insurance Group, Inc. (BIG), a holding company of workers' compensation insurance companies operating primarily in California, by FHC to Superior National Insurance Group, Inc. (Superior).

On March 3, 2000, the California Department of Insurance seized BIG and Superior's other California insurance subsidiaries. On April 26, 2000, Superior filed for bankruptcy. Two days later, Superior filed its lawsuit against us, FHC and M&R. Superior alleges in the lawsuit that:

- the BIG transaction was a fraudulent transfer under federal and California bankruptcy laws in that Superior did not receive reasonably equivalent value for the \$285 million in consideration paid for BIG;
- we, FHC and M&R defrauded Superior by making misstatements as to the adequacy of BIG's reserves;
- Superior is entitled to rescind its purchase of BIG;
- Superior is entitled to indemnification for losses it allegedly incurred in connection with the BIG transaction;
- FHC breached the stock purchase agreement relating to the sale of BIG; and
- we and FHC were guilty of California securities laws violations in connection with the sale of BIG.

Superior seeks \$300 million in compensatory damages, unspecified punitive damages and the costs of the action, including attorneys' fees. In discovery, Superior has offered testimony as to various damages claims, ranging as high as \$408 million plus unspecified amounts of punitive damages. We dispute all of Superior's claims, including the entire amount of damages claimed by Superior.

On August 1, 2000, a motion filed by us and FHC to remove the lawsuit from the jurisdiction of the Bankruptcy Court to the United States District Court for the Central District of California was granted. Pursuant to a June 12, 2002 intra-district transfer order, the lawsuit was transferred to Judge Percy A. Anderson. On August 23, 2002, Superior and M&R entered a stipulation dismissing M&R from the case pursuant to a settlement between those parties. On December 5, 2002, Judge Anderson recused himself and issued

a second intra-district transfer order. The lawsuit is now pending in the District Court under case number SACV-00-658 (GLT) (MLG) before Judge Gary L. Taylor. On April 16, 2003, Judge Taylor denied both parties' motions for summary judgment. Subsequently, on June 2, 2003, the Court conducted a hearing regarding our motion to reconsider the summary judgment ruling with respect to Superior's fraud and California securities fraud claims. The Court is still considering that motion, and thus certain claims may be disposed of before trial. The parties are otherwise engaged in pretrial matters, including completion of discovery, in anticipation of a trial in November 2003.

We intend to defend ourselves vigorously in this litigation. While the final outcome of these proceedings cannot be determined at this time, we believe that the final outcome of such proceedings will not have a material adverse effect upon our financial condition, results of operations or liquidity; however, our belief regarding the likely outcome of such proceedings could change in the future and an unfavorable outcome could have a material adverse effect upon our financial condition, results of operations or liquidity.

#### FPA MEDICAL MANAGEMENT, INC.

Since May 1998, several complaints have been filed in federal and state courts seeking an unspecified amount of damages on behalf of an alleged class of persons who purchased shares of common stock, convertible subordinated debentures and options to purchase common stock of FPA Medical Management, Inc. (FPA) at various times between February 3, 1997 and May 15, 1998. The complaints name as defendants FPA, certain of FPA's auditors, us and certain of our former officers, and were filed in the following courts: United States District Court for the Southern District of California; United States Bankruptcy Court for the District of Delaware; and California Superior Court in the County of Sacramento. The complaints allege that we and such former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between us and FPA, about FPA's business and about our 1997 sale of FPA common stock held by us. All claims against our former officers were voluntarily dismissed from the consolidated class actions in both federal and state court. In early 2000, we filed a motion to dismiss all claims asserted against us in the consolidated federal class actions but have not formally responded to the other complaints. That motion has been withdrawn without prejudice and the cases have been provisionally settled without calling for any payment from us or our insurer. The United States District Court for the Southern District of California has granted preliminary approval to the settlement and has scheduled a hearing for final review of the proposed settlement for October 2003. Except as described below, upon final approval of the settlement, all outstanding claims by FPA against the company will have been resolved.

In July 1998, FPA and its corporate affiliates filed petitions in the United States Bankruptcy Court for the District of Delaware (Bankruptcy Court) seeking protection from their creditors under Title 11 of the U.S. Code. In 2000, we were served with an adversary complaint filed in the Bankruptcy Court by Joseph Pardo, Trustee of The FPA Creditor Trust established under FPA's Chapter 11 Plan of Reorganization (Trustee) in connection with certain transactions between us and FPA entered into between 1996 and 1998. The adversary complaint was amended by the Trustee earlier this year and now alleges, among other things, (1) that certain of the transactions between us and FPA were actual or constructive fraudulent conveyances and therefore avoidable under the Bankruptcy Code; (2) that our affiliates received certain alleged preferential transfers in the period immediately prior to FPA's bankruptcy filing that are now recoverable; (3) that our affiliates are obligated for certain contractual payments allegedly due to FPA affiliates during the period immediately prior to and following FPA's bankruptcy filing; and (4) common law fraud. We intend to vigorously defend ourselves against the Trustee's allegations, and believe that we have valid defenses to the claims asserted in the adversary complaint.

While the final outcome of these proceedings can not be determined at this time, based on information presently available, we believe that the final outcome of such proceedings will not have a material adverse effect upon our financial condition, results of operations or liquidity. However, our belief regarding the likely outcome of such proceedings could change in the future and an unfavorable outcome could have a material adverse effect upon our financial condition, results of operations or liquidity.

#### STATE OF CONNECTICUT V. PHYSICIANS HEALTH SERVICES, INC.

Physicians Health Services, Inc. (PHS), a subsidiary of ours, was sued on December 14, 1999 in the United States District Court in Connecticut by the Attorney General of Connecticut, Richard Blumenthal, acting on behalf of a group of state residents. The lawsuit was premised on the Federal Employee Retirement Income Security Act (ERISA) and alleged that PHS violated its duties under ERISA by managing its prescription drug formulary in a manner that served its own financial interest rather than those of plan beneficiaries. The suit sought to have PHS revamp its formulary system and to provide patients with written denial notices and instructions on how to appeal. PHS filed a motion to dismiss which asserted that the state residents the Attorney General purported to represent all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that his office lacked standing to bring the suit and that the allegations failed to state a claim under ERISA. On July 12, 2000, the court granted PHS' motion and dismissed the action. On March 27, 2002, the United States Court of Appeals for the Second Circuit affirmed the district court's dismissal of the action. On June 25, 2002, the plaintiff filed a petition requesting that the United States Supreme Court review the Second Circuit's decision to affirm dismissal of the case. On October 7, 2002, the United States Supreme Court denied plaintiff's petition for review. As a result, we believe the Company has no further exposure for this case.

## IN RE MANAGED CARE LITIGATION

The Judicial Panel on Multidistrict Litigation (JPML) has transferred various class action lawsuits against managed care companies, including us, to the United States District Court for the Southern District of Florida for coordinated or consolidated pretrial proceedings in In re Managed Care Litigation, MDL 1334. This proceeding is divided into two tracks, the subscriber track, which includes actions brought on behalf of health plan members, and the provider track, which includes suits brought on behalf of physicians.

### *Subscriber Track*

The subscriber track included four actions involving us, three of which sought certification of nationwide class actions for unspecified damages and injunctive relief.

On September 26, 2002, the Court denied the motion for class certification in the lead action against us in the subscriber track. In the interest of avoiding the further expense and burden of continued litigation, we resolved all three actions which had sought nationwide class certification for immaterial amounts (\$5,000 in the aggregate), and the actions have been dismissed with prejudice, with no admission of liability. As a result of these settlements, the Romero and Pay actions were dismissed with prejudice on March 28, 2003 and the Albert action was dismissed with prejudice on July 22, 2003, all with no admission of liability.

One action remains pending against us in the subscriber track, State of Connecticut v. Physicians Health Services of Connecticut, Inc. (filed in the District of Connecticut on September 7, 2000). The suit asserts claims against our subsidiary, Physicians Health Services of Connecticut, Inc., and us that are similar, if not identical, to those asserted in the previous lawsuit which, as discussed above, the United States Court of Appeals for the Second Circuit affirmed dismissal of on March 27, 2002.

### *Provider Track*

The provider track includes the following actions involving us: Shane v. Humana, Inc., et al. (including Foundation Health Systems, Inc.) (filed in the Southern District of Florida on August 17, 2000 as an amendment to a suit filed in the Southern District of Mississippi), California Medical Association v. Blue Cross of California, Inc., PacifiCare Health Systems, Inc., PacifiCare Operations, Inc. and Foundation Health Systems, Inc. (filed in the Northern District of California in May 2000), Klay v. Prudential Ins. Co. of America, et al. (including Foundation Health Systems, Inc.) (filed in the Southern District of Florida on February 22, 2001 as an amendment to a case filed in the Northern District of California), Connecticut State Medical Society v. Physicians Health Services of Connecticut, Inc. (filed in Connecticut state court on February 14, 2001), Lynch v. Physicians Health Services of Connecticut, Inc. (filed in Connecticut state court on February 14, 2001), Sutter v. Health Net of the Northeast, Inc. (D. N.J.) (filed in New Jersey state court on April 26, 2002) and Medical Society of New Jersey v. Health Net, Inc., et al., (D. N.J.) (filed in New Jersey state court on May 8, 2002).

On March 2, 2001, the District Court for the Southern District of Florida issued an order in the lead provider action (Shane) granting the dismissal of certain claims with prejudice and the dismissal of certain other claims without prejudice, and denying the dismissal of certain claims.

On March 26, 2001, a consolidated amended complaint was filed in the lead provider action, which adds new plaintiffs, including Leonard Klay and the California Medical Association (who, as set forth below, had previously filed claims against the Company), and has, in addition to revising the pleadings of the original claims under the federal Racketeer Influenced and Corrupt Organizations Act (RICO), ERISA and various state laws, added a claim under the California Business and Professions Code. On May 1, 2001, we filed a motion to compel arbitration in Shane of the claims of all individual plaintiffs that allege to have treated persons insured by us. On that same date, we filed a motion to dismiss this action.

On September 26, 2002, the Court granted plaintiffs' motion for class certification and granted plaintiffs' request for leave to amend their complaint. The new complaint adds another managed care company as a defendant, adds the Florida Medical Society and the Louisiana Medical Society as plaintiffs, withdraws Dennis Breen as a named plaintiff, and adds claims under the New Jersey Consumer Fraud Act and the Connecticut Unfair Trade Practices Act against defendants other than Health Net. The Court has set a date of August 14, 2003 for oral argument on pending motions to compel arbitration and August 19, 2003 for oral argument on motions to dismiss this amended complaint. The court has also entered a scheduling order with a trial date set for June 2004. The action has also been referred for mediation. Discovery is ongoing in the case.

On November 20, 2002, the Eleventh Circuit granted the defendants' petition for review of the district court's certification decision. Oral argument on defendants' appeal of the class certification decision is scheduled to take place before the Eleventh Circuit on September 11, 2003.

The CMA action alleges violations of RICO, certain federal regulations and the California Business and Professions Code and seeks declaratory and injunctive relief, as well as costs and attorneys' fees. As set forth above, on March 26, 2001, the California Medical Association was named as an additional plaintiff in the consolidated amended complaint filed in the Shane action.

The Klay suit is a purported class action allegedly brought on behalf of individual physicians in California who provided health care services to members of the defendants' health plans. The complaint alleges violations of RICO, ERISA, certain federal regulations, the California Business and Professions Code and certain state common law doctrines, and seeks declaratory and injunctive relief and damages. As set forth above, on March 26, 2001, Leonard Klay was named as an additional plaintiff in the consolidated amended complaint filed in the Shane action.

The CSMS case was originally brought in Connecticut state court against Physicians Health Services of Connecticut, Inc. (PHS-CT) alleging violations of the Connecticut Unfair Trade Practices Act. The complaint alleges that PHS-CT engaged in conduct that was designed to delay, deny, impede and reduce lawful reimbursement to physicians who rendered medically necessary health care services to PHS-CT health plan members. The complaint, which is similar to others filed against us and other managed care companies, seeks declaratory and injunctive relief. On March 13, 2001, the Company removed this action to federal court. Before this case was transferred to MDL 1334, the plaintiffs moved to remand the action to state court and the federal District Court of Connecticut consolidated this action and Lynch v. Physicians Health Services of Connecticut, Inc., along with similar actions against Aetna, CIGNA and Anthem, into one case entitled CSMS v. Aetna Health Plans of Southern New England, et al. PHS-CT has not yet responded to the complaint.

The Lynch case was also originally filed in Connecticut state court. This case was brought by J. Kevin Lynch, M.D. and Karen Laugel, M.D. purportedly on behalf of physician members of the Connecticut State Medical Society who provide health care services to PHS-CT health plan members pursuant to provider service contracts. The complaint alleges that PHS-CT engaged in improper, unfair and deceptive practices by denying, impeding and/or delaying lawful reimbursement to physicians. The complaint seeks declaratory and injunctive relief and damages. On March 13, 2001, we removed this action to federal court. Before this case was transferred to MDL 1334, the plaintiffs moved to remand the action to state court and the case was consolidated as described above. PHS-CT has not yet responded to the complaint. On July 24, 2003, PHS-CT moved to compel to arbitration the claims of plaintiffs Lynch and Laugel.

On April 26, 2002, plaintiff John Ivan Sutter, M.D., P.A. filed an amended complaint in New Jersey state court joining Health Net of the Northeast, Inc. (Health Net of the Northeast), a subsidiary of ours, in an action originally brought against Horizon Blue Cross Blue Shield of New Jersey, Inc., CIGNA Healthcare of New Jersey, Inc. and CIGNA Corp (collectively known as CIGNA), United Healthcare of New Jersey, Inc. and United Healthcare Insurance Company and Oxford Health Plans, Inc. The complaint seeks certification of a statewide class of health care providers who render or have rendered services to patients who are members of health care plans sponsored by the defendants.

Plaintiff alleges that the defendants engage in unfair and deceptive acts and practices which are designed to delay, deny, impede and reduce compensation to physicians. The complaint seeks unspecified damages and sets forth various causes of action under New Jersey law. On May 22, 2002, the New Jersey state court severed the action into five separate cases. On May 24, 2002, Health Net of the Northeast removed the case against it to federal court. Plaintiff moved to remand, which motion was denied without prejudice. On July 18, 2002, the JPML transferred this action to MDL 1334 for coordinated or consolidated pretrial proceedings. On September 23, 2002, plaintiff filed in the MDL proceeding a motion to remand to state court. Remand briefing was completed on December 30, 2002. On July 24, 2003, the Health Net defendants moved to compel to arbitration the claims of plaintiff Sutter.

On May 8, 2002, the Medical Society of New Jersey filed a complaint in New Jersey state court against us and our subsidiaries, Health Net of the Northeast, Inc., First Option Health Plan of New Jersey, Inc., and Health Net of New Jersey, Inc. (the Health Net defendants). Plaintiff brought this action on its own behalf and purportedly on behalf of its physician members and alleges that the Health Net defendants engage in practices which are designed to delay, deny, impede and reduce compensation to physicians. Plaintiff has requested declaratory and injunctive relief and has set forth causes of action for violation of public policy, violations of the New Jersey Consumer Fraud Act, violations of the Healthcare Information Networks and Technologies Act (the HINT Act) and tortious interference with prospective economic relations. On June 14, 2002, the Health Net defendants removed this case to federal court. On July 3, 2002, the Health Net defendants filed a motion to stay this action pending ruling by the JPML on whether to transfer this case to MDL 1334. On July 15, 2002, plaintiff filed a motion to remand this case to state court. On August 2, 2002, the JPML transferred this case to MDL 1334 for coordinated or consolidated pretrial proceedings.

We intend to defend ourselves vigorously in all of this JPML litigation. While the final outcome of these proceedings cannot be determined at this time, based on information presently available, we believe that the final outcome of such proceedings will not have a material adverse effect upon our financial condition, results of operations or liquidity. However, our belief regarding the likely outcome of such proceedings could change in the future and an unfavorable outcome could have a material adverse effect upon our financial condition, results of operations or liquidity.

## MISCELLANEOUS PROCEEDINGS

We and certain of our subsidiaries are also parties to various other legal proceedings, many of which involve claims for coverage encountered in the ordinary course of our business. While the final outcome of these proceedings cannot be determined at this time, based on information presently available, we believe that the final outcome of such proceedings will not have a material adverse effect upon our financial condition, results of operations or liquidity. However, our belief regarding the likely outcome of such proceedings could change in the future and an unfavorable outcome could have a material adverse effect upon our financial condition, results of operations or liquidity.

## **8. SUBSEQUENT EVENT**

### **Nurse Advice Line and Other Related Services Agreement**

On August 6, 2003, we entered into an amendment to modify an existing ten-year agreement for a nurse advice line and other related services, which we entered into in December 1998 with an external third-party service provider. The effective date of the amendment is April 1, 2003. The amendment changes the pricing schedule of this services agreement to a cost-per-call basis from the per member per month (PMPM) basis of the original agreement. The amendment also provides for the modification of the exclusivity provision under the original agreement. Under the terms of the amendment, exclusivity for the provision of nurse advice line and audio health information services is not granted to the external third-party service provider.

## **Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations**

### *Restatements*

On February 11, 2004, we announced that we would restate our consolidated financial statements for the first three quarters of 2003 and for the years ended December 31, 2002 and 2001. The restatements reflect corrections of accounting errors, associated primarily with the period of accounting recognition, with respect to certain general and administrative (G&A) expenses. In addition, the restatements correct certain known errors that were previously not recorded because the amounts involved were not considered material to our consolidated financial statements.

The various restatement adjustments and their impact on our net income and diluted earnings per share are more fully described in Note 2 of the Notes to Condensed Consolidated Financial Statements (Unaudited) included elsewhere in this Form 10-Q/A. Throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations, all referenced amounts for all periods and comparisons reflect the balances and amounts on a restated basis.

### *Overview*

Health Net, Inc. (together with its subsidiaries, the Company, we, us or our) is an integrated managed care organization that administers the delivery of managed health care services. We are one of the nation's largest publicly traded managed health care companies. Our health plans and government contracts subsidiaries provide health benefits through our health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point of service (POS) plans to approximately 5.3 million individuals in 15 states through group, individual, Medicare, Medicaid and TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)) programs. Our subsidiaries also offer managed health care products related to behavioral health, dental, vision and prescription drugs. We also offer managed health care product coordination for workers' compensation insurance programs through our employer services group subsidiary. We also own health and life insurance companies licensed to sell PPO, POS and indemnity products, as well as auxiliary non-health products such as life and accidental death and disability insurance, in 35 states and the District of Columbia.

We currently operate within two reportable segments: Health Plan Services and Government Contracts. Our current Health Plan Services reportable segment includes the operations of our health plans in the states of Arizona, California, Connecticut, New Jersey, New York, Oregon and Pennsylvania, the operations of our health and life insurance companies and our behavioral health, dental, vision and pharmaceutical services subsidiaries. We have approximately 3.8 million at-risk and administrative services only (ASO) members in our Health Plan Services reportable segment. In March 2003, we announced that we will withdraw our commercial health plan from the commercial market in the Commonwealth of Pennsylvania effective September 30, 2003.

Our Government Contracts reportable segment includes government-sponsored managed care plans through the TRICARE programs and other government contracts. The Government Contracts reportable segment administers large, multi-year managed health care government contracts. Certain components of these contracts are subcontracted to unrelated third parties. The Company administers health care programs covering approximately 1.5 million eligible individuals under TRICARE. The Company has three TRICARE contracts that collectively cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon, Washington and parts of Arizona, Idaho, Louisiana and Texas. On August 1, 2002, the Department of Defense (DoD) issued a Request for Proposal (RFP) for the rebid of the TRICARE contracts, which we submitted in January 2003. See "Part II. Other Information—Item 5. Recent and Other Developments" for further information about the award date for the new contracts.

Revenues from our employer services group operating segment are included in our condensed consolidated statements of operations under "Other income."

Please refer to Note 4 to the condensed consolidated financial statements for a discussion on the changes to our reportable segments. We believe that our revised reportable segments presentation properly represents our chief operating decision maker's view of our financial data.

### *Cautionary Statements*

This discussion and analysis and other portions of this Form 10-Q/A contain "forward-looking statements" within the meaning of Section 21E of the Securities Exchange Act of 1934, as amended, and Section 27A of the Securities Act of 1933, as amended, that involve risks and uncertainties. All statements other than statements of historical information provided or incorporated by reference herein may be deemed to be forward-looking statements. Without limiting the foregoing, the words "believes," "anticipates," "plans," "expects" and similar expressions are intended to identify forward-looking statements. Factors that could cause actual results to differ materially from those reflected in the forward-looking statements include, but are not limited to, the risks discussed in the "Cautionary Statements" section in our Annual Report on Form 10-K for the fiscal year ended December 31, 2002, as amended, and the risks discussed in our other filings from time to time with the SEC.

We wish to caution readers that those factors, among others, could cause our actual financial or enrollment results to differ materially from those expressed in any projections, estimates or forward-looking statements relating to the Company. In addition, those factors should be considered in conjunction with any discussion of operations or results by us or our representatives, including any forward-looking discussion, as well as comments contained in press releases, presentations to securities analysts or investors, or other communications by us. You should not place undue reliance on any forward-looking statements, which reflect management's analysis, judgment, belief or expectation only as of the date thereof. Except as may be required by law, we undertake no obligation to publicly update or revise any forward-looking statements to reflect events or circumstances that arise after the date of this report.

### *Results of Operations*

#### *Consolidated Operating Results*

Our net income for the second quarter ended June 30, 2003 was \$74.8 million, or \$0.64 per basic share and \$0.63 per diluted share, compared to net income for the same period in 2002 of \$64.2 million, or \$0.51 per basic share and \$0.50 per diluted share. Our net income for the six months ended June 30, 2003 was \$146.9 million, or \$1.25 per basic share and \$1.23 per diluted share, compared to net income for the same period in 2002 of \$113.8 million, or \$0.91 per basic share and \$0.90 per diluted share. Included in our results for the six months ended June 30, 2002 is a cumulative effect of a change in accounting principle of \$(8.9) million, or \$(0.07) per basic and diluted share, as a result of adopting Statement of Financial Accounting Standards (SFAS) No. 142, "Goodwill and Other Intangible Assets" (SFAS No. 142).

The table below and the discussion that follows summarize our financial performance for the second quarters and six months ended June 30, 2003 and 2002.

	Second Quarter Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
(Amounts in thousands, except per member per month data)				
<b>REVENUES</b>				
Health plan services premiums	\$2,259,867	\$2,106,110	\$4,497,195	\$4,196,427
Government contracts	465,727	368,660	919,283	718,162
Net investment income	14,364	15,104	27,343	30,705
Other income	12,704	15,376	24,526	29,290
<b>Total revenues</b>	<b>2,752,662</b>	<b>2,505,250</b>	<b>5,468,347</b>	<b>4,974,584</b>
<b>EXPENSES</b>				
Health plan services	1,888,966	1,769,753	3,750,156	3,520,656
Government contracts	443,549	356,885	877,066	696,306
General and administrative	219,942	205,361	443,994	421,192
Selling	56,800	46,188	111,936	93,699
Depreciation	14,453	15,132	29,464	28,610
Amortization	669	2,522	1,338	4,983
Interest	9,769	10,338	19,531	20,527
Loss on assets held for sale	—	2,600	—	2,600
<b>Total expenses</b>	<b>2,634,148</b>	<b>2,408,779</b>	<b>5,233,485</b>	<b>4,788,573</b>
Income from operations before income taxes and cumulative effect of a change in accounting principle	118,514	96,471	234,862	186,011
Income tax provision	43,730	32,257	87,943	63,239
Income before cumulative effect of a change in accounting principle	74,784	\$ 64,214	146,919	122,772
Cumulative effect of a change in accounting principle, net of tax	—	—	—	(8,941)
<b>Net income</b>	<b>\$ 74,784</b>	<b>\$ 64,214</b>	<b>\$ 146,919</b>	<b>\$ 113,831</b>
Health plan services medical care ratio (MCR)	83.6%	84.0%	83.4%	83.9%
Government contracts cost ratio	95.2%	96.8%	95.4%	97.0%
Administrative ratio (a)	10.3%	10.4%	10.5%	10.6%
Selling costs ratio (b)	2.5%	2.2%	2.5%	2.2%
Health plan services premiums per member per month (PMPM) (c)	\$ 200.59	\$ 184.57	\$ 200.24	\$ 184.15
Health plan services PMPM (c)	\$ 167.67	\$ 155.09	\$ 167.02	\$ 154.50

- (a) The administrative ratio is computed as the sum of G&A and depreciation expenses divided by the sum of health plan services premium revenues and other income.
- (b) The selling costs ratio is computed as selling expenses divided by health plan services premium revenues.
- (c) PMPM is calculated based on total medical at-risk member months and excludes ASO member months.

## Enrollment Information

The table below summarizes our at-risk insured and ASO enrollment information as of June 30:

	2003	2002	Percent Change
	(Enrollees in Thousands)		
<b>Health Plan Services:</b>			
Commercial	2,697	2,734	(1.4)%
Medicare Risk	172	188	(8.5)%
Medicaid	880	851	3.4%
	<u>3,749</u>	<u>3,773</u>	<u>(0.6)%</u>
Continuing plans			
Discontinued plan (Pennsylvania)	28	42	(33.3)%
	<u>3,777</u>	<u>3,815</u>	<u>(1.0)%</u>
<b>Total Health Plan Services</b>			
	<u>3,777</u>	<u>3,815</u>	<u>(1.0)%</u>
<b>ASO</b>	<u>89</u>	<u>75</u>	<u>18.7%</u>

Government contracts covered approximately 1.5 million eligible individuals under the TRICARE program as of June 30, 2003 and 2002. Dependents of active-duty military personnel and retirees and their dependents are automatically eligible to receive benefits under the TRICARE program. Any changes in the enrollment reflect the timing of when the individuals become eligible.

Commercial membership for our health plans decreased by 37,000 members or 1.4% as of June 30, 2003 compared to June 30, 2002. The decrease in the commercial membership is primarily due to exits from unprofitable large employer group accounts offset by increases in enrollment in key products and markets that we have been targeting in an effort to achieve a greater product and segment diversity. These changes have resulted in the following:

- Decrease in Connecticut of 39,000 members as a result of membership decreases in our large group market due to our pricing discipline and in our small group market due to aggressive pricing by one of our competitors,
- Net decrease in California of 22,000 members as a result of a 130,000 member decrease in our large group HMO market. The large group membership decline is primarily the result of the loss of the California Public Employees' Retirement System (CalPERS) account effective January 1, 2003. The CalPERS account had more than 175,000 members. This loss is partially offset by increases of 102,000, 34,000 and 6,000 members in our small group, mid-market and individual segments, respectively, within our HMO, PPO and POS markets, and
- Decrease in Arizona of 18,000 members as a result of membership decreases primarily in our large group HMO market due to termination of certain accounts due to premium rate increases, offset by
- Increase in New York of 24,000 members primarily in our large and small group markets due to pricing consistent with our competitive cost structure. The small group market experienced a noticeable growth during the second quarter ended June 30, 2003, and
- Increase in Oregon of 21,000 members primarily due to the addition of two new accounts in our large group market.

In March 2003, we announced that we will withdraw our commercial health plan from the commercial market in the Commonwealth of Pennsylvania effective September 30, 2003. Coverage for our members enrolled in the Federal Employee Health Benefit Plan (FEHBP) will continue until December 31, 2003. As of June 30, 2003, we had approximately 28,000 members enrolled in our commercial health plan in Pennsylvania.

Membership in the federal Medicare program decreased by 16,000 members or 8.5% as of June 30, 2003 compared to the same period in 2002. The decrease in the federal Medicare program membership is primarily due to planned exits from counties with inadequate reimbursement levels as follows:

- Decrease in California of 5,000 members,
- Decrease in Arizona of 4,000 members, and

- Decrease in Pennsylvania of 5,000 members as our withdrawal from the Pennsylvania Medicare program was completed in December 2002.

Membership in the Medicaid programs increased by approximately 29,000 members or 3.4% as of June 30, 2003, compared to the same period in 2002, primarily due to the following:

- Increase in California of 23,000 members, primarily from the Healthy Families program which provides health insurance to children from low-income families, and
- Increase in Connecticut of 8,000 members due to expansion of the Medicaid eligible population.

#### *Health Plan Services Premiums*

Health Plan Services premiums increased \$153.8 million or 7.3% for the second quarter ended June 30, 2003 and \$300.8 million or 7.2% for the six months ended June 30, 2003 compared to the same periods in 2002. Total health plan services premiums on a PMPM basis increased to \$200.59 or 8.7% for the second quarter ended June 30, 2003 and to \$200.24 or 8.7% for the six months ended June 30, 2003 from \$184.57 and \$184.15, respectively, for the same periods in 2002, primarily due to the following:

- Increase in commercial premiums of \$151.6 million or 10.4% for the second quarter ended June 30, 2003 and \$294.1 million or 10.1% for the six months ended June 30, 2003 as compared to the same periods in 2002. These increases are due to increases of 13.3% and 13.8% in premiums on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, partially offset by decreases of 2.5% and 3.2% in member months for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002. The premium increases on a PMPM basis were in large and small groups and were observed across all states, with California, Connecticut and New Jersey having the largest increases ranging from 13% to 16%. The majority of the decreases in member months is due to the loss of the CalPERS account, and
- Increase in Medicaid premiums of \$21.3 million or 7.8% for the second quarter ended June 30, 2003 and \$51.2 million or 9.6% for the six months ended June 30, 2003 as compared to the same periods in 2002. These increases are driven by increases of 4.5% and 6.7% in member months for the second quarter and six months ended June 30, 2003, respectively, combined with increases of 3.1% and 2.7% in premiums on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002. The premium increases were seen across all states, and the increases in member months are due to growth in Medicaid enrollment primarily in California and Connecticut, offset by
- Decreases in Medicare risk premiums of \$16.0 million or 4.5% for the second quarter ended June 30, 2003 and \$39.3 million or 5.4% for the six months ended June 30, 2003 as compared to the same periods in 2002. These decreases are primarily due to decreases of 9.1% and 10.5% in member months for the second quarter and six months ended June 30, 2003, respectively, partially offset by increases of 5.1% and 5.7% in premiums on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002. The decreases in member months are the result of our exit from certain counties in California, Arizona and Pennsylvania. The increases in Medicare risk premiums were seen across all states.

#### *Government Contracts Revenues*

Government Contracts revenues increased by \$97.1 million or 26.3% for the second quarter ended June 30, 2003 and \$201.1 million or 28.0% for the six months ended June 30, 2003 as compared to the same periods in 2002 primarily due to the following:

- Increase in risk sharing revenue of \$47.7 million and \$91.3 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 from increased health care cost estimates resulting from the call-up of reservists in support of the nation's heightened military activity and an increased number of enrollees seeking care in the private sector as many military health care professionals were deployed abroad,
- Increase in revenues of \$16.1 million and \$49.1 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 from higher change order costs,
- Increase in revenues of \$24.9 million and \$42.1 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 due to higher base contract pricing on new option periods, and

- Increase in revenues of \$6.6 million and \$12.3 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 due to favorable bid price adjustments.

On August 1, 2002, the DoD issued a RFP for the rebid of the TRICARE contracts. The RFP divides the United States into three regions (North, South and West) and provides for the award of one contract for each region. The RFP also provides that each of the three new contracts will be awarded to a different prime contractor. We submitted proposals in response to the RFP for each of the three regions in January 2003, and the latest DoD schedule reflects award of the three new TRICARE contracts in mid-to-late August 2003.

As planned in the RFP, health care delivery ends March 31, 2004 for the Region 11 contract, on June 30, 2004 for the Regions 9, 10 and 12 contract and on October 31, 2004 for the Region 6 contract. However, the delay of the anticipated award date until mid-to-late August 2003 implies a minor slippage in the transition dates for the Region 11 contract. As set forth above, we are competing for the new TRICARE contracts in response to the RFP. See “Part II. Other Information—Item 5. Recent and Other Developments” for additional information regarding the TRICARE contracts.

#### *Net Investment Income*

Net investment income decreased by \$0.7 million or 4.9% for the second quarter ended June 30, 2003 and \$3.4 million or 10.9% for the six months ended June 30, 2003 as compared to the same periods in 2002. These declines are primarily a result of continued declines in interest rates in the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002.

#### *Other Income*

Other income is primarily comprised of revenues from our employer services group subsidiary. Other income decreased by \$2.7 million or 17.4% for the second quarter ended June 30, 2003 and \$4.8 million or 16.3% for the six months ended June 30, 2003 as compared to the same periods in 2002. This decrease is primarily due to the sale of our claims processing subsidiary effective July 1, 2002.

#### *Health Plan Services Costs*

Health plan services costs increased by \$119.2 million or 6.7% for the second quarter ended June 30, 2003 and \$229.5 million or 6.5% for the six months ended June 30, 2003 as compared to the same periods in 2002. Total health plan services costs on a PMPM basis increased to \$167.67 or 8.1% for the second quarter ended June 30, 2003 and to \$167.02 or 8.1% for the six months ended June 30, 2003 from \$155.09 and \$154.50 for the same periods in 2002, respectively, primarily due to the following:

- Increase in commercial health care costs of \$117.3 million or 9.6% for the second quarter ended June 30, 2003 and \$237.5 million or 9.9% for the six months ended June 30, 2003 as compared to the same periods in 2002. These increases are primarily due to increases of 12.4% and 13.6% in commercial health care costs on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, and reflect increased unit cost trends in higher hospital and physician costs as compared to same periods in 2002. The increases in our commercial health care costs are partially offset by decreases of 2.5% and 3.2% in member months for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002, and
- Increase in Medicaid health care costs of \$21.3 million or 9.5% for the second quarter ended June 30, 2003 and \$42.7 million or 9.6% for the six months ended June 30, 2003 as compared to the same periods in 2002. These increases are primarily due to increases of 4.5% and 6.7% in member months for the second quarter and six months ended June 30, 2003, respectively, due to Medicaid membership growth in California and Connecticut and increases of 4.7% and 2.8% in health care costs on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 as a result of several hospitals and a pharmacy provider in California converting from capitated contracts to fee-for-service in 2003, offset by
- Decrease in Medicare risk health care costs of \$19.2 million or 6.0% for the second quarter ended June 30, 2003 and \$50.7 million or 7.6% for the six months ended June 30, 2003 as compared to the same periods in 2002. These decreases are primarily due to decreases of 9.1% and 10.5% in member months for the second quarter and six months ended June 30, 2003, respectively, partially offset by increases of 3.5% and 3.2% in Medicare health care costs on a PMPM basis for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002. The increases in health care costs on a PMPM basis are primarily in California which experienced higher physician capitation rates and increased inpatient and outpatient utilization, partially offset by lower physician claims.

Health Plan Services MCR decreased to 83.6% for the second quarter ended June 30, 2003 and 83.4% for the six months ended June 30, 2003 as compared to 84.0% and 83.9% for the same periods in 2002, respectively. These decreases are primarily due to a continued focus on pricing discipline combined with pricing increases above the health care cost trend for our commercial and Medicare Risk products. The increases in our overall Health Plan Services premiums on a PMPM basis of 8.7% for the second quarter and six months ended June 30, 2003 as compared to the same periods in 2002 outpaced the increases in our overall health care costs on a PMPM basis of 8.1% for the second quarter and six months ended June 30, 2003 as compared to the same periods in 2002.

As our estimates for health care costs are based on actuarially developed estimates, incurred claims related to prior years may differ from previously estimated amounts. Cumulative prior period incurred amounts expensed during the six months ended June 30, 2003 were approximately 0.1% of the most recent 12 months incurred costs.

#### *Government Contracts Costs*

Government Contracts costs increased by \$86.7 million or 24.3% for the second quarter ended June 30, 2003 and \$180.8 million or 26.0% for the six months ended June 30, 2003 compared to the same periods in 2002, primarily due to the following:

- Increases in health care cost estimates of \$72.8 million and \$138.0 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 resulting from the call-up of reservists in support of the nation's heightened military activity and an increased number of enrollees seeking care in the private sector as many military health care professionals were deployed abroad, and
- Increases in administrative and health care change order costs of \$15.1 million and \$46.7 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002, partially offset by
- Decreases in administrative costs of \$5.0 million and \$7.5 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 attributed to cost reduction efforts.

Government Contracts cost ratio decreased to 95.2% and 95.4% for the second quarter and six months ended June 30, 2003, respectively, as compared to 96.8% and 97.0% for the same periods in 2002. The improvements are primarily due to higher pricing on new option periods and higher change order volume.

#### *General and Administrative (G&A) Costs*

G&A costs increased by \$14.6 million or 7.1% for the second quarter ended June 30, 2003 and \$22.8 million or 5.4% for the six months ended June 30, 2003 as compared to the same periods in 2002. These increases reflect continued investment in our operations and systems consolidation projects. The administrative expense ratio decreased to 10.3% for the second quarter ended June 30, 2003 as compared to 10.4% for the same period in 2002. The administrative expense ratio decreased to 10.5% for the six months ended June 30, 2003 as compared to 10.6% for the same period in 2002. We continue to realize operating and administrative cost reductions attributed to the restructuring plan we implemented in 2001 to consolidate certain administrative, financial and technology functions. The 8 and 17 basis point improvements in our administrative expense ratio for the three and six months ended June 30, 2003 as compared to the same periods in 2002, are due to increases of 7.3% and 7.2%, respectively, in health plan services premium revenues outpacing the 7.1% and 5.4%, respectively, increases in G&A costs.

#### *Selling Costs*

Selling costs consist of broker commissions paid to brokers and agents and sales incentives paid to our sales associates. During the fourth quarter ended December 31, 2002, we separated selling costs from G&A expenses to better reflect the shift in our commercial health plan mix from large group to small group, which generally have higher selling costs. The selling costs ratio increased to 2.5% for the second quarter and six months ended June 30, 2003 compared to 2.2% for the same periods in 2002. These increases reflect the continued shift of our commercial health plan mix to small group with its higher selling costs.

### *Amortization and Depreciation*

Amortization and depreciation expense decreased by \$2.5 million or 14.3% for the second quarter ended June 30, 2003 and \$2.8 million or 8.3% for the six months ended June 30, 2003 as compared to the same periods in 2002. These decreases are primarily due to the following:

- Decrease in amortization expense of \$1.9 million and \$3.6 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 due to certain intangible assets reaching the end of their useful lives and thus becoming fully amortized, and
- Decrease in depreciation expense of \$2.8 million and \$5.9 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 from the assets impaired during the fourth quarter ended December 31, 2002 as a result of our systems consolidation project, offset by
- Increase in depreciation expense of \$0 and \$2.2 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 due to additional investment in IT assets, net of asset retirements, and
- Increase of \$2.2 million and \$4.4 million for the second quarter and six months ended June 30, 2003, respectively, as compared to the same periods in 2002 from the accelerated depreciation of certain capitalized software as a result of our systems consolidation project.

### *Interest Expense*

Interest expense decreased by \$0.6 million or 5.5% for the second quarter ended June 30, 2003 and \$1.0 million or 4.9% for the six months ended June 30, 2003 as compared to the same periods in 2002. During the third quarter ended September 30, 2002, we repaid the entire outstanding revolving credit facility balance of \$120 million. This repayment has resulted in the decreases in our interest expense for the second quarter and six months ended June 30, 2003 as compared to the same periods in 2002.

### *Loss on Assets Held for Sale*

Effective July 2002, we sold our claims processing subsidiary, EOS Claims Services, Inc. (EOS Claims), to Tristar Insurance Group, Inc. (Tristar). In connection with the sale, we received \$500,000 in cash, and also entered into a Payor Services Agreement. Under the Payor Services Agreement, Tristar has agreed to exclusively use EOS Managed Care Services, Inc. (one of our remaining subsidiaries) for various managed care services to its customers and clients.

We estimated and recorded a \$2.6 million pretax loss on the sale of EOS Claims during the second quarter ended June 30, 2002. EOS Claims, excluding the \$2.6 million pretax loss on sale, had total revenues of \$3.6 million and \$7.2 million for the second quarter and six months ended June 30, 2002, respectively, and income before income taxes and cumulative effect of a change in accounting principle of \$0.1 million for the second quarter and six months ended June 30, 2002.

### *Income Tax Provision*

The effective income tax rate was 36.9% and 37.4% for the second quarter and six months ended June 30, 2003, respectively, compared with 33.4% and 34.0% for the same periods in 2002. The increases in the effective tax rates are primarily due to the reduction in the tax benefit associated with tax return examination settlements in the current year compared to prior year which was partially offset by a tax law change in New York which changed the treatment of certain tax payments to premium taxes (included in G&A for the second quarter and six months ended June 30, 2003) from income tax expense.

The effective tax rates differed from the statutory federal tax rate of 35.0% due primarily to state income taxes offset by tax return examination settlements.

### *Cumulative Effect of a Change in Accounting Principle*

Effective January 1, 2002, we adopted SFAS No. 142 which, among other things, eliminates amortization of goodwill and other intangibles with indefinite lives. Intangible assets, including goodwill, that are not subject to amortization will be tested for impairment annually or more frequently if events or changes in circumstances indicate that we might not recover the carrying value of these assets.

We identified the following six reporting units within our businesses: Health Plans, Government Contracts, Behavioral Health, Dental & Vision, Subacute and Employer Services Group. In accordance with the transition requirements of SFAS No. 142, we completed an evaluation of goodwill at each of our reporting units upon adoption of this Standard. We used an independent third-party

professional services firm with knowledge and experience in performing fair value measurements to assist us in the impairment testing and measurement process. As a result of these impairment tests, we identified goodwill impairment at our behavioral health subsidiary and at our employer services group subsidiary in the amounts of \$3.5 million and \$5.4 million, respectively. Accordingly, we recorded an impairment charge of goodwill of \$8.9 million, net of tax benefit of \$0, which has been reflected as a cumulative effect of a change in accounting principle in the consolidated statement of operations for the first quarter ended March 31, 2002.

We performed our annual impairment test on our goodwill and other intangible assets as of June 30, 2003 at each of our reporting units and also re-evaluated the useful lives of our other intangible assets with the assistance of the same independent third-party professional services firm that assisted us in the impairment testing and measurement process in the prior year. No goodwill impairments were identified in any of our reporting units. We also determined that the estimated useful lives of our other intangible assets properly reflected the current estimated useful lives. See Note 3 to the condensed consolidated financial statements.

#### **IMPACT OF INFLATION AND OTHER ELEMENTS**

The managed health care industry is labor intensive and its profit margin is low. As a result, it is especially sensitive to inflation. Increases in medical expenses or contracted medical rates without corresponding increases in premiums could have a material adverse effect on the Company.

Various federal and state legislative initiatives regarding the health care industry continue to be proposed during legislative sessions. If further health care reform or similar legislation is enacted, such legislation could impact the Company. Management cannot at this time predict whether any such initiative will be enacted and, if enacted, the impact on the financial condition or results of operations of the Company.

The Company's ability to expand its business is dependent, in part, on competitive premium pricing and its ability to secure cost-effective contracts with providers. Achieving these objectives is becoming increasingly difficult due to the competitive environment. In addition, the Company's profitability is dependent, in part, on its ability to maintain effective control over health care costs while providing members with quality care. Factors such as health care reform, regulatory changes, increased cost of medical services, mandated benefits, utilization, new technologies and drugs, hospital costs, major epidemics and numerous other external influences may affect the Company's operating results. Accordingly, past financial performance is not necessarily a reliable indicator of future performance, and investors should not use historical records to anticipate results or future period trends.

The Company's HMO and insurance subsidiaries are required to maintain reserves to cover their estimated ultimate liability for expenses with respect to reported and unreported claims incurred. These reserves are estimates of future costs based on various assumptions. Establishment of appropriate reserves is an inherently uncertain process, and there can be no certainty that currently established reserves will prove adequate in light of subsequent actual experience, which in the past has resulted, and in the future could result, in loss reserves being too high or too low. The accuracy of these estimates may be affected by external forces such as changes in the rate of inflation, the regulatory environment, the judicious administration of claims, medical costs and other factors. Future loss development or governmental regulators could require reserves for prior periods to be increased, which would adversely impact earnings in the periods in which such additional reserves are accrued. In light of present facts and current legal interpretations, management believes that adequate provisions have been made for claims and loss reserves.

We contract with physician providers in California and Connecticut primarily through capitation fee arrangements for our HMO products. We also use capitation fee arrangements in areas other than California and Connecticut to a lesser extent. Under a capitation fee arrangement, we pay the provider a fixed amount per member on a regular basis and the provider accepts the risk of the frequency and cost of member utilization of services. The inability of providers to properly manage costs under capitation arrangements can result in financial instability of such providers. Any financial instability of capitated providers could lead to claims for unpaid health care against us, even if we have made our regular payments to the capitated providers. Depending on state law, we may or may not be liable for such claims. The California agency that until July 1, 1999 acted as regulator of HMOs, had issued a written statement to the effect that HMOs are not liable for such claims. In addition, recent court decisions have narrowed the scope of such liability in a manner generally favorable to HMOs. However, ongoing litigation on the subject continues among providers and HMOs, including the Company's California HMO subsidiary.

In 2001, the United States Senate and House of Representatives passed separate bills, sometimes referred to as "patients' rights" or "patients' bill of rights" legislation, that sought, among other things, to hold health plans liable for claims regarding health care delivery and improper denial of care. This legislation would have removed or limited federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA) that currently precludes most individuals from suing health plans for causes of action based upon state law and would enable plan members to challenge coverage and benefits decisions in state and federal courts. Although both bills provided for independent review of decisions regarding medical care, the bills differed on the circumstances and procedures under which lawsuits could be brought against managed care organizations and the scope of their liability. Although Congress did not

ultimately enact legislation based on the 2001 bills and adjourned in 2002 without reconciling the two bills, we expect the issue to be considered again in 2003 and that similar bills will be introduced. If patients' bill of rights legislation is enacted into law, we could be subject to significant additional litigation risk and regulatory compliance costs, which could be costly to us and could have a significant adverse effect on our results of operations. Although we could attempt to mitigate our ultimate exposure to litigation and regulatory compliance costs through, among other things, increases in premiums, there can be no assurance that we would be able to mitigate or cover the costs stemming from litigation arising under patients' bill of rights legislation or the other costs that we could incur in connection with complying with patients' bill of rights legislation.

## **LIQUIDITY AND CAPITAL RESOURCES**

The Company believes that cash from operations, existing working capital, lines of credit, and funds from any potential divestitures of business are adequate to fund existing obligations, introduce new products and services, and continue to develop health care-related businesses. The Company regularly evaluates cash requirements for current operations and commitments, and for capital acquisitions and other strategic transactions. The Company may elect to raise additional funds for these purposes, either through additional debt or equity, the sale of investment securities or otherwise, as appropriate.

The Company's investment objective is to maintain safety and preservation of principal by investing in high-quality, investment grade securities while maintaining liquidity in each portfolio sufficient to meet the Company's cash flow requirements and attaining the highest total return on invested funds.

Government health care receivables are best estimates of payments that are ultimately collectible or payable. Since these amounts are subject to government audit, negotiation and appropriations, amounts ultimately collected may vary significantly from current estimates. Additionally, the timely collection of these receivables is also impacted by government audit and negotiation and could extend for periods beyond a year. Amounts receivable under government contracts were \$93.0 million and \$78.0 million as of June 30, 2003 and December 31, 2002, respectively.

### *Operating Cash Flows*

Net cash provided by operating activities was \$120.1 million for the six months ended June 30, 2003 as compared to net cash used in operating activities of \$51.1 million for the same period in 2002. The increase in operating cash flows of \$171.2 million was due to the following:

- Net increase in cash flows from reserves for claims and other settlements of \$122.1 million. This increase reflects higher incurred claims and expected increases in claims inventories due to the impact of systems and operations conversion activities on certain of our health plans during the six months ended June 30, 2003,
- Net increase in cash flows from amounts receivable/payable under government contracts of \$85.9 million, primarily due to the early receipt of several bid price adjustments from the government, and
- Net increase in net income plus amortization and depreciation and non-cash charges of \$17.9 million, partially offset by
- Net decrease in cash flows from premiums receivable and unearned premiums of \$35.0 million primarily due to an increase in the Medicaid receivable as of June 30, 2003 due from the State of California as a result of its budget crisis.

### *Investing Activities*

Net cash used in investing activities was \$28.2 million for the six months ended June 30, 2003 as compared to net cash used in investing activities of \$122.8 million for the same period in 2002. During the six months ended June 30, 2003, a number of our security holdings were called or prepaid. During the six months ended June 30, 2002, we repositioned certain of our investable assets to those with longer durations within our regulated health plans in order to increase our investment income.

### *Financing Activities*

Net cash used in financing activities was \$136.5 million for the six months ended June 30, 2003 as compared to \$62.7 million for the same period in 2002. During the six months ended June 30, 2003, we repurchased 5,899,655 shares of our common stock for \$154.4 million under our stock repurchase program. During the second quarter ended June 30, 2003, we borrowed \$5.7 million under a term loan promissory note related to the termination of certain service and performance provisions under a service agreement with an external third-party service provider (see —Operating Leases and Other Commitments). We repaid these borrowings in the same

quarter. We paid down the entire outstanding balance of our revolving credit facility as of December 31, 2002. Accordingly, we had no repayments on our credit facility during the six months ended June 30, 2003 as compared to \$125.1 million paid on our revolving credit facility during the same period in 2002. During the same period in 2002, we also borrowed \$50 million under our revolving credit facility.

In April 2002, our Board of Directors authorized us to repurchase up to \$250 million (net of exercise proceeds and tax benefits from the exercise of employee stock options) of the Company's Class A Common Stock under our stock repurchase program. Share repurchases are made under our stock repurchase program from time to time through open market purchases or through privately negotiated transactions. We use cash flows from operations to fund the share repurchases. During 2002, we received approximately \$49 million in cash and \$18 million in tax benefits as a result of option exercises. During the six months ended June 30, 2003, we received approximately \$22 million in cash and recognized \$7 million in tax benefits as a result of option exercises. For the six months ended December 31, 2003, we expect to receive approximately \$37 million in cash and \$20 million in tax benefits from estimated option exercises during the remainder of the year. As a result of the \$67 million (in 2002), \$29 million (in the first six months ended June 30, 2003) and \$57 million (estimated for the six months ended December 31, 2003) in realized and estimated benefits, our total authority under our stock repurchase program is estimated at \$403 million based on the authorization we received from our Board of Directors to repurchase up to \$250 million (net of exercise proceeds and tax benefits from the exercise of employee stock options). As of August 8, 2003, we repurchased 12,869,255 shares at an average price of \$25.41 per share pursuant to our stock repurchase program.

On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent Senior Notes due in April 2011. The effective interest rate on the notes when all offering costs are taken into account and amortized over the term of the notes is 8.54 percent per annum. The net proceeds of \$395.1 million from the Senior Notes were used to repay outstanding borrowings under our then-existing revolving credit facility. On October 4, 2001, we completed an exchange offer for the Senior Notes in which the outstanding Senior Notes were exchanged for an equal aggregate principal amount of new 8.375 percent Senior Notes due 2011 that have been registered under the Securities Act of 1933, as amended.

On June 28, 2001, we refinanced our previous \$1.5 billion revolving credit facility with credit agreements for two new revolving syndicated credit facilities, with Bank of America, N.A. as administrative agent. The new facilities, providing for an aggregate of \$700 million in borrowings, consist of a \$175 million 364-day revolving credit facility and a \$525 million five-year revolving credit and competitive advance facility. Committed loans under the credit facilities bear interest at a rate equal to either (1) the greater of the federal funds rate plus 0.5% and the applicable prime rate or (2) LIBOR plus a margin that depends on our senior unsecured credit rating. Loans obtained through the bidding process bear interest at a rate determined in the bidding process. Swingline loans under the five-year credit facility bear interest equal to, at our option, either a base rate plus a margin that depends on our senior unsecured credit rating or a rate quoted to us by the swingline lender. We pay fees on outstanding letters of credit and a facility fee, computed as a percentage of the lenders' commitments under the credit facilities, which varies from 0.130% to 0.320% per annum for the 364-day credit facility and from 0.155% to 0.375% per annum for the five-year credit facility, depending on our senior unsecured credit rating.

The credit agreements contain negative covenants, including financial covenants, that impose restrictions on our operations. As of June 30, 2003, we were in compliance with the covenants of the credit facilities.

#### *Operating Leases and Other Commitments*

We lease office space under various operating leases. In addition, we have entered into long-term service agreements with third parties. As of June 30, 2003, there are six years remaining on these service agreements with minimum future commitments totaling \$37.1 million. These lease and service agreements are cancelable with substantial penalties.

Effective April 1, 2003, we entered into an amendment to modify an existing ten-year pharmacy benefit services agreement that we had entered into in February 1999 with an external third-party service provider. The amendment provides for the termination of certain service and performance provisions of the existing pharmacy benefit services agreement and the modification of certain other service and performance provisions of the existing pharmacy benefit services agreement. In consideration for the agreements set forth in the amendment, we paid approximately \$11.5 million in May 2003 (the Amendment Payment) to the external third-party service provider. As part of the original set of transactions with this external third-party service provider, in which we sold our non-affiliate health plan pharmacy benefit management operations, we were issued a warrant to acquire 800,000 shares of common stock (as adjusted for stock splits) of the external third-party service provider. The external third-party service provider also agreed under the amendment to honor the original terms and conditions of the warrant agreement entered into as part of the consideration for the sale of our non-affiliate pharmacy benefit management operations to them in February 1999. Of the 800,000 shares for which the warrant is exercisable, 640,000 were vested as of April 1, 2003. The remaining 160,000 are scheduled to vest on April 1, 2004. In April 2003, we exercised the vested portion of the warrants. Following a 30-day holding period, we sold the underlying common stock for a gain of

approximately \$11.5 million. We recorded the Amendment Payment as well as the gain realized on the sale of the underlying common stock in G&A expenses in May 2003. Under the amendment, we may terminate the pharmacy benefit services agreement on April 1, 2004, subject to certain termination provisions which include a termination fee of approximately \$3.9 million.

In April 2003, we paid \$2.9 million to this external third-party service provider for amounts previously accrued under another provision of the pharmacy benefit services agreement.

We also entered into a one-year consulting services agreement for \$5 million with this external third-party service provider to provide us with consulting services on specialty pharmacy strategic planning, benefit design strategy and e-prescribing services. This consulting services agreement ends on March 31, 2004.

As of June 30, 2003, our future minimum commitments for operating leases and service agreements for the years ending December 31 are as follows (amounts in thousands):

2003 (excluding January—June)	\$ 30,073
2004	57,000
2005	38,907
2006	35,530
2007	27,396
Thereafter	86,332
	<hr/>
Total minimum commitments	\$275,238
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### *Recent Developments*

#### Sale of Dental and Vision Subsidiaries

On April 7, 2003, we announced the sale of our dental subsidiary to SafeGuard Health Enterprises, Inc. (SafeGuard). On June 30, 2003, we entered into definitive agreements with SafeGuard, under which SafeGuard will acquire our vision subsidiary and its California commercial membership. We expect these sales to close in the fourth quarter ended December 31, 2003 subject to regulatory approval. We will retain the Health Net Dental and Vision brands.

On June 15, 2003, we entered into a strategic relationship with EyeMed Vision Care, LLC (EyeMed) focused on the expansion of market share and the delivery of competitive vision benefit products that will be sold in conjunction with our medical plans. See Note 5 to the condensed consolidated financial statements.

#### Nurse Advice Line and Other Related Services Agreement

On August 6, 2003, we entered into an amendment to modify an existing ten-year agreement for a nurse advice line and other related services, which we entered into in December 1998 with an external third-party service provider. The effective date of the amendment is April 1, 2003. The amendment changes the pricing schedule of this services agreement to a cost-per-call basis from the per member per month (PMPM) basis of the original agreement. The amendment also provides for the modification of the exclusivity provision under the original agreement. Under the terms of the amendment, exclusivity for the provision of nurse advice line and audio health information services is not granted to the external third-party service provider.

### **CRITICAL ACCOUNTING POLICIES**

In our Annual Report on Form 10-K for the year ended December 31, 2002, we identified the critical accounting policies which affect our more significant estimates and assumptions used in preparing our consolidated financial statements. Those policies include revenue recognition, health care services, reserves for contingent liabilities, government contracts, goodwill and recoverability of long-lived assets and investments. We have not changed these policies from those previously disclosed in our Annual Report.

### **STATUTORY CAPITAL REQUIREMENTS**

Certain of the Company's subsidiaries must comply with minimum capital and surplus requirements under applicable state laws and regulations, and must have adequate reserves for claims. We generally manage our aggregate regulated subsidiary capital against 150% of Risk Based Capital (RBC) Company Action Levels, although RBC standards are not yet applicable to all of our regulated subsidiaries. Certain subsidiaries must maintain ratios of current assets to current liabilities pursuant to certain government contracts. The Company believes it is in compliance with these contractual and regulatory requirements in all material respects.

As necessary, we make contributions to and issue standby letters of credit on behalf of our subsidiaries to meet risk-based capital or other statutory capital requirements under state laws and regulations. Our parent company did not make any contributions to its subsidiaries to meet risk-based capital or other statutory capital requirements under state laws and regulations during the six months ended June 30, 2003 or thereafter through the date of the filing of this Form 10-Q.

Legislation has been or may be enacted in certain states in which the Company's subsidiaries operate imposing substantially increased minimum capital and/or statutory deposit requirements for HMOs in such states. Such statutory deposits may only be drawn upon under limited circumstances relating to the protection of policyholders.

As a result of the above requirements and other regulatory requirements, certain subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to the Company. Such restrictions, unless amended or waived, limit the use of any cash generated by these subsidiaries to pay obligations of the Company. The maximum amount of dividends which can be paid by the insurance company subsidiaries to the Company without prior approval of the insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. Management believes that as of June 30, 2003, all of the Company's health plans and insurance subsidiaries met their respective regulatory requirements.

#### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

The purposes of HIPAA are to (i) limit pre-existing condition exclusions applicable to individuals changing jobs or moving to individual coverage, (ii) guarantee the availability of health insurance for employees in the small group market, (iii) prevent the exclusion of individuals from coverage under group plans based on health status, and (iv) establish national standards for the electronic exchange of health information. In December 2000, the Department of Health and Human Services (DHHS) promulgated regulations under HIPAA related to the privacy and security of electronically transmitted protected health information (PHI). The new regulations consisting of privacy regulations, transactions and codeset requirements and security regulations require health plans, clearinghouses and providers to (a) comply with various requirements and restrictions related to the use, storage and disclosure of PHI, (b) adopt rigorous internal procedures to protect PHI, (c) create policies related to the privacy of PHI and (d) enter into specific written agreements with business associates to whom PHI is disclosed. The regulations also establish significant criminal penalties and civil sanctions for non-compliance. Health Net has completed the work required to be compliant with the HIPAA Privacy Regulations prior to the effective date of April 14, 2003. Further, Health Net is on target to be in compliance with the Transactions and Codesets requirements prior to the effective date of October 2003. The Security regulations have been recently made final and will not be enforced until approximately April 2005, and Health Net has created a security plan to ensure appropriate compliance prior to the effective date.

We expect to spend approximately \$7.6 million in 2003 and \$4.5 million in 2004 on HIPAA related expenses. We will record these amounts in accordance with our current accounting policies.

#### **Item 4. Controls and Procedures**

We maintain disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act") that are designed to ensure that information required to be disclosed in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management necessarily is required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

On February 11, 2004, we announced that, due to improper recording of workers' compensation liabilities, operating leases and certain other items, we would restate our consolidated financial statements for 2002 and 2001 and for the first three quarters of 2003. For a detailed description of the restatements, see Amendment No. 1 to our Annual Report on Form 10-K/A for the year ended December 31, 2002 and Note 2 to our condensed consolidated financial statements contained in this Amended Quarterly Report on Form 10-Q/A. Our independent auditors, in connection with their audit of our 2003 financial statements, have noted certain matters involving our internal control and its operation in connection with the improper recording of workers' compensation liabilities and operating leases in the periods affected by the restatements that they consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants and have advised us that, in their judgment, the reportable conditions constitute a material weakness under such standards.

Even before we received this communication from our independent auditors, we had instituted changes to our disclosure controls and procedures and to our internal control over financial reporting to provide greater assurance that we have mitigated the control deficiencies that resulted in the restatement of our financial statements. Such changes include, among other things, changes in our operating and accounting procedures to, among other things, provide more detailed reviews of estimation procedures for worker's compensation liabilities and account properly for operating leases and termination benefits. We had also commenced the process of defining and implementing other changes to enhance our internal control over financial reporting and to ensure that our disclosure controls and procedures are effective at the reasonable assurance level. For example, we are in the process of defining and implementing enhanced communication practices to ensure that persons outside the finance department are aware that they must notify the finance department of any contractual or other financial commitment involving Health Net so that the finance department can determine whether any such commitment could give rise to a financial reporting obligation. In addition, we have initiated a reorganization of our finance department, including the hiring of additional senior level personnel, which we expect to complete by mid-2004. We believe that the process we have undertaken to address the factors that gave rise to the restatements constitutes an appropriate response to the reportable conditions discussed above.

As required by SEC Rule 13a-15(b), we carried out an evaluation, under the supervision and with the participation of our management, including our Chief Executive Officer and our Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report. In making this evaluation, we considered matters relating to the restatement of our consolidated financial statements for 2002 and 2001 and for the first three quarters of 2003, including the material weakness in our internal control over financial reporting. Our management, including our Chief Executive Officer and our Chief Financial Officer, believe that certain of the errors giving rise to restatement adjustments occurred because our control processes and procedures related to the matters underlying such adjustments were not effective during the periods in which the errors occurred. Our evaluation considered, among other things, the substantial process that was undertaken to ensure that all material adjustments necessary to correct the previously issued financial statements were recorded as part of the restatements, as well as the actions described above to enhance our internal control over financial reporting and our disclosure controls and procedures.

Based upon the evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report, our Chief Executive Officer and Chief Financial Officer concluded that, except as described above, our disclosure controls and procedures were effective at the reasonable assurance level as of the end of such period.

There were not any changes in the Company's internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) during the second quarter ended June 30, 2003 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting. However, as described above, in the first quarter of 2004, we instituted certain changes to our disclosure controls and procedures and to our internal control over financial reporting to provide greater assurance that we have mitigated the control deficiencies that resulted in the restatement of our financial statements.

## PART II. OTHER INFORMATION

### Item 6. Exhibits and Reports on Form 8-K

#### (a) Exhibits

The following exhibits are filed as part of this Quarterly Report on Form 10-Q/A:

- 11.1 Statement relative to computation of per share earnings of the Company (included in Note 3 to the condensed consolidated financial statements included in this Quarterly Report on Form 10-Q/A).
- 31.1 Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.
- 31.2 Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.
- 32 Certification of Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.

#### (b) Reports on Form 8-K

Current Report on Form 8-K filed by the Company on May 5, 2003 incorporating by reference under Item 9 thereof and pursuant to Item 12 thereof the Company's May 5, 2003 press release reporting first quarter ended March 31, 2003 earnings.



### **Exhibit Index**

- 11.1 Statement relative to computation of per share earnings of the Company (included in Note 3 to the condensed consolidated financial statements included in this Quarterly Report on Form 10-Q/A).
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- 32 Certification of Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.

**Certification of Chief Executive Officer  
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002**

I, Jay M. Gellert, certify that:

1. I have reviewed this quarterly report on Form 10-Q/A of Health Net, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:
  - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - c) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):
  - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 15, 2004

/s/ Jay M. Gellert

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Jay M. Gellert  
*President and Chief Executive Officer*

**Certification of Chief Financial Officer  
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002**

I, Marvin P. Rich, certify that:

1. I have reviewed this quarterly report on Form 10-Q/A of Health Net, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:
  - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - c) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):
  - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 15, 2004

/s/ Marvin P. Rich

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Marvin P. Rich  
*Executive Vice President, Finance and Operations*

**Certification of CEO and CFO Pursuant to  
18 U.S.C. Section 1350,  
as Adopted Pursuant to  
Section 906 of the Sarbanes-Oxley Act of 2002**

In connection with the Quarterly Report of Health Net, Inc. (the "Company") on Form 10-Q/A for the period ending June 30, 2003 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Jay M. Gellert, as Chief Executive Officer of the Company, and Marvin P. Rich, as Chief Financial Officer of the Company, each hereby certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to the best of their respective knowledge:

- (1) The Report fully complies with the requirements of Section 13(a) and 15(d) of the Securities Exchange Act of 1934, as amended; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Jay M. Gellert

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Jay M. Gellert  
Chief Executive Officer  
March 15, 2004

/s/ Marvin P. Rich

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Marvin P. Rich  
Chief Financial Officer  
March 15, 2004