SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

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

FOR THE FISCAL YEAR ENDED: DECEMBER 31, 1999

/ / 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

FOUNDATION HEALTH SYSTEMS, INC.
(Exact Name of Registrant as Specified in Its Charter)

DELAWARE	95-4288333
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

21650 OXNARD STREET, WOODLAND HILLS, CA	91367
(Address of Principal Executive Offices)	(Zip Code)

REGISTRANT'S TELEPHONE NUMBER, INCLUDING AREA CODE: (818) 676-6978

SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT:

TITLE OF EACH CLASS	NAME OF EACH EXCHANGE ON WHICH REGISTERED
Class A Common Stock, $.001 par value	New York Stock Exchange, Inc.

SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT: None

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

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

The aggregate market value of the voting stock held by non-affiliates of the registrant at March 17, 2000 was $965,797,495 (which represents 121,675,275 shares of Class A Common Stock held by such non-affiliates multiplied by $7.9375, the closing sales price of such stock on the New York Stock Exchange on March 17, 2000).

The number of shares outstanding of the registrant's Class A Common Stock as of March 17, 2000 was 121,835,631 (excluding 3,194,374 shares held as treasury stock), and 563,742 shares of the registrant's Class B Common Stock were outstanding as of such date.

DOCUMENTS INCORPORATED BY REFERENCE

Part II of this Form 10-K incorporates by reference certain information from the registrant's Annual Report to Stockholders for the year ended December 31, 1999 ("Annual Report to Stockholders"). Part III of this Form 10-K incorporates by reference certain information from the registrant's definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the close of the year ended December 31, 1999.

PART I

ITEM 1. BUSINESS

Foundation Health Systems, Inc. (the "Company" or "FHS") is an integrated managed care organization which administers the delivery of managed health care services. The Company's health maintenance organizations ("HMOs"), insured preferred provider organizations ("PPOs") and government contracts subsidiaries provide health benefits to approximately 5.5 million individuals in 18 states through group, individual, Medicare risk, Medicaid and TRICARE (formerly Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS")) programs. The Company's subsidiaries also offer managed health care products related to behavioral health, dental, vision and prescription drugs, and offer managed health care product coordination for multi-region employers and administrative services for medical groups and self-funded benefits programs. The Company operates and conducts its HMO and other businesses through its subsidiaries.

The Company currently operates within two segments of the managed health care industry: Health Plan Services and Government Contracts/Specialty Services. During 1999, the Health Plan Services segment consisted of four regional divisions: Arizona (Arizona and Utah), California (encompassing only the state of California), Central (Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington) and Northeast (Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia). During 1999, the Company divested its health plans or entered into arrangements to transition the membership of its health plans in the states of Colorado, Idaho, Louisiana, New Mexico, Oklahoma, Texas, Utah and Washington. See "Discontinued Operations and Anticipated Divestitures." Effective January 1, 2000, as a result of such divestitures, the Company consolidated and reorganized its Health Plan Services segment into two regional divisions, the Eastern Division (Connecticut, Florida, New Jersey, New York, Ohio, Pennsylvania and West Virginia) and the Western Division (Arizona, California and Oregon). The Company is one of the largest managed health care companies in the United States, with approximately 4 million at-risk and administrative services only ("ASO") members in its Health Plan Services segment. The Company also owns health and life insurance companies licensed to sell insurance in 33 states and the District of Columbia.

The Company's HMOs market traditional HMO products to employer groups and Medicare and Medicaid products to employer groups and directly to individuals. Health care services that are provided to the Company's commercial and individual members include primary and specialty physician care, hospital care, laboratory and radiology services, prescription drugs, dental and vision care, skilled nursing care, physical therapy and mental health. The Company's HMO service networks include approximately 56,000 primary care physicians and 69,000 specialists.

The Company's Government Contracts/Specialty Services segment consists of the Government Contracts Division and the Specialty Services Division. The Company's Government Contracts Division oversees the provision of contractual services to federal government programs such as TRICARE (formerly CHAMPUS). The Company receives revenues for administrative and management services and, under most of its contracts, also accepts financial responsibility for a portion of the health care costs. The Company's Specialty Services Division oversees the provision of supplemental programs to enrollees in the Company's HMOs, as well as to members whose basic medical coverage is provided by non-FHS companies, including vision coverage, dental coverage, managed behavioral health programs and a prescription drug program. The Specialty Services Division consists of both operations in which the Company assumes underwriting risk in return for premium revenue, and operations in which the Company provides administrative services only, including certain of the behavioral health and pharmacy benefits management programs. Such Division also provides certain bill review and third party administrative services as described elsewhere in this Annual Report.

The Company continues to evaluate the profitability realized or likely to be realized by its existing businesses and operations, and the opportunities to expand its businesses in profitable markets. In 1999,

the Company substantially completed its divestiture program by selling a PPO network subsidiary, a third-party administrator subsidiary, two Southern California hospitals, its HMO operations in Louisiana, New Mexico, Oklahoma, Texas and Utah, certain of its pharmacy benefits management assets, a regional claims processing facility and accompanying real estate in Colorado, and certain care centers and other real estate. The Company also entered into definitive agreements to transition to third parties its health plan and indemnity plan membership in the states of Colorado, Idaho and Washington. In addition, the Company purchased the remaining minority interests of FOHP, Inc., a then majority-owned subsidiary of the Company which owns a managed health care company in New Jersey. See "Discontinued Operations and Anticipated Divestitures" and "Other Information--Recent Developments."

The Company was incorporated in 1990. The current operations of the Company are the result of the April 1, 1997 merger transaction (the "FHS Combination") involving Health Systems International, Inc. ("HSI") and Foundation Health Corporation ("FHC"). Pursuant to the Agreement and Plan of Merger (the "Merger Agreement") that evidenced the FHS Combination, FH Acquisition Corp., a wholly-owned subsidiary of HSI, merged with and into FHC and FHC survived as a wholly-owned subsidiary of HSI, which changed its name to "Foundation Health Systems, Inc." and thereby became the Company.

The FHS Combination was accounted for as a pooling of interests for accounting and financial reporting purposes. The pooling of interests method of accounting is intended to present, as a single interest, two or more common stockholder interests which were previously independent and assumes that the combining companies have been merged from inception. Consequently, the Company's consolidated financial statements incorporated by reference into this Annual Report on Form 10-K have been prepared and/or restated as though HSI and FHC always had been combined on a calendar year basis.

Prior to the FHS Combination, the Company was the successor to the business conducted by Health Net, now the Company's HMO subsidiary in California, which became a subsidiary of the Company in 1992, and HMO and PPO networks operated by QualMed, Inc. ("QualMed"), which combined with the Company in 1994 to create HSI. FHC was incorporated in Delaware in 1984. The executive offices of the Company are located at 21650 Oxnard Street, Woodland Hills, CA 91367. Except as the context otherwise requires, the term "Company" refers to FHS and its subsidiaries.

HEALTH PLAN DIVISIONS

HMO AND PPO OPERATIONS. The Company's HMOs offer members a comprehensive range of health care services, including ambulatory and outpatient physician care, hospital care, pharmacy services, eye care, behavioral health and ancillary diagnostic and therapeutic services. The Company offers a full spectrum of managed health care products.

The integrated health care programs offered by the Company's HMOs include products offered through both traditional Network Model HMOs (in which the HMOs contract with individual physicians, physician groups and independent or individual practice associations ("IPAs")) and IPA Model HMOs (in which the HMOs contract with one or more IPAs that in turn subcontract with individual physicians to provide HMO patient services) which offer quality care, cost containment and comprehensive coverage; a matrix package which allows employees to select their desired coverage from alternatives that have interchangeable outpatient and inpatient co-payment levels; point-of-service programs which offer a multi-tier design that provides both conventional HMO and indemnity-like (in-network and out-of-network) tiers; a PPO-like tier which allows members to self-refer to the network physician of their choice; and a managed indemnity plan which is provided for employees who reside outside of their HMO service areas.

The Company's strategy is to offer a wide range of managed health care products and services to employers to assist them in containing health care costs. The pricing of the products offered is designed to provide incentives to both employers and employees to select and enroll in the products with greater managed health care and cost containment elements. In general, the Company's HMO subsidiaries provide comprehensive health care coverage for a fixed fee or premium that does not vary with the extent or

frequency of medical services actually received by the member. PPO enrollees choose their medical care from among the various contracting providers or choose a non-contracting provider and are reimbursed on a traditional indemnity plan basis after reaching an annual deductible. The Company assumes both underwriting and administrative expense risk in return for the premium revenue it receives from its HMO and PPO products. The Company's subsidiaries have contractual relationships with health care providers for the delivery of health care to the Company's enrollees. While a majority of the Company's members are covered by conventional HMO products, the Company is continuing to expand its other product lines, thereby enabling it to offer flexibility to an employer and to tailor its products to an employer's particular needs.

The following table contains certain information relating to commercial HMO and PPO members, Medicare members and employer groups under contract as of December 31, 1999 in each region in which the Company operated in 1999 (excluding point-of-service):

	ARIZONA DIVISION	CALIFORNIA DIVISION	CENTRAL DIVISION	NORTHEAST DIVISION
Commercial HMO and PPO Members	290,949	1,428,692	337,654	813,017
Medicare Members (risk only)	56,942	124,396	32,570	51,798
Medicaid Members	--	500,076	77,986	100,291

In addition, the following sets forth certain data regarding the Company's employer groups in the commercial managed care operations of its Health Plan Divisions as of December 31, 1999:

Number of Employer Groups	30,385
Largest Employer Group as % of enrollment	11.9%
10 largest Employer Groups as % of enrollment	15.7%

ARIZONA DIVISION

In Arizona, the Company believes that its commercial managed care operations rank it second largest both as measured by total membership and by size of provider network. The Company's commercial HMO membership in Arizona was 283,478 as of December 31, 1999. The Company's Medicare risk membership in Arizona was 56,942 as of December 31, 1999, which represented an increase of 11% during 1999. During 1999, the Arizona Division also oversaw certain of the Company's health and life insurance companies licensed to sell insurance in 33 states and the District of Columbia. In October 1999, the Company sold its HMO operations in Utah. See "Discontinued Operations and Anticipated Divestitures." Effective January 1, 2000, the Arizona Division, the California Division and the Company's HMO operations in Oregon were consolidated to form the Company's new Western Division.

CALIFORNIA DIVISION

The California market is characterized by a concentrated population. Health Net, the Company's California HMO, is believed by the Company to be the third-largest HMO in the state of California in terms of membership and the largest in terms of size of provider network. The Company's commercial HMO membership in California as of December 31, 1999 was 1,387,049, which represented a decrease of 10% during 1999. The Company's Medicare risk membership in California as of December 31, 1999 was 124,396, which represented a decrease of 3% during 1999. The decreases in commercial HMO and Medicare risk membership are due, in part, to the Company's pricing discipline and its focus on profitable accounts. The Company's Medicaid membership in California as of December 31, 1999 was 500,076 members, an increase of approximately 14% during 1999. As referenced above, effective January 1, 2000, the Arizona Division, the California Division and the Company's HMO operations in Oregon were consolidated to form the Company's new Western Division.

CENTRAL DIVISION

During 1999, the Central Division included Health Plan operations in Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington. During 1999, the Company sold its HMO operations in the states of Louisiana, New Mexico, Oklahoma and Texas, and a portion of its HMO operations in the state of Washington, and entered into definitive agreements to transition its HMO and indemnity membership in the states of Colorado, Idaho and Washington to third parties. See "Discontinued Operations and Anticipated Divestitures." Subsequently, the Company consolidated and reorganized its Health Plan Divisions into the Eastern Division, which consists of the Northeast Division and Florida, and the Western Division, which consists of the Arizona Division, California Division and Oregon.

The Company believes its Florida HMO and PPO operations make it the ninth largest HMO managed care provider in terms of membership and second largest HMO in terms of size of provider network in the state of Florida. The Company's commercial HMO membership in Florida was 88,064 as of December 31, 1999, which represented an increase of 5% during 1999. The Company's Medicare risk membership in Florida was 29,053 as of December 31, 1999, which represented an increase of 17% during 1999. The Company's Medicaid membership in Florida was 18,325 as of December 31, 1999, which represented a 35% decrease in 1999.

The Company believes that its Oregon HMO and PPO operations make it the sixth largest HMO managed care provider in terms of membership and third largest HMO in terms of size of provider network. The Company's commercial HMO and PPO membership in Oregon was 100,437 as of December 31, 1999, which represented a decrease of 24% during 1999. The decrease is due, in part, to the Company's pricing discipline and its focus on profitable accounts.

NORTHEAST DIVISION

During 1999, the Northeast Division included Company operations in Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia. As referenced above, effective January 1, 2000, the Northeast Division and the Company's operations in Florida were consolidated to form the Company's new Eastern Division.

In Connecticut, New Jersey and New York, the Company and The Guardian Life Insurance Company of America ("The Guardian") together offer both HMO and indemnity products through a joint venture doing business as "Healthcare Solutions." In general, the Company and The Guardian share equally in the profits of the joint venture, subject to certain terms of the joint venture arrangement related to expenses. The Guardian is a mutual insurer (owned by its policy owners) which offers financial products and services, including individual life and disability income insurance, employee benefits, pensions and 401(k) products. The Guardian is headquartered in New York and has more than 2,400 financial representatives in 119 general agencies.

The Company believes its Connecticut HMO and PPO operations make it the largest HMO managed care provider in terms of membership and size of provider network in the state of Connecticut. The Company's commercial HMO membership in Connecticut was 338,072 as of December 31, 1999 (including 54,681 members under The Guardian arrangement), a decrease of approximately 5% since the end of 1998. The Company's Medicare risk membership in Connecticut was 27,150 as of December 31, 1999, which represented a decrease of 39% during 1999, and the Company's Medicaid membership in Connecticut was 74,593 as of December 31, 1999, which represented an increase of 19% during 1999. The decreases in commercial HMO and Medicare risk membership are due, in part, to the Company's pricing discipline and its focus on profitable accounts.

The Company believes its New Jersey HMO and PPO operations make it the third largest HMO managed care provider in terms of membership and the second largest in terms of size of provider network in the state of New Jersey. The Company's commercial HMO membership in New Jersey was 215,473 as of

December 31, 1999 (including 83,054 members under The Guardian arrangement), a decrease of 7% since the end of 1998. The Company's Medicare risk membership in New Jersey was 1,897 as of December 31, 1999, which represented a decrease of 30% during 1999, and the Company's Medicaid membership in New Jersey was 25,698 as of December 31, 1999, which represented an increase of 16% during 1999. The decreases in commercial HMO and Medicare risk membership are due, in part, to the Company's pricing discipline and its focus on profitable accounts.

In New York, the Company had 227,119 members as of December 31, 1999, which represented an increase of 21% during 1999. Such membership included 117,009 members under The Guardian arrangement. The Company believes its New York HMO and PPO operations make it the fifth largest HMO managed care provider in terms of membership and the second largest in terms of size of provider network in the state of New York.

The Company's commercial HMO membership in eastern Pennsylvania was 41,738 as of December 31, 1999, which represented a decrease of 13% during 1999. The Company's Medicare risk membership in eastern Pennsylvania was 13,366 as of December 31, 1999, which represented a decrease of 5% during 1999. The decreases in commercial HMO and Medicare risk membership are due, in part, to the Company's pricing discipline and its focus on profitable accounts. Collectively, the Company's commercial HMO membership in Ohio, western Pennsylvania and West Virginia was approximately 16,500 as of December 31, 1999. The Company's Medicare risk membership in Ohio, western Pennsylvania and West Virginia was approximately 2,500 collectively as of December 31, 1999.

MEDICARE. The Company's Medicare+ Choice plans as of December 31, 1999 had a combined membership of approximately 265,751 compared to 322,171 as of December 31, 1998. The decrease in membership is due, in part, to exiting certain markets in connection with the substantial completion of the Company's divestiture program in 1999, the Company's pricing discipline and its focus on profitable accounts.

The Company offers its Medicare+ Choice products directly to individuals and to employer groups. To enroll in a Company Medicare+ Choice plan, covered persons must be eligible for Medicare. Health care services normally covered by Medicare are provided or arranged by the Company, in conjunction with a broad range of preventive health care services. The federal Health Care Financing Administration ("HCFA") pays the Company a monthly amount for each enrolled member based, in part, upon the "Adjusted Average Per Capita Cost," as determined by HCFA's analysis of fee-for-service costs related to beneficiary demographics. Depending on plan design and other factors, the Company may charge a monthly premium.

The Company's California Medicare+ Choice product, Seniority Plus, was licensed and certified to operate in 22 California counties as of December 31, 1999. The Company's other HMOs are licensed and certified to offer Medicare+ Choice plans in 9 counties in Pennsylvania, 34 counties in Oregon, 7 counties in Connecticut, 6 counties in Arizona, 3 counties in Florida, 20 counties in New Jersey and 12 counties in New York.

MEDICAID PRODUCTS. As of December 31, 1999, the Company had an aggregate of approximately 678,353 Medicaid members, principally in California. To enroll in these Medicaid products, an individual must be eligible for Medicaid benefits under the appropriate state regulatory requirements. The respective HMOs offer, in addition to standard Medicaid coverage, certain additional services including dental and vision benefits. The applicable state agency pays the Company's HMOs a monthly fee for each Medicaid member enrolled on a percentage of fee-for-service costs. In 1999, the Company had Medicaid members and operations in California, Connecticut, Florida, New Jersey, New York and Washington.

ADMINISTRATIVE SERVICES ONLY BUSINESS. The Company also provides third-party administrative services to large employer groups throughout its service areas. Under these arrangements, the Company provides claims processing, customer service, medical management and other administrative services without

assuming the risk for medical costs. The Company is generally compensated for these services on a fixed per member per month basis.

INDEMNITY INSURANCE PRODUCTS. The Company offers indemnity products as "stand-alone" products and as part of multiple option products in various markets. These products are offered by the Company's health and life insurance subsidiaries which are licensed to sell insurance in 33 states and the District of Columbia. Through these subsidiaries, the Company also offers HMO members certain auxiliary non-health products such as group life and accidental death and disability insurance.

The Company's health and life insurance products are provided throughout most of the Company's service areas. The following table contains certain information relating to such health and life insurance companies' insured PPO, point of service ("POS"), indemnity and group life products as of December 31, 1999 in each of the four Health Plan Divisions in which the Company operated in **1999:**

	ARIZONA DIVISION	CALIFORNIA DIVISION	CENTRAL DIVISION	NORTHEAST DIVISION
Insured PPO Members	7,471	41,643	3,124	0
Point of Service Members	1,937	99,997	24,418	230,292(a)
Indemnity Members	261	8,324	279	0
Group Life Members	2,791	19,441	14,802	0

(a) Represents members under the Company's arrangement with The Guardian described elsewhere in this Annual Report on Form 10-K.

GOVERNMENT CONTRACTS DIVISION

TRICARE. The Company's wholly-owned subsidiary, Foundation Health Federal Services, Inc. ("Federal Services"), administers large, multi-year managed care federal contracts with the United States Department of Defense ("DoD").

Federal Services currently administers health care contracts for DoD's TRICARE program covering 1.5 million eligible individuals under TRICARE (formerly CHAMPUS). Through the federal government's TRICARE program, Federal Services provides TRICARE-eligible beneficiaries with improved access to care, lower out-of-pocket expenses and fewer claims forms. Federal Services currently administers three TRICARE contracts for five regions that cover the following states:

- Region 11: Washington, Oregon and part of Idaho

- Region 6: Arkansas, Oklahoma, most of Texas, and part of Louisiana

- Regions 9, 10 and 12: California, Hawaii, Alaska and part of Arizona

During 1999, enrollment of TRICARE beneficiaries in the HMO option (called "TRICARE Prime") of the TRICARE program for the Region 11 contract increased by 3% to 136,212 while the total estimated number of eligible beneficiaries, based on DoD data, decreased by 1% to 247,717. During 1999, enrollment of TRICARE beneficiaries in TRICARE Prime for the Region 6 contract increased by 13% to 364,099 while the total estimated number of eligible beneficiaries, based on DoD data, decreased by 1% to 614,166. During 1999, enrollment of TRICARE beneficiaries in TRICARE Prime for the Regions 9, 10 and 12 contract increased by 6% to 351,513 while the total estimated number of eligible beneficiaries, based on DoD data and excluding Alaska, decreased by 2% to 633,483. DoD estimated numbers of eligible beneficiaries are subject to revision when actual numbers become available.

Under the TRICARE contracts, Federal Services shares health care cost risk with DoD for both gains and losses. Federal Services subcontracts to affiliated and unrelated third parties for the administration and health care risk of parts of these contracts. If all option periods are exercised by DoD and no further extensions of the performance period are made, health care delivery ends on October 31, 2000 for the

Region 6 contract, on March 31, 2001 for the Regions 9, 10 and 12 contract, and February 28, 2002 for the Region 11 contract. The DoD Authorization Act for government fiscal year 1999 authorized DoD to extend the term of the current TRICARE contracts for two years. Federal Services and DoD negotiated a modification to the contract for Region 11 to add additional option periods which, if exercised, will extend the period of health care delivery to February 28, 2002. Federal Services and DoD are currently negotiating modifications to the contracts for Region 6 and Regions 9, 10 and 12 to add additional option periods which, if exercised, will extend the period of health care delivery to October 31, 2002 for the Region 6 contract and March 31, 2003 for the Regions 9, 10 and 12 contract. Federal Services also expects to compete for the rebid of those contracts.

Federal Services protested to the U.S. General Accounting Office (the "GAO") concerning the award of the TRICARE contract for Regions 2 and 5 (mid-Atlantic and mid-west states) to a competitor of Federal Services. The GAO sustained the protest and recommended that DoD conduct another round of competition for that contract. DoD filed a petition for reconsideration of the protest decision by the GAO. The GAO denied DoD's petition for reconsideration of the Regions 2 and 5 decision and DoD re-opened the competition for that contract on July 27, 1999. Federal Services expects to compete for the rebid of the contract for Regions 2 and 5. Proposals for the Regions 2 and 5 contract are currently due to be submitted to DoD on April 14, 2000 and health care delivery is currently scheduled to commence on September 1, 2001.

VETERANS AFFAIRS. During 1999, Federal Services administered nine contracts with the U.S. Department of Veterans Affairs to manage Community Based Outpatient Clinics ("CBOCs") in five states. Federal services also manages four contracts with the U.S. Department of Veterans Affairs for claims re-pricing services.

SPECIALTY SERVICES DIVISION

The Company's Specialty Services Division offers behavioral health, dental, vision and pharmacy benefit management products and services as well as managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

DENTAL AND VISION. Through DentiCare of California, Inc. ("DentiCare"), the Company operates a dental HMO in California and Hawaii and performs dental administrative services for an affiliate company in California and Colorado, serving in the aggregate approximately 562,000 enrollees as of December 31, 1999. This enrollment includes 122,832 enrollees who are beneficiaries under Medicaid dental programs, of which 34,431 enrollees are beneficiaries of Hawaii's Medicaid program, and 88,401 enrollees who are also enrollees of affiliated Health Plans. DentiCare is also a participant in California's Healthy Families Program, for which initial beneficiary enrollment and service delivery commenced in July 1998. Acquired by the Company in 1991, DentiCare has grown from total revenues in 1992 of $24 million to $51 million for the year ended December 31, 1999.

Operating on administrative and information system platforms in common with DentiCare is Foundation Health Vision Services, Inc., d.b.a. AVP Vision Services ("AVP"). AVP operates in California and Arizona and provides at-risk and administrative services under various programs that result in the delivery of vision benefits to over 685,000 enrollees. Total revenues from AVP operations for the year ended December 31, 1999 were $11 million. Since its acquisition by the Company in 1992, AVP has grown from 30,000 covered enrollees to 423,000 enrollees in full-risk products and 262,000 enrollees covered under administrative services contracts as of December 31, 1999.

Both DentiCare and AVP are licensed in California under the Knox-Keene Health Care Service Plan Act of 1975, as amended (the "Knox-Keene Act"), as Specialized Health Care Service Plans, and compete with other HMOs, traditional insurance companies, self-funded plans, PPOs and discounted fee-for-service plans. The two companies share a common strategy to maximize the value and quality of managed dental

and vision care services while appropriately balancing financial risk assumption among providers, enrollees and other entities to achieve the effective and efficient use of available resources.

BEHAVIORAL HEALTH. The Company's behavioral health subsidiary, Managed Health Network ("MHN"), is licensed in California under the Knox-Keene Act as a Specialized Health Care Service Plan. MHN, directly and through Specialty Services affiliates, offers behavioral health, substance abuse and employee assistance programs ("EAPs") on an insured and self-funded basis to employers, governmental entities and other payors in various states.

MHN provides managed behavioral health programs to employers, governmental agencies and public entitlement programs, such as TRICARE and Medicaid. Employer group sizes range from Fortune 100 to mid-sized companies with 200 employees. MHN's strategy is to continue its market share achievement in the Fortune 500, health plan and TRICARE markets through a combination of direct and consultant/ broker sales. MHN intends to achieve additional market share by capitalizing on competitor consolidation, remaining TRICARE procurement opportunities and the growing state and county Medicaid behavioral carve-outs, funded on either a risk or administrative-services-only ("ASO") basis.

These products and services were provided to over 8.6 million individuals in the year ended December 31, 1999, with approximately 3.6 million individuals under risk-based programs, approximately 1.4 million individuals under self-funded programs, and approximately 3.6 million individuals under EAP programs.

WORKERS' COMPENSATION ADMINISTRATIVE SERVICES. The Company's subsidiaries organized under Employer & Occupational Services Group, Inc. ("EOS"), formerly WC Division, Inc., provide a full range of workers' compensation administrative services to insurers, self-funded employers, third-party claims administrators and public agencies. These services include injury reporting and provider referral, automated bill review and PPO network access, field and telephonic case management, direction of care and practice management, claim/benefit administration, claim investigation and adjudication, litigation management and employer personnel services. During 1999, EOS' Managed Care Services unit provided services on more than $1.2 billion of billed charges for medical care for covered beneficiaries of its customers. The unit processed over 2.6 million bills from providers and hospitals located in 50 states and handled 90,000 intake calls resulting in the processing of over 47,000 injury reports and 40,000 medical care cases referred for case management services and/or utilization review services. EOS' Claims Administration Services unit handled more than 26,000 claims, with aggregate benefit payments by its payor customers in excess of $237 million. Also, EOS' Employment Services unit, a temporary staffing and direct placement service for managed care, workers' compensation and information technology specialists, placed 3,200 temporary assignments and had 127 personnel available for assignment in 14 states.

PHARMACY BENEFIT MANAGEMENT. Effective March 31, 1999, the Company sold certain pharmacy benefit management assets to Advance Paradigm, Inc. ("Advance Paradigm"). In addition, the Company and Advance Paradigm entered into a services agreement, whereby Advance Paradigm provides to the Company's Health Plan Divisions certain pharmacy benefit management services, primarily, processing of claims with respect to pharmacy benefits, mail order service and retail pharmacy network management. See "Discontinued Operations and Anticipated Divestitures." The Company continues to manage drug manufacturer rebates, clinical management of the pharmacy benefit and pharmacy reporting.

PROVIDER RELATIONSHIPS AND RESPONSIBILITIES

PHYSICIAN RELATIONSHIPS. Upon enrollment in most of the Company's HMO plans, each member selects a participating physician group ("PPG") or primary care physician from the HMO's provider panel. The primary care physicians and PPGs assume overall responsibility for the care of members. Medical care provided directly by such physicians includes the treatment of illnesses not requiring referral, as well as physical examinations, routine immunizations, maternity and child care, and other preventive health

services. The primary care physicians and PPGs are responsible for making referrals (approved by the HMO's or PPG's medical director) to specialists and hospitals. Certain Company HMOs offer enrollees "open panels" under which members may access any physician in the network without first consulting a primary care physician.

The following table sets forth the number of primary care and specialist physicians with whom the Company's HMOs (and certain of such HMOs' PPGs) were contracted as of December 31, 1999 in each of the four Health Plan Divisions operated by the Company in 1999:

	ARIZONA DIVISION	CALIFORNIA DIVISION	CENTRAL DIVISION	NORTHEAST DIVISION
Primary Care Physicians.....	1,090	33,424	7,506	14,020
Specialist Physicians.....	2,764	23,312	13,233	29,670
Total.....	3,854	56,736	20,739	43,690

PPG and physician contracts are generally for a period of at least one year and are automatically renewable unless terminated, with certain requirements for maintenance of good professional standing and compliance with the Company's quality, utilization and administrative procedures. In California PPGs generally receive a monthly "capitation" fee for every member served. The capitation fee represents payment in full for all medical and ancillary services specified in the provider agreements. The non-physician component of all hospital services is covered by a combination of capitation and/or per diem charges. In such capitated arrangements, in cases where the capitated provider cannot provide the health care services needed, such providers generally contract with specialists and other ancillary service providers to furnish the requisite services pursuant to capitation agreements or negotiated fee schedules with specialists. Many of the Company's HMOs outside California reimburse physicians according to a discounted fee-for-service schedule, although several HMOs have commenced capitation arrangements with certain providers and provider groups in their market areas.

HOSPITAL RELATIONSHIPS. The Company's HMOs arrange for hospital care primarily through contracts with selected hospitals in their service areas. Such hospital contracts generally provide for multi-year terms and provide for payments on a variety of bases, including capitation, per diem rates, case rates and discounted fee-for-service schedules.

Covered inpatient hospital care for a member is comprehensive; it includes the services of physicians, nurses and other hospital personnel, room and board, intensive care, laboratory and x-ray services, diagnostic imaging and generally all other services normally provided by acute-care hospitals. HMO or PPG nurses and medical directors are actively involved in discharge planning and case management, which often involves the coordination of community support services, including visiting nurses, physical therapy, durable medical equipment and home intravenous therapy.

In August 1999, the Company sold two hospitals which it owned and operated: a 128-bed hospital located in Los Angeles, California, the East Los Angeles Doctors Hospital, and a 200-bed hospital located in Gardena, California, the Memorial Hospital of Gardena. See "Discontinued Operations and Anticipated Divestitures."

COST CONTAINMENT. In most HMO plan designs, the primary care physician or PPG is responsible for authorizing all needed medical care except for emergency medical services. By coordinating care through such physicians in cases where reimbursement includes risk-sharing arrangements, the Company believes that inappropriate use of medical resources is reduced and efficiencies are achieved.

To limit possible abuse in utilization of hospital services in non-emergency situations, a certification process precedes the inpatient admission of each member, followed by continuing review during the member's hospital stay. In addition to reviewing the appropriateness of hospital admissions and continued

hospital stay, the Company plays an active role in evaluating alternative means of providing care to members and encourages the use of outpatient care, when appropriate, to reduce the cost that would otherwise be associated with an inpatient admission.

QUALITY ASSESSMENT. Quality assessment is a continuing priority for the Company. Most of the Company's health plans have a quality assessment plan administered by a committee comprised of medical directors and primary care and specialist physicians. The committees' responsibilities include periodic review of medical records, development and implementation of standards of care based on current medical literature and community standards, and the collection of data relating to results of treatment. All of the Company's health plans also have a subscriber grievance procedure and/or a member satisfaction program designed to respond promptly to member grievances. Aspects of such member service programs take place both within the PPGs and within the Company's health plans. Set forth under the heading "National Committee for Quality Assurance" below is information regarding certain quality assessment accreditations received by the Company's subsidiaries.

Health Benchmarks, Inc. ("HBI"), formerly the Company's Quality Initiatives Division, was incorporated in 1999 as a wholly-owned subsidiary of the Company. HBI is a health services information company which provides services to the managed care sector, employers and the pharmaceutical industry. These services include data management (data warehouse tools) and data analysis, pharmacoeconomic analysis, Phase III and IV clinical trial support, and disease management programs and services that support NCQA and Health Plan Employer Data and Information Set ("HEDIS") initiatives. HBI assists decision-makers in allocating health resources cost-effectively through evidence-based programs. HBI also supports certain quality assessment activities of the Company's health plans. In addition, HBI designs, implements and administers performance-based contracting programs for hospitals and physicians on behalf of managed care companies.

MANAGEMENT INFORMATION SYSTEMS

Effective information technology systems are critical to the Company's operations. The Company's information technology systems include several computer systems, each utilizing a combination of packaged and customized software and a network of on-line terminals. The information technology systems gather and store data on the Company's members and physician and hospital providers. The systems contain all of the Company's necessary membership and claims-processing capabilities as well as marketing and medical utilization programs. These systems provide the Company with an integrated and efficient system of billing, reporting, member services and claims processing, and the ability to examine member encounter information for the optimization of clinical outcomes.

The Company implemented a Year 2000 project to address the challenges posed by the "Year 2000" issue. The Year 2000 issue is the result of computer programs having been written in a language that used two digits rather than four to define the applicable year. Any of the Company's computer programs (both external and internal) that have date/time sensitive software and the outdated software language may recognize a date using "00" as the year 1900 rather than the year 2000. This could result in a system failure or material miscalculations causing disruptions of operations, including, among other things, the inability to process transactions, prepare invoices or engage in normal business activities. As of March 15, 2000, the Company has not identified any significant disruptions or operational problems resulting from Year 2000 issues. There can be no assurance, however, that the Company will not still experience significant Year 2000 problems, including as a result of third party Year 2000 problems.

The costs of the Company's Year 2000 project are set forth under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Company's 1999 Annual Report to Stockholders attached as an exhibit to this Annual Report on Form 10-K.

DISCONTINUED OPERATIONS AND ANTICIPATED DIVESTITURES

PHARMACY BENEFIT MANAGEMENT ASSETS. On March 31, 1999, the Company completed the sale to Advance Paradigm of the capital stock of Foundation Health Pharmaceutical Services, Inc., and certain pharmacy benefit management assets of Integrated Pharmaceutical Services for approximately $65 million in cash. In addition, the Company and Advance Paradigm entered into a services agreement, whereby Advance Paradigm provides to the Company's Health Plan Divisions certain pharmacy benefit management services, primarily, processing of claims with respect to pharmacy benefits, mail order service and retail pharmacy network management. For a period of five years, the Company may not compete with respect to such services in any market in which Advance Paradigm conducts business, subject to certain exceptions.

LOUISIANA, OKLAHOMA AND TEXAS HMO OPERATIONS. On April 30, 1999, the Company completed the sale of its HMO operations in the states of Texas, Louisiana and Oklahoma to AmCareco, Inc. As part of the transaction, the Company received convertible preferred stock of the buyer and cash in excess of certain statutory surplus and minimum working capital requirements of the plans sold.

PREFERRED HEALTH NETWORK, INC. In May 1999, the Company sold the capital stock of Preferred Health Network, Inc., a PPO network ("PHN"), to Beyond Benefits, Inc. PHN and the Company, or certain affiliates thereof, entered into agreements at closing to provide each other with certain continued access to each other's networks.

SOUTHERN CALIFORNIA HOSPITALS. In August 1999, the Company sold East Los Angeles Doctors Hospital and Memorial Hospital of Gardena, two Southern California hospitals, to HealthPlus+ Corporation and certain affiliated entities. Certain subsidiaries of the Company continue to maintain contractual arrangements with the hospitals following the sale.

FHPA. In September 1999, the Company sold the capital stock of Foundation Health Preferred Administrators, Inc., a third-party administrator subsidiary of the Company, to Capitol Administrators, Inc.

NEW MEXICO OPERATIONS. In September 1999, the Company sold the capital stock of QualMed Plans for Health, Inc., the Company's HMO subsidiary in the state of New Mexico, to Health Care Horizons, Inc.

UTAH OPERATIONS. In October 1999, the Company sold the outstanding capital stock of Intergroup of Utah, Inc., the Company's HMO subsidiary in the state of Utah, to Altius Health Plans Inc.

HN REINSURANCE LIMITED. In October 1999, the Company sold the outstanding capital stock of HN Reinsurance Limited, a Cayman Island reinsurance subsidiary, to AmCareco, Inc.

COLORADO OPERATIONS. In November 1999, the Company commenced the transition of its membership in Colorado to PacifiCare of Colorado, Inc. ("PacifiCare-CO") pursuant to a definitive agreement with PacifiCare-CO. The Company believes the transition will be completed during the first half of 2000. Pursuant to the definitive agreement, PacifiCare-CO is offering replacement coverage to substantially all of the Company's Colorado HMO membership and PacifiCare Life Assurance Company is issuing replacement indemnity coverage to substantially all of the Company's Colorado POS membership. PacifiCare-CO is offering to enroll such HMO members at the earliest date possible in comparable PacifiCare-CO benefit plans within PacifiCare-CO's service area at PacifiCare's rates.

In August 1999, in connection with the Company's wind down of its business in Colorado, the Company sold its regional claims processing facility and accompanying real estate in Pueblo, Colorado, including certain equipment and other assets located at the facility, to the Pueblo Economic Development Company for total aggregate proceeds of approximately $5 million and certain other consideration

(including a complete release from the City of Pueblo of liabilities arising out of certain agreements between the City and the Company).

WASHINGTON OPERATIONS. In December 1999, the Company sold the capital stock of QualMed Washington Health Plan, Inc., the Company's HMO subsidiary in the state of Washington ("QM-Washington"), to American Family Care Inc. ("AFC"). AFC assumed control of the health-plan license and acquired the Medicaid and Basic Health Plan membership of QM-Washington. The commercial HMO membership of QM-Washington is being transitioned to PacifiCare of Washington, Inc. ("PacifiCare-WA"), Premera Blue Cross and Blue Cross of Idaho pursuant to definitive agreements with such companies. As part of such agreements, PacifiCare-WA will offer replacement coverage to QM-Washington's HMO and POS groups in western Washington, Premera Blue Cross will offer replacement coverage to substantially all of QM-Washington's HMO and POS group membership in eastern Washington and Blue Cross of Idaho will offer replacement coverage for certain members who reside in Idaho. Replacement coverage will consist of the new company's benefit plans in the new company's service areas at the new company's rates. The transition commenced in January 2000 and is anticipated to be substantially completed during the first half of 2000.

QUALMED PLANS FOR HEALTH OF PENNSYLVANIA, INC. Effective December 31, 1998, the Company purchased the minority interests in QualMed Plans for Health of Pennsylvania, Inc. ("QualMed-PA"), a then majority-owned subsidiary of the Company. Previously, the Company owned approximately 83% of the common stock of QualMed-PA. In January 1999, the Company transferred certain assets of QualMed-PA, including the assets relating to its preferred provider organization, MaxNet-Registered Trademark-, to Preferred Health Network, Inc., then another wholly-owned subsidiary of the Company. As set forth above in this "Discontinued Operations and Anticipated Divestitures," the Company subsequently sold the capital stock of Preferred Health Network, Inc.

INSURANCE SUBSIDIARIES. In July 1999, the Company completed the restructuring of certain of its insurance subsidiaries by merging Foundation Health National Life Insurance Company ("FHNL") with Foundation Health Systems Life and Health Insurance Company ("FHS Life") under a holding company subsidiary of the Company, FHS Life Holdings Company, Inc.

GEM INSURANCE COMPANY. Since October of 1997, Gem Insurance Company ("Gem"), a subsidiary of the Company, has implemented a restructuring plan to reduce operating losses and its in-force insurance risk. As part of such restructuring, Gem is withdrawing from certain insurance markets. Upon completion of its current withdrawals, Gem will be operating in only two states. As of December 31, 1999, the number of Gem's insureds was under 1,000. Currently, Foundation Health Systems Life and Health Insurance Company, a subsidiary of the Company, services Gem's insureds through an administrative services agreement between the companies. The Company is reviewing the possibility of winding up the operations of Gem or merging such operations into another insurance subsidiary of the Company.

REAL ESTATE TRANSACTIONS. During 1999, the Company completed the sale of nine health care centers for net proceeds of approximately $17.6 million. Such care centers were part of fourteen care centers originally leased to, and subsequently vacated by, FPA Medical Management, Inc. As of March 17, 2000, the Company has sold twelve such care centers. As set forth above, in August 1999, in connection with the Company's wind down of its business in Colorado, the Company sold its regional claims processing facility and accompanying real estate in Pueblo, Colorado, including certain equipment and other assets located at the facility, to the Pueblo Economic Development Company for total aggregate proceeds of approximately $5 million and certain other consideration. In addition, in 1999, the Company sold a land parcel in Roseville, California and certain other real estate located in Pueblo, Colorado for aggregate net proceeds of approximately $913,000.

CERTAIN OTHER OPERATIONS. The Company continues to evaluate the profitability realized or likely to be realized by its existing businesses and operations, and is reviewing from a strategic standpoint which of such businesses or operations should be divested.

ADDITIONAL INFORMATION CONCERNING THE COMPANY'S BUSINESS

MARKETING AND SALES. Marketing for group Health Plan business is a two-step process in which the Company first markets to employer groups and then provides information directly to employees once the employer has selected a Company HMO. The Company typically uses its internal sales staff to serve the large employer groups while independent brokers work with the Company's internal sales staff to develop business with smaller employer groups. Once selected by an employer, the Company solicits enrollees from the employee base directly. In 1999, the Company marketed its programs and services primarily through its direct sales staff and independent brokers, agents and consultants. During "open enrollment" periods when employees are permitted to change health care programs, the Company uses direct mail, work day and health fair presentations, telemarketing, outdoor print, radio and television advertisements to attract new enrollees. The Company's sales efforts are supported by its marketing division which includes research and product development, corporate communications, public relations and marketing services.

Premiums for each employer group are generally contracted for on a yearly basis, payable monthly. Numerous factors are considered by the Company in fixing its monthly premiums, including employer group needs and anticipated health-care utilization rates as forecasted by the Company's management based on the demographic composition of, and the Company's prior experience in, its service areas. Premiums are also affected by applicable regulations that prohibit experience rating of group accounts (i.e., setting the premium for the group based on its past use of health care services) and by state regulations governing the manner in which premiums are structured.

The Company believes that the importance of the ultimate health care consumer (or member) in the health care product purchasing process is likely to increase in the future. Accordingly, the Company intends to focus its marketing strategies on the development of distinct brand identities and innovative product service offerings that will appeal to potential Health Plan members.

COMPETITION. HMOs operate in a highly competitive environment in an industry currently subject to significant changes from business consolidations, new strategic alliances, legislative reform and market pressures brought about by a better informed and better organized customer base. The Company's HMOs face substantial competition from for-profit and nonprofit HMOs, PPOs, self-funded plans (including self-insured employers and union trust funds), Blue Cross/Blue Shield plans, and traditional indemnity insurance carriers, some of which have substantially larger enrollments and greater financial resources than the Company. The Company believes that the principal competitive features affecting its ability to retain and increase membership include the range and prices of benefit plans offered, provider network, quality of service, responsiveness to user demands, financial stability, comprehensiveness of coverage, diversity of product offerings, and market presence and reputation. The relative importance of each of these features and key competitors vary by market. The Company believes that it competes effectively with respect to all of these factors.

Kaiser Foundation Health Plan ("Kaiser") is the largest HMO in California and is a competitor of the Company in the California HMO industry. In addition to Kaiser, the Company's other HMO competitors include PacifiCare of California, California Care (Blue Cross), Blue Shield, Aetna and CIGNA Healthplans of California, Inc. There are also a number of other types of competitors including self-directed plans, traditional indemnity insurance plans, and other managed care plans. Despite the concentration of membership in the large health plans, the environment in the state is also impacted by small, regional-based HMOs, whose combined membership constitutes approximately 20-25% of the market. In addition, the Company competes in California against a variety of PPOs.

The Company's largest competitor in Arizona is Health Partners. The Company's Arizona HMO also competes with CIGNA, PacifiCare, Aetna and Blue Cross/Blue Shield. The Company's Oregon HMO competes primarily against other HMOs including Kaiser, PacifiCare of Oregon, Providence, Blue Cross Lifewise and Blue Shield Regions, and with various PPOs.

The Company's HMOs in Connecticut compete for business with commercial insurance carriers, Blue Cross and Blue Shield of Connecticut, Aetna/U.S. Healthcare and more than ten other HMOs. The Company's main competitors in Pennsylvania, New York and New Jersey are Aetna/U.S. Healthcare, Independence Blue Cross, Empire Blue Cross, Oxford Health Plans, AmeriHealth, United Health Care, Horizon Blue Cross and Keystone Health Plan East. The Company's HMO operations in Florida compete for business with Humana Medical Plan, United Health Care, Health Options and Prudential HealthCare, among others.

In 1999, the Company sold its HMO operations in Louisiana, New Mexico, Oklahoma, Texas and Utah, and a portion of its HMO operations in Washington, and entered into definitive agreements to transition its HMO and indemnity membership in Colorado, Idaho and Washington to third parties. See "Discontinued Operations and Anticipated Divestitures."

GOVERNMENT REGULATION. The Company believes it is in compliance in all material respects with all current state and federal regulatory requirements applicable to the business being conducted by its subsidiaries. Certain of these requirements are discussed below.

CALIFORNIA HMO REGULATIONS. California HMOs such as Health Net and certain of the Company's specialty plans are subject to California state regulation, principally by the DOC under the Knox-Keene Act. In 1999, California enacted a law transferring jurisdiction of the Knox-Keene Act to a new agency, the Department of Managed Care, which will become effective no later than July 1, 2000. Among the areas regulated by the Knox-Keene Act are: (i) adequacy of administrative operations, (ii) the scope of benefits required to be made available to members, (iii) manner in which premiums are structured, (iv) procedures for review of quality assurance, (v) enrollment requirements, (vi) composition of policy making bodies to assure that plan members have access to representation, (vii) procedures for resolving grievances, (viii) the interrelationship between HMOs and their health care providers, (ix) adequacy and accessibility of the network of health care providers, (x) provider contracts, and (xi) initial and continuing financial viability of the HMO and its risk-bearing providers. Any material modifications to the organization or operations of Health Net are subject to prior review and approval by the DOC. This approval process can be lengthy and there is no certainty of approval. Other significant changes require filing with the DOC, which may then comment and require changes. In addition, under the Knox-Keene Act, Health Net and certain other Company subsidiaries must file periodic reports with, and are subject to periodic review and investigation by, the DOC. Non-compliance with the Knox-Keene Act may result in an enforcement action, fines and penalties, and in egregious cases, limitations on or revocation of the Knox-Keene license.

The DOC has also required the Company and its Knox-Keene licensed subsidiaries to provide the DOC with a number of undertakings in connection with the FHS Combination and the merger of the Company's two California full-service HMOs in 1998. These undertakings obligate the affected companies to certain requirements not applicable to licensees generally, or prohibit or require regulatory approval preceding the institution of certain changes. While the Company has been permitted to withdraw a number of these undertakings, others remain in effect and constrain the Company's flexibility of operations. The Company does not believe, however, that the remaining undertakings have a material adverse effect on the Company and its licensees taken as a whole.

FEDERAL HMO REGULATION. Under the Federal Health Maintenance Organization Act of 1973 (the "HMO Act"), services to members must be provided substantially on a fixed, prepaid basis without regard to the actual degree of utilization of services. Premiums established by an HMO may vary from account to account through composite rate factors and special treatment of certain broad classes of members, and through prospective (but not retrospective) rating adjustments. Several of the Company's HMOs are federally qualified in certain parts of their respective service areas under the HMO Act and are therefore subject to the requirements of such act to the extent federally qualified products are offered and sold.

Additionally, there are a number of recently enacted federal laws that further regulate managed health care. Such legislation includes the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The primary effects of HIPAA are that it (i) limits pre-existing condition exclusions applicable to individuals changing jobs or moving to individual coverage, (ii) guarantees the availability of health insurance for employees in the small group market and (iii) prevents the exclusion of individuals from coverage under group plans based on health status.

The Company's Medicare risk contracts are subject to regulation by HCFA. HCFA has the right to audit HMOs operating under Medicare contracts to determine the quality of care being rendered and the degree of compliance with HCFA's contracts and regulations. The Company's Medicaid business is also subject to regulation by HCFA, as well as state agencies.

PENDING FEDERAL AND STATE LEGISLATION. There are a number of initiatives and regulations currently pending at the federal and state level which could increase regulation of the health care industry. Such legislation includes "managed care reform," "patients bill of rights," regulations under HIPAA and certain other initiatives which, if enacted, could have significant adverse effects on the Company's operations. See "Item 4--Cautionary Statements--Federal and State Legislation." The Company cannot predict the outcome of any of the pending legislative or regulatory proposals, nor the extent to which the Company may be affected by the enactment of any such legislation or regulation.

OTHER HMO REGULATIONS. In each state in which the Company does business, HMOs must file periodic reports with, and their operations are subject to periodic examination by, state licensing authorities. In addition, each HMO must meet numerous state licensing criteria and secure the approval of state licensing authorities before implementing certain operational changes, including the development of new product offerings and, in some states, the expansion of service areas. To remain licensed, each HMO must continue to comply with state laws and regulations and may from time to time be required to change services, procedures or other aspects of its operations to comply with changes in applicable laws and regulations. HMOs are required by state law to meet certain minimum capital and deposit and/or reserve requirements in each state and may be restricted from paying dividends to their parent corporations under certain circumstances from time to time. Several states have increased minimum capital requirements, pursuant to proposals by the National Association of Insurance Commissioners to institute risk-based capital requirements. Regulations in these and other states may be changed in the future to further increase equity requirements. Such increases could require the Company to contribute additional capital to its HMOs. Any adverse change in governmental regulation or in the regulatory climate in any state could materially impact the HMOs operating in that state. The HMO Act and state laws place various restrictions on the ability of HMOs to price their products freely. The Company must comply with certain provisions of state insurance and similar laws, including regulations governing the Company's ability to seek ownership interests in new HMOs, PPOs and insurance companies, or otherwise expand its geographic markets or diversify its product lines.

INSURANCE REGULATIONS. State departments of insurance (the "DOIs") regulate insurance and third-party administrator business conducted by certain subsidiaries of the Company (the "Insurance Subsidiaries") pursuant to various provisions of state insurance codes and regulations promulgated thereunder. The Insurance Subsidiaries are subject to various capital reserve and other financial, operating and disclosure requirements established by the DOIs and state laws. The Insurance Subsidiaries must also file periodic reports regarding their activities regulated by the DOIs and are subject to periodic reviews of those activities by the DOIs. The Company must also obtain approval from, or file copies with, the DOIs for all of its group and individual policies prior to issuing those policies. The Company does not believe that the requirements imposed by the DOIs will have a material impact on the ability of the Insurance Subsidiaries to conduct their business profitably.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE ("NCQA"). NCQA is an independent, non-profit organization that reviews and accredits HMOs and assesses an HMO's quality improvement, utilization management, credentialing process, commitment to members' rights and preventive health services. HMOs that comply with NCQA's review requirements and quality standards receive NCQA accreditation. After an NCQA review is completed, NCQA will issue one of four designations. These are (i) accreditation for three years; (ii) accreditation for one year; (iii) provisional accreditation for twelve to eighteen months to correct certain problems with a follow-up review to determine qualification for accreditation; and (iv) not accredited. Foundation Health, A Florida Health Plan, Inc.; Health Net, the Company's HMO in California; and Intergroup Prepaid Health Services of Arizona, Inc., the Company's HMO in Arizona, have all received NCQA accreditations for three years. QualMed Plans for Health, Inc. (Pennsylvania) and QualMed Plans for Health of Western Pennsylvania, Inc. have each received one year provisional accreditation from NCQA. QualMed Plans for Health of Ohio and West Virginia, Inc. applied for NCQA accreditation in October 1998, but did not receive it. Certain of the Company's other Health Plan subsidiaries are in the process of applying for NCQA accreditation.

SERVICE MARKS

The Company's service marks and/or trademarks include, among others: THE ACUTE CARE ALTERNATIVE-Registered Trademark-, Alliance 2000-SM- Alliance 1000-SM-, Asthmawise-SM-, AVP-SM-, AVP Vision Plans-SM-, BabyWell-SM-, BEING WELL-Registered Trademark-, CARECAID-Registered Trademark-, CMP-Registered Trademark-, COMBINED CARE-Registered Trademark-, COMBINED CARE PLUS-SM-, COMMUNITY MEDICAL PLAN, INC. and design-Registered Trademark-, A CURE FOR THE COMMON HMO-Registered Trademark-, Feetbeat Worksite Walking Program-SM-, FIRM SOLUTIONS-Registered Trademark-, FLEX ADVANTAGE-Registered Trademark-, FLEX NET-SM-, FOUNDATION HEALTH and design-Registered Trademark-, FOUNDATION HEALTH GOLD-Registered Trademark-, Foundation Health Systems-SM-, HANK-Registered Trademark-, HANK and design-Registered Trademark-, HEALTH NET-Registered Trademark-, Health Net ACCESS-SM-, Health Net Comp.24-SM-, Health Net ELECT-SM-, Health Net INSIGHT-SM-, Health Net OPTIONS-SM-, Health Net SELECT-SM-, Health Net Seniority Plus-SM-, Health Smart and design-SM-, Healthworks (stylized)-SM-, Heart & Soul-SM-, IMET and design-Registered Trademark-, Indian design-Registered Trademark-, INDIVIDUAL PREFERRED PPO-Registered Trademark-, InterCare-SM-, InterComp-SM-, InterFlex-SM-, Inter Mountain Employers Trust-SM-, InterPlus-SM-, LIFE WITH DIGNITY AND HOPE-Registered Trademark-, MAKING QUALITY HEALTH CARE AFFORDABLE-Registered Trademark-, M.D. Health Plan Personal Medical Management-SM-, On the Road to Good Health-SM-, PHYSICIANS HEALTH SERVICES-Registered Trademark-, QUALASSIST-Registered Trademark-, QUALADMIT-Registered Trademark-, QUALCARE-Registered Trademark-, QUALCARE PREFERRED-Registered Trademark-, QUAL-MED-Registered Trademark-, QUALMED-SM-, QUALMED HEALTH & LIFE INSURANCE COMPANY-Registered Trademark-, QUALMED PLANS FOR HEALTH-Registered Trademark-, Rapid Access-SM-, SENIOR SECURITY-Registered Trademark-, SENIOR VALUE-Registered Trademark-, Someone at Your Side-SM-, Sun/Mountain design-Registered Trademark-, The Final Piece of the Healthcare Puzzle-SM-, VitalLine-SM-, VITALTEAM-Registered Trademark-, WELL MANAGED CARE RIGHT FROM THE START-Registered Trademark-, WELL REWARDS-Registered Trademark-, Well Woman-SM-, Wise Choice-SM-, WORKING WELL TOGETHER-Registered Trademark-, and Your Partner in Healthy Living-SM-, and certain designs related to the foregoing.

The Company utilizes these and other marks in connection with the marketing and identification of products and services. The Company believes such marks are valuable and material to its marketing efforts.

EMPLOYEES

The Company currently employs approximately 12,000 employees, excluding temporary employees. Such employees perform a variety of functions, including administrative services for employers, providers and members, negotiation of agreements with physician groups, hospitals, pharmacies and other health care providers, handling claims for payment of hospital and other services, and providing data processing services. The Company's employees are not unionized and the Company has not experienced any work stoppage since its organization. The Company considers its relations with its employees to be very good.

In connection with the FHS Combination, the Company adopted a significant restructuring plan which provides for a workforce reduction, the consolidation of employee benefit plans and the consolidation of certain office locations, which the Company has been effectuating. In addition, the Company's

substantial completion of its divestiture program in 1999 resulted in additional workforce reductions and operational consolidations.

ITEM 2. PROPERTIES

The Company leases office space for its principal executive offices in Woodland Hills, California and its offices in Rancho Cordova, California.

The Woodland Hills facility, with approximately 410,000 square feet, is leased pursuant to two leases, the earlier of which expires in December 2001 with respect to 300,000 square feet. The Company has a right to renew each of such leases. The aggregate rent for the two leases for 1999 was approximately $11.1 million. The Company's principal executive offices are located in the Woodland Hills facility, as are much of the Company's California HMO operations.

The Company and its subsidiaries also lease an aggregate of approximately 390,000 square feet of office space in Rancho Cordova, California. The Company's aggregate rent obligations under these leases were approximately $6.1 million in 1999. These leases expire at various dates through January 2003. The Rancho Cordova facilities serve as a regional data processing center and house certain Specialty Services and California HMO operations.

The Company also leases a total of approximately 250,000 square feet of office space in Irvine, California and San Rafael, California for certain Specialty Services operations. In addition to the Company's office space referenced above, the Company and its subsidiaries lease approximately 140 sites in 23 states, comprising roughly 1.85 million square feet of space.

In addition, the Company owns facilities comprising, in the aggregate, nearly 1.1 million square feet of space. These facilities include headquarters for the Company's health plan subsidiaries in Connecticut and Arizona, as well as data processing facilities located in Rancho Cordova, California. The Company is currently considering the sale of certain care centers in California and Arizona.

In August 1999, in connection with the Company's wind down of its business in Colorado, the Company sold its regional claims processing facility and accompanying real estate in Pueblo, Colorado, including certain equipment and other assets located at the facility. See "Discontinued Operations and Anticipated Divestitures." Such facility consisted of approximately 72,500 square feet of office space. The Company is in the process of selling certain remaining facilities in Pueblo, Colorado. Also in August 1999, the Company sold two Southern California hospitals owned and operated by the Company, which hospitals comprised approximately 250,000 square feet of space.

Management believes that its ownership and rental costs are consistent with those available for similar space in the applicable local area. The Company's properties are well maintained, considered adequate and are being utilized for their intended purposes.

ITEM 3. LEGAL PROCEEDINGS

MEDAPHIS CORPORATION

In July 1996, the Company's predecessor, HSI, the owner of 1,234,544 shares of Series F Preferred Stock of Health Data Sciences Corporation ("HDS"), voted its HDS shares in favor of the acquisition of HDS by Medaphis Corporation ("Medaphis"). HSI received as the result of the acquisition 976,771 shares of Medaphis common stock in exchange for its Series F Preferred Stock. In November 1996, HSI filed a lawsuit against Medaphis and its former Chairman and Chief Executive Officer. The Company alleged that Medaphis and certain insiders deceived the Company by presenting materially false financial statements and by failing to disclose that Medaphis would shortly reveal a "write off" of up to $40 million in reorganization costs and would lower its earnings estimate for the following year, thereby more than halving the value of the Medaphis shares received by the Company.

In September 1999, the Company and Medaphis (which changed its name to Per-Se Technologies, Inc. ("Per-Se")) entered into a Settlement Agreement and Release pursuant to which the Company received net proceeds of approximately $25 million consisting of cash from Per-Se and Per-Se's insurers and proceeds from the sale of both the 976,771 shares of Medaphis (now Per-Se) common stock then owned by the Company and additional shares of Per-Se common stock issued to the Company as part of the settlement. In exchange, the Company and Per-Se terminated the ongoing litigation and granted each other a general release.

FPA MEDICAL MANAGEMENT, INC.

Since May 1998, several complaints (the "FPA 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 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 FPA Complaints name as defendants FPA, certain of FPA's auditors, the Company and certain of the Company's former officers. The FPA Complaints allege that the Company and such former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between the Company and FPA, about FPA's business and about the Company's 1997 sale of FPA common stock held by the Company. All claims against the Company's former officers were voluntarily dismissed from the consolidated class actions in both federal and state court. The Company has filed a motion to dismiss all claims asserted against it in the consolidated federal class actions but has not formally responded to the other complaints. Management believes these suits against the Company and its former officers are without merit and intends to defend the actions vigorously.

PAY V. FOUNDATION HEALTH SYSTEMS, INC.

On November 22, 1999, a complaint was filed in the United States District Court for the Southern District of Mississippi in a lawsuit entitled PAY V. FOUNDATION HEALTH SYSTEMS, INC. (2:99CV329). The two count complaint seeks certification of a nationwide class action and alleges that cost containment measures used by FHS-affiliated health maintenance organizations, preferred provider organizations and point-of-service health plans violate provisions of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") and the federal Employee Retirement Income Security Act ("ERISA"). The action seeks unspecified damages and injunctive relief. On January 24, 2000, FHS filed a motion to stay consideration of class certification issues until the resolution of a motion to transfer or dismiss the action for lack of jurisdiction and venue. On January 25, 2000, the court stayed the case pending resolution of matters in an action pending in the Southern District of Mississippi against Humana, Inc. Management believes the suit is without merit and intends to vigorously defend the action.

BAJA INC. V. LOS ANGELES MEDICAL MANAGEMENT CORP., EAST LOS ANGELES DOCTORS HOSPITAL FOUNDATION, INC.

In September 1983, a lawsuit was filed in Los Angeles Superior Court by Baja Inc. ("Baja") against East Los Angeles Doctors Hospital Foundation, Inc. ("Hospital") and Century Medicorp ("Century") arising out of a multi-phase written contract for operation of a pharmacy at the Hospital during the period September 1978 through September 1983. In October 1992, Foundation Health Corporation, now a subsidiary of the Company, acquired the Hospital and Century, and thereafter continued the vigorous defense of this action. In August 1993, the Court awarded Baja $549,532 on a portion of its claim. In December 1994, the Court concluded that Baja also could seek certain additional damages subject to proof. On July 5, 1995, the Court awarded Baja an additional $1,015,173 (plus interest) in lost profits damages. In October 1995, both of the parties appealed. The Court of Appeal reversed portions of the judgment, directing the trial court to conduct additional hearings on Baja's damages. In January 2000, after further proceedings on the issue of Baja's lost profits, the Court awarded Baja an additional $4,996,019,

plus prejudgment interest. The Company is in the process of preparing appropriate post trial motions in this case, and is also considering an appeal of the Court's final judgment.

STATE OF CONNECTICUT V. PHYSICIANS HEALTH SERVICES, INC.

Physicians Health Services, Inc. ("PHS"), a subsidiary of the Company, was sued on Dec. 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 is premised on ERISA, and alleges that PHS has violated its duties under that Act by managing its prescription drug formulary in a manner that serves its own financial interest rather than those of plan beneficiaries. The suit seeks to have PHS revamp its formulary system, and to provide patients with written denial notices and instructions on how to appeal. PHS intends to defend the suit vigorously, and has filed a motion to dismiss which asserts that the state residents the Attorney General purports to represent all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that his office lacks standing to bring the suit and that the allegations fail to state a claim under ERISA. The State must file an answer to the motion by March 15, 2000, and a decision is expected this spring.

MISCELLANEOUS PROCEEDINGS

The Company and certain of its subsidiaries are also parties to various other legal proceedings, many of which involve claims for coverage encountered in the ordinary course of its business. Based in part on advice from litigation counsel to the Company and upon information presently available, management of the Company is of the opinion that the final outcome of all such proceedings should not have a material adverse effect upon the Company's results of operations or financial condition.

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

There were no matters submitted to a vote of the security holders of the Company, either through solicitation of proxies or otherwise, during the fourth quarter of the year ended December 31, 1999.

OTHER INFORMATION

REVOLVING CREDIT FACILITY

The Company has an unsecured, five-year $1.5 billion revolving credit facility pursuant to a Credit Agreement dated July 8, 1997 (the "Credit Agreement") with the banks identified in the Credit Agreement (the "Banks") and Bank of America National Trust and Savings Association ("Bank of America") as Administrative Agent. All previous revolving credit facilities were terminated and rolled into the Credit Agreement. The Credit Agreement contains customary representations and warranties, affirmative and negative covenants, and events of default. Specifically, Section 7.11 of the Credit Agreement provides that the Company and its subsidiaries may, so long as no event of default exists: (i) declare and distribute stock as a dividend; (ii) purchase, redeem or acquire its stock, options and warrants with the proceeds of concurrent public offerings; and (iii) declare and pay dividends or purchase, redeem or otherwise acquire its capital stock, warrants, options or similar rights with cash subject to certain specified limitations.

Under the Credit Agreement, as amended pursuant to a Letter Agreement dated as of March 27, 1998, the First Amendment and Waiver to Credit Agreement dated as of April 6, 1998, the Second Amendment to Credit Agreement dated as of July 31, 1998, the Third Amendment to Credit Agreement dated as of November 6, 1998 and the Fourth Amendment of Credit Agreement dated as of March 26, 1999 (collectively, the "Amendments") with the Banks, the Company is: (i) obligated to maintain certain covenants keyed to the Company's financial condition and performance (including a Total Leverage Ratio and Fixed Charge Ratio); (ii) obligated to limit liens; (iii) subject to customary covenants, including (A) disposition of assets only in the ordinary course and generally at fair value and (B) restrictions on acquisitions, mergers, consolidations, loans, leases, joint ventures, contingent obligations and certain

transactions with affiliates; and (iv) permitted to incur additional indebtedness in an aggregate amount not to exceed $1,000,000,000 upon certain terms and conditions. The Credit Agreement also provides for mandatory prepayment of the outstanding loans under the Credit Agreement with a certain portion of the proceeds from the issuance of such indebtedness and from the sales of assets, resulting in a permanent reduction of the aggregate amount of commitments under the Credit Agreement by the amount so prepaid. As of December 31, 1999, the maximum commitment level permitted under the Credit Agreement was approximately $1.37 billion, of which approximately $330 million remained available. The Amendments also provided for an increase in the interest and facility fees under the Credit Agreement.

SHAREHOLDER RIGHTS PLAN

On May 20, 1996, the Board of Directors of the Company declared a dividend distribution of one right (a "Right") for each outstanding share of the Company's Class A Common Stock and Class B Common Stock (collectively, the "Common Stock"), to stockholders of record at the close of business on July 31, 1996 (the "Record Date"). The Board of Directors of the Company also authorized the issuance of one Right for each share of Common Stock issued after the Record Date and prior to the earliest of the Distribution Date (as defined below), the redemption of the Rights and the expiration of the Rights, and in certain other circumstances. Rights will attach to all Common Stock certificates representing shares then outstanding and no separate Rights certificates will be distributed. Subject to certain exceptions contained in the Rights Agreement dated as of June 1, 1996 by and between the Company and Harris Trust and Savings Bank, as Rights Agent (the "Rights Agreement"), the Rights will separate from the Common Stock in the event any person acquires 15% or more of the outstanding Class A Common Stock, the Board of Directors of the Company declares a holder of 10% or more of the outstanding Class A Common Stock to be an "Adverse Person," or any person commences a tender offer for 15% or more of the Class A Common Stock (each event causing a "Distribution Date").

Except as set forth below and subject to adjustment as provided in the Rights Agreement, each Right entitles its registered holder, upon the occurrence of a Distribution Date, to purchase from the Company one one-thousandth of a share of Series A Junior Participating Preferred Stock at a price of $170.00 per one-thousandth share. However, in the event any person acquires or commences a tender offer for 15% or more of the outstanding Class A Common Stock, or the Board of Directors of the Company declares a holder of 10% or more of the outstanding Class A Common Stock to be an "Adverse Person," the Rights (subject to certain exceptions contained in the Rights Agreement) will instead become exercisable for Class A Common Stock having a market value at such time equal to $340.00. The Rights are redeemable under certain circumstances at $.01 per Right and will expire, unless earlier redeemed, on July 31, 2006.

A copy of the Rights Agreement has been filed with the Securities and Exchange Commission as Exhibit 99.1 to the Company's Registration Statement on Form 8-A (File No. 001-12718). In connection with its execution of the Merger Agreement for the merger transaction involving Foundation Health Corporation and Health Systems International, Inc., the Company's predecessors, the Company entered into Amendment No. 1 (the "Rights Amendment") to the Rights Agreement to exempt the Merger Agreement and related transactions from triggering the Rights. In addition, the Rights Amendment modifies certain terms of the Rights Agreement applicable to the determination of certain "Adverse Persons," which modifications became effective upon consummation of the transactions provided for under the Merger Agreement. This summary description of the Rights does not purport to be complete and is qualified in its entirely by reference to the Rights Agreement.

THE CALIFORNIA WELLNESS FOUNDATION

Pursuant to the Amended California Wellness Foundation Shareholder Agreement, dated as of January 28, 1992 (the "CWF Shareholder Agreement"), by and among the Company, The California Wellness Foundation (the "CWF"), and certain stockholders (the "HNMH Stockholders") of HN Management Holdings, Inc. (a predecessor to the Company) ("HNMH") named therein, the CWF was subject to various volume and manner of sale restrictions specified in the CWF Shareholder Agreement which limited the number of shares of Class B Common Stock that the CWF could dispose of prior to December 31, 1998. The CWF and the Company are also party to a Registration Rights Agreement dated as of March 2, 1995 (the "CWF Registration Rights Agreement") pursuant to which the CWF has the right to demand registration for sale in underwritten public offerings of up to 8,026,298 shares of Class B Common Stock.

Under the relevant provisions of California law, when a corporation converts from nonprofit to for-profit corporate status, the equivalent of the fair market value of the nonprofit corporation must be contributed to a successor charity that has a charitable purpose consistent with the purposes of the nonprofit entity. The CWF was formed to be the charitable recipient of the conversion settlement when Health Net (a subsidiary of the Company) effected a conversion from nonprofit to for-profit status, which occurred in February 1992 (the "Conversion"). In connection with the Conversion, Health Net issued to the CWF promissory notes in the original principal amount of $225 million (the "CWF Notes") and shares of Class B Common Stock (which immediately prior to the business combination involving HNMH and QualMed, Inc. were split to become 25,684,152 shares of Class B Common Stock then held by the CWF). While such shares are held by the CWF, they are entitled to the same economic benefit as Class A Common Stock, but are non-voting in nature. If the CWF sells or transfers such shares to an unrelated third party, they automatically convert to Class A Common Stock.

Pursuant to certain agreements with the CWF, the Company redeemed 4,550,000 shares of Class B Common Stock from the CWF on June 27, 1997. The CWF has also sold shares of Class B Common Stock to unrelated third parties, which shares of common stock automatically converted into shares of Class A Common Stock at the time of such sales.

As a result of various sales of Class B Common Stock by CWF, CWF has gradually reduced its holdings and, as of March 17, 2000, held 563,742 shares of Class B Common Stock. On November 15, 1999, $13,482,745, representing the remaining principal and interest under the CWF Notes, was paid off. As a result, the CWF Notes are no longer outstanding.

CAUTIONARY STATEMENTS

In connection with the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995, the Company is hereby filing cautionary statements identifying important risk factors that could cause the Company's actual results to differ materially from those projected in forward-looking statements of the Company made by or on behalf of the Company.

The Company wishes to caution readers that these factors, among others, could cause the Company's actual financial or enrollment results to differ materially from those expressed in any projected, estimated or forward-looking statements relating to the Company. The following factors should be considered in conjunction with any discussion of operations or results by the Company or its representatives, including any forward-looking discussion, as well as comments contained in press releases, presentations to securities analysts or investors, or other communications by the Company.

In making these statements, the Company is not undertaking to address or update each factor in future filings or communications regarding the Company's business or results, and is not undertaking to address how any of these factors may have caused changes to discussions or information contained in previous filings or communications. In addition, certain of these matters may have affected the Company's past results and may affect future results.

HEALTH CARE COSTS. A large portion of the revenue received by the Company is expended to pay the costs of health care services or supplies delivered to its members. The total health care costs incurred by the Company are affected by the number of individual services rendered and the cost of each service. Much of the Company's premium revenue is set in advance of the actual delivery of services and the related incurring of the cost, usually on a prospective annual basis. While the Company attempts to base the premiums it charges at least in part on its estimate of expected health care costs over the fixed premium period, competition, regulations and other circumstances may limit the Company's ability to fully base premiums on estimated costs. In addition, many factors may and often do cause actual health care costs to exceed those costs estimated and reflected in premiums. These factors may include increased utilization of services, increased cost of individual services, catastrophes, epidemics, seasonality, new mandated benefits or other regulatory changes, and insured population characteristics.

The managed health care industry is labor intensive and its profit margin is low. Hence, it is especially sensitive to inflation. Health care industry costs have been rising annually at rates higher than the Consumer Price Index. Increases in medical expenses without corresponding increases in premiums could have a material adverse effect on the Company.

PHARMACEUTICAL COSTS. The costs of pharmaceutical products and services are increasing faster than the costs of other medical products and services. Thus, the Company's HMOs face ever higher pharmaceutical expenses. The inability to manage pharmaceutical costs could have an adverse effect on the Company's financial condition.

MEDICAL MANAGEMENT. The Company's profitability is dependent, to a large extent, upon its ability to accurately project and manage health care costs, including without limitation, appropriate benefit design, utilization review and case management programs, and to secure appropriate risk-sharing arrangements with providers, while providing members with quality health care. For example, high out-of-network utilization of health care providers and services may have significant adverse affects on the Company's ability to manage health care costs and member utilization of health care. There can be no assurance that the Company through its medical management programs will be able to continue to manage medical costs sufficiently to restore and/or maintain profitability in all of its product lines.

FEDERAL AND STATE LEGISLATION. There are numerous legislative proposals currently before Congress and the state legislatures which, if enacted, could materially affect the managed health care industry and the regulatory environment. Recent financial difficulties of certain health care service providers and plans and/or continued publicity of the health care industry could alter or increase legislative consideration of these or additional proposals. These proposals include "managed care reform," "patients bill of rights" and certain other initiatives which, if enacted, could have significant adverse effects on the Company's operations. Such measures propose, among other things, to:

- expand a health plan's exposure to tort and other liability, under federal and/or state law, including for coverage determinations and provider malpractice and care decisions;

- restrict a health plan's ability to limit coverage to medically necessary care;

- require third party review of certain care decisions;

- expedite or modify grievance and appeals procedures;

- mandate certain benefits and services that could increase costs;

- limit a health plan's ability to use medical information for managed care coordination, disease management and research;

- mandate additional administrative oversight and structure for handling medical information;

- restrict a health plan's ability to select and/or terminate providers; and

- restrict or eliminate the use of prescription drug formularies.

In particular, the Department of Health and Human Services has proposed certain regulations under the Health Insurance Portability and Accountability Act of 1996. Currently, the primary effects of HIPAA are that it (i) limits pre-existing condition exclusions applicable to individuals changing jobs or moving to

individual coverage, (ii) guarantees the availability of health insurance for employees in the small group market and (iii) prevents the exclusion of individuals from coverage under group plans based on health status. The proposed regulations under HIPAA could significantly impact how individually identifiable health information is stored and disclosed, as well as materially increase the responsibilities, and potential liabilities, of parties who handle such information. While such regulations have not yet been enacted and are subject to change, there can be no assurance that such regulations or similar regulations will not be enacted.

The Company cannot predict the outcome of any of these legislative or regulatory proposals, nor the extent to which the Company may be affected by the enactment of any such legislation or regulation. Legislation or regulation which causes the Company to change its current manner of operation or increases its exposure to liability could have a material adverse effect on the Company's results of operations, financial condition and ability to compete.

COMPETITION. The Company competes with a number of other entities in the geographic and product markets in which it operates, some of which other entities may have certain characteristics, capabilities or resources which give them an advantage in competing with the Company. These competitors include HMOs, PPOs, self-funded employers, insurance companies, hospitals, health care facilities and other health care providers. The Company believes there are few barriers to entry in these markets, so that the addition of new competitors can readily occur. Certain of the Company's customers may decide to perform for themselves functions or services currently provided by the Company, which could result in a decrease in the Company's revenues. Certain of the Company's providers may decide to market products and services to Company customers in competition with the Company. In addition, significant merger and acquisition activity has occurred in the industry in which the Company operates as well as in industries which act as suppliers to the Company such as the hospital, physician, pharmaceutical and medical device industries. This activity may create stronger competitors and/or result in higher health care costs. Provider service organizations may be created by health care providers to offer competing managed care products. To the extent that there is strong competition or that competition intensifies in any market, the Company's ability to retain or increase customers, its revenue growth, its pricing flexibility, its control over medical cost trends and its marketing expenses may all be adversely affected.

PROVIDER RELATIONS. One of the significant techniques the Company uses to manage health care costs and utilization and to monitor the quality of care being delivered is to contract with physicians, hospitals and other providers. Because of the large number of providers with which the Company's health plans contract, the Company currently believes it has a limited exposure to provider relations issues. In any particular market, however, providers could refuse to contract with the Company, demand higher payments or take other actions which could result in higher health care costs, less desirable products for customers and members, insufficient provider access for current members or to support growth, or difficulty in meeting regulatory or accreditation requirements.

In some markets, certain providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or even monopolies. Many of these providers may compete directly with the Company. If such providers refuse to contract with the Company or utilize their market position to negotiate favorable contracts or place the Company at a competitive disadvantage, the Company's ability to market products or to be profitable in those areas could be adversely affected.

The Company contracts with providers in California and to a lesser degree in other areas, primarily through capitation fee arrangements. Under a capitation fee arrangement, the Company pays 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. Providers who enter into such arrangements generally contract with specialists and other secondary providers to provide services not offered by the primary provider. The inability of providers to properly manage costs under capitation arrangements can result in financial instability of such providers and the termination of their relationship with the Company. In addition,

payment or other disputes between the primary provider and specialists with whom it contracts can result in a disruption in the provision of services to the Company's members or a reduction in the services available. A primary provider's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from the Company, even though the Company has made its regular capitated payments to the primary provider. Depending on state law, the Company could be liable for such claims. In California, the liability of the Company's HMO subsidiaries for unpaid provider claims has not been definitively settled. There can be no assurance that the Company's subsidiaries will not be liable for unpaid provider claims. There can also be no assurance that providers with whom the Company contracts will properly manage the costs of services, maintain financial solvency or avoid disputes with secondary providers, the failure of any of which could have an adverse effect on the provision of services to members and the Company's operations.

MARKETING. The Company markets its products and services through both employed sales people and independent sales agents. Although the Company has a number of such sales employees and agents, if certain key sales employees or agents or a large subset of such individuals were to leave the Company, its ability to retain existing customers and members could be impaired. In addition, certain of the Company's customers or potential customers consider rating, accreditation or certification of the Company by various private or governmental bodies or rating agencies necessary or important. Certain of the Company's health plans or other business units may not have obtained or may not desire or be able to obtain or maintain such accreditation or certification which could adversely affect the Company's ability to obtain or retain business with such customers.

The managed health care industry has recently received a significant amount of negative publicity. Such general publicity, or any negative publicity regarding the Company in particular, could adversely affect the Company's ability to sell its products or services, could require changes to the Company's products or services, or could create regulatory problems for the Company. In this connection, certain of the Company's subsidiaries have experienced significant negative enrollment trends in certain lines of business. Furthermore, the managed care industry recently has experienced significant merger and acquisition activity. Speculation, uncertainty or negative publicity about the Company or certain of its lines of business could adversely affect the ability of the Company to market its products.

GOVERNMENT PROGRAMS AND REGULATION. The Company's business is subject to extensive federal and state laws and regulations, including, but not limited to, financial requirements, licensing requirements, enrollment requirements and periodic examinations by governmental agencies. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. For example, as described earlier in this Annual Report on Form 10-K, in the section entitled "California HMO Regulations," the California legislature has recently made significant changes to the laws regulating HMOs operating in that state. Existing or future laws and rules could force the Company to change how it does business and may restrict the Company's revenue and/or enrollment growth, and/or increase its health care and administrative costs, and/or increase the Company's exposure to liability with respect to members, providers or others. In particular, the Company's HMO and insurance subsidiaries are subject to regulations relating to cash reserves, minimum net worth, premium rates, and approval of policy language and benefits. Although such regulations have not significantly impeded the growth of the Company's business to date, there can be no assurance that the Company will be able to continue to obtain or maintain required governmental approvals or licenses or that regulatory changes will not have a material adverse effect on the Company's business. Delays in obtaining or failure to obtain or maintain such approvals, or moratoria imposed by regulatory authorities, could adversely affect the Company's revenue or the number of its members, increase costs or adversely affect the Company's ability to bring new products to market as forecasted. In addition, efforts to enact changes to Medicare could impact the structure of the Medicare program, benefit designs and reimbursement. Changes to the current operation of the Company's Medicare services could have a material adverse affect on the Company's results of operations.

A significant portion of the Company's revenues relate to federal, state and local government health care coverage programs, such as Medicare and Medicaid programs. Such contracts carry certain risks such as higher comparative medical costs, government regulatory and reporting requirements, the possibility of reduced or insufficient government reimbursement in the future, and higher marketing and advertising costs per member as a result of marketing to individuals as opposed to groups. Such risk contracts also are generally subject to frequent change including changes which may reduce the number of persons enrolled or eligible, reduce the revenue received by the Company or increase the Company's administrative or health care costs under such programs. In the event government reimbursement were to decline from projected amounts, the Company's failure to reduce the health care costs associated with such programs could have a material adverse effect upon the Company's business. Changes to such government programs in the future may also affect the Company's willingness to participate in such programs.

The Company is also subject to various governmental audits and investigations. Such activities could result in the loss of licensure or the right to participate in certain programs, or the imposition of fines, penalties and other sanctions. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect the Company's reputation in various markets and make it more difficult for the Company to sell its products and services.

The amount of government receivables set forth in the Company's financial statements represents the Company's best estimate of the government's liability. As of December 31, 1999, the Company's government receivables were $290.3 million. The receivables are estimates and generally subject to government audit and negotiation. In addition, inherent in government contracts are an uncertainty of and vulnerability to government disagreements. The final amounts actually received by the Company may be significantly greater or less than the amounts recognized by the Company.

MANAGEMENT INFORMATION SYSTEMS. The Company's business is significantly dependent on effective information systems. The information gathered and processed by the Company's management information systems assists the Company in, among other things, pricing its services, monitoring utilization and other cost factors, processing provider claims, billing its customers on a timely basis and identifying accounts for collection. The Company's customers and providers also depend upon the Company's information systems for membership verification, claims status and other information. The Company has many different information systems for its various businesses and such systems require continual maintenance, upgrading and enhancement to meet the Company's operational needs. Moreover, the merger, acquisition and divestiture activity of the Company requires frequent transitions to or from, and the integration of, various information management systems. The Company is in the process of attempting to reduce the number of its systems and also to upgrade and expand its information systems capabilities. Any difficulty associated with the transition to or from information systems, any inability or failure to properly maintain management information systems, or any inability or failure to successfully update or expand processing capability in the future in accordance with the Company's business needs, could result in operational disruptions, loss of existing customers and difficulty in attracting new customers, customer and provider disputes, regulatory problems, increases in administrative expenses and/or other adverse consequences. In addition, the Company may, from time-to-time, obtain significant portions of its systems-related or other services or facilities from independent third parties which may make the Company's operations vulnerable to such third parties' failure to perform adequately.

The Company undertook an extensive effort to assess and modify its computer applications and business processes to provide for their continued functionality in light of the "Year 2000" issue. The "Year 2000" issue is the result of computer programs having been written in a language that used two digits rather than four to define the applicable year. Any of the Company's computer programs that have time sensitive software and the outdated software language may recognize a date using "00" as the year 1900 rather than the year 2000. This could result in a system failure or miscalculations causing disruptions of operations, including, among other things, a temporary inability to process transactions, prepare invoices or engage in normal business activities.

As of March 15, 2000, the Company has not identified any significant disruptions or operational problems resulting from Year 2000 issues. In addition, the Company is not aware of any significant problems experienced by delegated authorities or strategically important third parties that would have a material adverse impact on the Company's operations. There can be no assurance, however, that the Company will not still experience significant disruptions or operational problems related to Year 2000 issues, including as a result of Year 2000 problems experienced by third parties.

The costs of the Company's Year 2000 project are set forth under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Company's 1999 Annual Report to Stockholders attached as an exhibit to this Annual Report on Form 10-K.

ADMINISTRATION AND MANAGEMENT. The level of administrative expense is a partial determinant of the Company's profitability. While the Company attempts to effectively manage such expenses, increases in staff-related and other administrative expenses may occur from time to time due to business or product start-ups or expansions, growth or changes in business, acquisitions, regulatory requirements or other reasons. Such expense increases are not clearly predictable and increases in administrative expenses may adversely affect results.

The Company currently believes it has a relatively experienced, capable management staff. Loss of certain managers or a number of such managers could adversely affect the Company's ability to administer and manage its business.

MANAGEMENT OF GROWTH. The Company has made several large acquisitions in recent years, and continues to explore acquisition opportunities. Failure to effectively integrate acquired operations could result in increased administrative costs or customer confusion or dissatisfaction. The Company may also not be able to manage this growth effectively, including not being able to continue to develop processes and systems to support growing operations. There can be no assurance that the Company will be able to maintain its historic growth rate or efficiently or effectively expand its operations.

POTENTIAL DIVESTITURES. In 1999, the Company substantially completed a program to divest certain non-core assets. There can be no assurance that indemnification obligations, unknown liabilities or unforeseen post-transaction costs related to such transactions will not have an adverse effect on the Company's business or financial condition. Furthermore, there can be no assurance that, having divested such non-core operations, the Company will be able to achieve greater profitability, or any profitability, strengthen its core operations or compete more effectively in its existing markets. In addition, the Company continues to evaluate the profitability realized or likely to be realized by its existing businesses and operations, and is reviewing from a strategic standpoint which of its businesses or operations should be divested. Entering into, evaluating or consummating divestiture transactions may entail certain risks and uncertainties in addition to those which may result from any such change in the Company's business operations, including but not limited to extraordinary transaction costs, unknown indemnification liabilities or unforeseen administrative needs, any of which could result in reduced revenues, increased charges, post-transaction administrative costs or could otherwise have a material adverse effect on the Company's business, financial condition or results of operations. See "Discontinued Operations and Anticipated Divestitures."

LOSS RESERVES. The Company's loss reserves are estimates of future costs based on various assumptions. 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. Included in the loss reserves are estimates for the costs of services which have been incurred but not reported ("IBNR"). Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. Moreover, if the assumptions on which the estimates are based prove to be incorrect and reserves are inadequate to cover the Company's actual experience, the Company's financial condition could be adversely affected.

LITIGATION AND INSURANCE. The Company is subject to a variety of legal actions to which any corporation may be subject, including employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, including for securities fraud, and intellectual property related litigation. In addition, because of the nature of its business, the Company incurs and likely will continue to incur potential liability for claims related to its business, such as failure to pay for or provide health care, poor outcomes for care delivered or arranged, provider disputes, including disputes over withheld compensation, and claims related to self-funded business. In some cases, substantial non-economic or punitive damages may be sought. While the Company currently has insurance coverage for some of these potential liabilities, others may not be covered by insurance (such as punitive damages), the insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future.

STOCK MARKET. Recently, the market prices of the securities of certain of the publicly-held companies in the industry in which the Company operates have shown volatility and sensitivity in response to many factors, including public communications regarding managed care, legislative or regulatory actions, litigation or threatened litigation, health care cost trends, pricing trends, competition, earning or membership reports of particular industry participants, and acquisition activity. There can be no assurances regarding the level or stability of the Company's share price at any time or the impact of these or any other factors on the share price.

RECENT DEVELOPMENTS

PHARMACY BENEFITS MANAGEMENT ASSETS. On March 31, 1999, the Company completed the sale to Advance Paradigm of the capital stock of Foundation Health Pharmaceutical Services, Inc., and certain pharmacy benefit management assets of Integrated Pharmaceutical Services for approximately $65 million in cash. In addition, the Company and Advance Paradigm entered into a services agreement, whereby Advance Paradigm provides to the Company's Health Plan Divisions certain pharmacy benefit management services, primarily, processing of claims with respect to pharmacy benefits, mail order service and retail pharmacy network management. For a period of five years, the Company may not compete with respect to such services in any market in which Advance Paradigm conducts business, subject to certain exceptions.

LOUISIANA, OKLAHOMA AND TEXAS HMO OPERATIONS. On April 30, 1999, the Company completed the sale of its HMO operations in the states of Texas, Louisiana and Oklahoma to AmCareco, Inc. As part of the transaction, the Company received convertible preferred stock of the buyer and cash in excess of certain statutory surplus and minimum working capital requirements of the plans sold.

PREFERRED HEALTH NETWORK, INC. In May 1999, the Company sold the capital stock of Preferred Health Network, Inc., a PPO network ("PHN"), to Beyond Benefits, Inc. PHN and the Company, or certain affiliates thereof, entered into agreements at closing to provide each other with certain continued access to each other's networks.

SOUTHERN CALIFORNIA HOSPITALS. In August 1999, the Company sold East Los Angeles Doctor's Hospital and Memorial Hospital of Gardena, two Southern California hospitals, to HealthPlus+ Corporation and certain affiliated entities. Certain subsidiaries of the Company continue to maintain contractual arrangements with the hospitals following the sale.

FHPA. In September 1999, the Company sold the capital stock of Foundation Health Preferred Administrators, Inc., a third-party administrator subsidiary of the Company, to Capitol Administrators, Inc.

NEW MEXICO OPERATIONS. In September 1999, the Company sold the capital stock of QualMed Plans for Health, Inc., the Company's HMO subsidiary in the state of New Mexico, to Health Care Horizons, Inc.

UTAH OPERATIONS. In October 1999, the Company sold the outstanding capital stock of Intergroup of Utah, Inc., the Company's HMO subsidiary in the state of Utah, to Altius Health Plans Inc.

HN REINSURANCE LIMITED. In October 1999, the Company sold the outstanding capital stock of HN Reinsurance Limited, a Cayman Island reinsurance subsidiary, to AmCareco, Inc.

COLORADO OPERATIONS. Effective November 16, 1999, the Company commenced the transition of its membership in Colorado to PacifiCare of Colorado, Inc. ("PacifiCare-CO") pursuant to a definitive agreement with PacifiCare-CO. The Company believes the transition will be completed during the first half of 2000. Pursuant to the definitive agreement, PacifiCare-CO is offering replacement coverage to substantially all of the Company's Colorado HMO membership and PacifiCare Life Assurance Company is issuing replacement indemnity coverage to substantially all of the Company's Colorado POS membership. PacifiCare-CO is offering to enroll such HMO members at the earliest date possible in comparable PacifiCare-CO benefit plans within PacifiCare-CO's service area at PacifiCare's rates.

In August 1999, in connection with the Company's wind down of its business in Colorado, the Company sold its regional claims processing facility and accompanying real estate in Pueblo, Colorado, including certain equipment and other assets located at the facility, to the Pueblo Economic Development Company for total aggregate proceeds of approximately $5 million and certain other consideration (including a complete release from the City of Pueblo of liabilities arising out of certain agreements between the City and the Company).

WASHINGTON OPERATIONS. In December 1999, the Company sold the capital stock of QualMed Washington Health Plan, Inc., the Company's HMO subsidiary in the state of Washington ("QM-Washington"), to American Family Care Inc. ("AFC"). AFC assumed control of the health-plan license and acquired the Medicaid and Basic Health Plan membership of QM-Washington. The commercial HMO membership of QM-Washington is being transitioned to PacifiCare of Washington, Inc. ("PacifiCare-WA"), Premera Blue Cross and Blue Cross of Idaho pursuant to definitive agreements with such companies. As part of such agreements, PacifiCare-WA will offer replacement coverage to QM-Washington's HMO and POS groups in western Washington, Premera Blue Cross will offer replacement coverage to substantially all of QM-Washington's HMO and POS group membership in eastern Washington and Blue Cross of Idaho will offer replacement coverage for certain members who reside in Idaho. Replacement coverage will consist of the new company's benefit plans in the new company's service areas at the new company's rates. The transition commenced on January 1, 2000 and is anticipated to be substantially completed during the first half of 2000.

MEDAPHIS. In July 1996, the Company's predecessor, HSI, the owner of 1,234,544 shares of Series F Preferred Stock of Health Data Sciences Corporation ("HDS"), voted its HDS shares in favor of the acquisition of HDS by Medaphis Corporation ("Medaphis"). HSI received as the result of the acquisition 976,771 shares of Medaphis common stock in exchange for its Series F Preferred Stock. In November 1996, HSI filed a lawsuit against Medaphis and its former Chairman and Chief Executive Officer. The Company alleged that Medaphis and certain insiders deceived the Company by presenting materially false financial statements and by failing to disclose that Medaphis would shortly reveal a "write off" of up to $40 million in reorganization costs and would lower its earnings estimate for the following year, thereby more than halving the value of the Medaphis shares received by the Company.

In September 1999, the Company and Medaphis (which changed its name to Per-Se Technologies, Inc. ("Per-Se")) entered into a Settlement Agreement and Release pursuant to which the Company received net proceeds of approximately $25 million consisting of cash from Per-Se and Per-Se's insurers and proceeds from the sale of both the 976,771 shares of Medaphis (now Per-Se) common stock then owned by

the Company and additional shares of Per-Se common stock issued to the Company as part of the settlement. In exchange, the Company and Per-Se terminated the ongoing litigation and granted each other a general release.

MEDPARTNERS PROVIDER NETWORK, INC. On March 11, 1999, MedPartners Provider Network, Inc. ("MPN"), a Knox-Keene licensed entity and a subsidiary of MedPartners, Inc., a publicly-held physician practice and pharmacy benefit management company (now known as Caremark Rx, Inc.) was placed into conservatorship by the State of California under Section 1393(c) of the California Health and Safety Code. The conservator immediately filed a petition under Chapter 11 of the Bankruptcy Code on behalf of MPN.

MedPartners, Inc., MPN and the State of California executed an Amended and Restated Operations and Settlement Agreement dated as of June 16, 1999 (the "O&S Agreement"), containing the basic principles for an orderly transition of the California operations of MedPartners, Inc., and the resolution of unpaid provider claims. A Bankruptcy Court Order approving the O&S Agreement was obtained by MPN on July 19, 1999. Although court approval of the O&S Agreement has been obtained, a number of conditions subsequent and third party consents required by such agreement are yet to occur or be obtained before the transactions reflected therein will become effective.

At this time, no assurances can be given that a final settlement agreement on the terms reflected in the O&S Agreement will become effective or be implemented. In the event of a final implementation of a settlement on the terms reflected in the O&S Agreement, the Company believes that the bankruptcy of MPN will not have a material adverse effect on the Company's California operations. If the settlement reflected in the O&S Agreement is not fully implemented, such failure could have a material adverse effect on the Company's California operations in the event the Company is ultimately held liable to pay unpaid provider claims.

At the time MPN was placed into conservatorship, MPN and various provider groups and clinics affiliated with MedPartners, Inc. provided health care services to approximately 215,000 enrollees of the Company's Health Net HMO subsidiary. As of August 1999, sales had been consummated on all of the physician groups associated with MedPartners, Inc. Accordingly, all Health Net enrollees have been moved to the successor physician groups or other providers.

REAL ESTATE TRANSACTIONS. During 1999, the Company completed the sale of nine health care centers for net proceeds of approximately $17.6 million. Such care centers were part of fourteen care centers originally leased to, and subsequently vacated by, FPA Medical Management, Inc. As of March 17, 2000, the Company has sold twelve such care centers. As set forth above, in August 1999, in connection with the Company's wind down of its business in Colorado, the Company sold its regional claims processing facility and accompanying real estate in Pueblo, Colorado, including certain equipment and other assets located at the facility, to the Pueblo Economic Development Company for total aggregate proceeds of approximately $5 million and certain other consideration. In addition, in 1999, the Company sold a land parcel in Roseville, California and certain other real estate located in Pueblo, Colorado for aggregate net proceeds of approximately $913,000.

FOHP. In 1997, the Company purchased convertible and nonconvertible debentures of FOHP, Inc., a New Jersey corporation ("FOHP"), in the aggregate principal amounts of approximately $80.7 million and $24 million, respectively. In 1997 and 1998, the Company converted certain of the convertible debentures into shares of Common Stock of FOHP, resulting in the Company owning 99.6% of the outstanding common stock of FOHP. The nonconvertible debentures mature on December 31, 2002.

Effective January 1, 1999, Physicians Health Services of New Jersey, Inc., a New Jersey HMO wholly-owned by the Company, merged with and into First Option Health Plan of New Jersey ("FOHP-NJ"), a New Jersey HMO subsidiary of FOHP, and FOHP-NJ changed its name to Physicians Health Services of New Jersey, Inc. ("PHS-NJ"). Effective July 30, 1999, upon approval by the stockholders of FOHP at a special meeting, a wholly-owned subsidiary of the Company merged into FOHP and FOHP became a

wholly-owned subsidiary of the Company. In connection with the merger, the former minority shareholders of FOHP are entitled to either $0.25 per share (the value per FOHP share as of December 31, 1998 as determined by an outside appraiser) or payment rights which entitle the holders to receive as much as $15.00 per payment right on or about July 1, 2001, provided certain hospital and other provider participation conditions are met. Additional consideration of $2.25 per payment right will be paid to certain holders of the payment rights if PHS-NJ achieves certain annual returns on common equity and the participation conditions are met.

QUALMED PLANS FOR HEALTH OF PENNSYLVANIA, INC. Effective December 31, 1998, the Company purchased the minority interests in QualMed Plans for Health of Pennsylvania, Inc. ("QualMed-PA"), a then majority-owned subsidiary of the Company. Previously, the Company owned approximately 83% of the common stock of QualMed-PA. In January 1999, the Company transferred certain assets of QualMed-PA, including the assets relating to its preferred provider organization, MaxNet-Registered Trademark-, to Preferred Health Network, Inc., then another wholly-owned subsidiary of the Company. As set forth above in this "Recent Developments," the Company subsequently sold the capital stock of Preferred Health Network, Inc.

INSURANCE SUBSIDIARIES. In July 1999, the Company completed the restructuring of certain of its insurance subsidiaries by merging Foundation Health National Life Insurance Company ("FHNL") with Foundation Health Systems Life and Health Insurance Company ("FHS Life") under a holding company subsidiary of the Company, FHS Life Holdings Company, Inc.

GEM INSURANCE COMPANY. Since October of 1997, Gem Insurance Company ("Gem"), a subsidiary of the Company, has implemented a restructuring plan to reduce operating losses and its in-force insurance risk. As part of such restructuring, Gem is withdrawing from certain insurance markets. Upon completion of its current withdrawals, Gem will be operating in only two states. As of December 31, 1999, the number of Gem's insureds was under 1,000. Currently, Foundation Health Systems Life and Health Insurance Company, a subsidiary of the Company, services Gem's insureds through an administrative services agreement between the companies. The Company is reviewing the possibility of winding up the operations of Gem or merging such operations into another insurance subsidiary of the Company.

OTHER POTENTIAL DIVESTITURES

CERTAIN OTHER OPERATIONS. The Company continues to evaluate the profitability realized or likely to be realized by its existing businesses and operations, and is reviewing from a strategic standpoint which of such businesses or operations should be divested.

NEW VENTURES GROUP

The Company believes that the Internet and related new technologies will fundamentally change managed care organizations. Accordingly, the Company has created a New Ventures Group to focus on the strategic direction of the Company in light of the Internet and related technologies and to pursue opportunities consistent with such direction. Currently, the Company is developing collaborative approaches with business partners to transform their existing assets and expertise into new e-business opportunities. The Company believes that net-enabled connectivity among purchasers, consumers, managed care organizations, providers and other trading partners is a prerequisite to creating and capturing e-business opportunities. The Company is currently developing business concepts to take advantage of those market opportunities that provide value to consumers, purchasers of benefits and the providers of medical and health care services.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

The following table sets forth the high and low sales prices of the Company's Class A Common Stock, par value $.001 per share (the "Class A Common Stock"), on The New York Stock Exchange, Inc. ("NYSE") since January 2, 1998.

	HIGH	LOW
Calendar Quarter--1998		
First Quarter	29 1/16	22 1/4
Second Quarter	32 5/8	25 3/8
Third Quarter	26 7/8	9
Fourth Quarter	15 3/4	5 7/8
Calendar Quarter--1999		
First Quarter	12 7/16	7 11/16
Second Quarter	20 1/16	10 13/16
Third Quarter	16 15/16	8 7/8
Fourth Quarter	10 1/2	6 1/4
Calendar Quarter--2000		
First Quarter (through March 17, 2000)	11 11/16	7 7/8

On March 17, 2000, the last reported sales price per share of the Class A Common Stock was $7 15/16 per share.

DIVIDENDS

No dividends have been paid by the Company during the preceding two fiscal years. The Company has no present intention of paying any dividends on its Common Stock.

The Company is a holding company and, therefore, its ability to pay dividends depends on distributions received from its subsidiaries, which are subject to regulatory net worth requirements and certain additional state regulations which may restrict the declaration of dividends by HMOs, insurance companies and licensed managed health care plans. The payment of any dividend is at the discretion of the Company's Board of Directors and depends upon the Company's earnings, financial position, capital requirements and such other factors as the Company's Board of Directors deems relevant.

Under the Credit Agreement entered into on July 8, 1997 with Bank of America as agent, the Company cannot declare or pay cash dividends to its stockholders or purchase, redeem or otherwise acquire shares of its capital stock or warrants, rights or options to acquire such shares for cash except to the extent permitted under such Credit Agreement as described elsewhere in this Annual Report on Form 10-K.

HOLDERS

As of March 17, 2000, there were approximately 2,000 holders of record of Class A Common Stock. The California Wellness Foundation (the "CWF") is the only holder of record of the Company's Class B Common Stock, par value $.001 per share (the "Class B Common Stock"), which constitutes less than 1% of the Company's aggregate equity. Under the Company's Fourth Amended and Restated Certificate of Incorporation, shares of the Company's Class B Common Stock have the same economic benefits as shares of the Company's Class A Common Stock, but are non-voting. Upon the sale or other transfer of shares of

Class B Common Stock by the CWF to an unrelated third party, such shares automatically convert into Class A Common Stock.

ITEM 6. SELECTED FINANCIAL DATA

The information required by this Item is set forth in the Company's Annual Report to Stockholders on page 1, and is incorporated herein by reference and made a part hereof.

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

The information required by this Item is set forth in the Company's Annual Report to Stockholders on pages 15 through 23, and is incorporated herein by reference and made a part hereof.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The information required by this Item is set forth in the Company's Annual Report to Stockholders on page 24, and is incorporated herein by reference and made a part hereof.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The information required by this Item is set forth in the Company's Annual Report to Stockholders on pages 25 through 53, and is incorporated herein by reference and made a part hereof.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not Applicable.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information required by this Item is set forth in the Company's definitive proxy statement, which will be filed with the Securities and Exchange Commission within 120 days of December 31, 1999. Such information is incorporated herein by reference and made a part hereof.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is set forth in the Company's definitive proxy statement, which will be filed with the Securities and Exchange Commission within 120 days of December 31, 1999. Such information is incorporated herein by reference and made a part hereof.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information required by this Item is set forth in the Company's definitive proxy statement, which will be filed with the Securities and Exchange Commission within 120 days of December 31, 1999. Such information is incorporated herein by reference and made a part hereof.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information required by this Item is set forth in the Company's definitive proxy statement, which will be filed with the Securities and Exchange Commission within 120 days of December 31, 1999. Such information is incorporated herein by reference and made a part hereof.

PART IV

ITEM 14. EXHIBITS, FINANCIAL STATEMENT SCHEDULES, AND REPORTS ON FORM 8-K

(A) FINANCIAL STATEMENTS, SCHEDULES AND EXHIBITS

1. FINANCIAL STATEMENTS

The following consolidated financial statements are incorporated by reference into this Annual Report on Form 10-K from pages 25 to 53 of the Company's Annual Report to Stockholders for the year ended December 31, 1999:

Report of Deloitte & Touche LLP

Consolidated balance sheets at December 31, 1999 and 1998

Consolidated statements of operations for each of the three years in the period ended December 31, 1999

Consolidated statements of stockholders' equity for each of the three years in the period ended December 31, 1999

Consolidated statements of cash flows for each of the three years in the period ended December 31, 1999

Notes to consolidated financial statements

2. FINANCIAL STATEMENT SCHEDULES

The following financial statement schedule and accompanying report thereon are filed as a part of this Annual Report on Form 10-K:

Report of Deloitte & Touche LLP

Schedule I--Condensed Financial Information of Registrant (Parent Company Only)

All other schedules are omitted because they are not applicable, not required or because the required information is included in the consolidated financial statements or notes thereto which are incorporated by reference into this Annual Report on Form 10-K from the Company's 1999 Annual Report to Stockholders.

3. EXHIBITS

The following exhibits are filed as part of this Annual Report on Form 10-K or are incorporated herein by reference:

2.1	Agreement and Plan of Merger, dated October 1, 1996, by and among Health Systems International, Inc., FH Acquisition Corp. and Foundation Health Corporation (filed as Exhibit 2.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 1996, which is incorporated by reference herein).
2.2	Agreement and Plan of Merger, dated May 8, 1997, by and among the Company, PHS Acquisition Corp. and Physicians Health Services, Inc. (filed as Exhibit 2.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1997, which is incorporated by reference herein).

2.3 Amendment No. 1 to Agreement and Plan of Merger, dated October 20, 1997, by and among the Company, PHS Acquisition Corp. and Physicians Health Services, Inc. (filed as Exhibit 2.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1997, which is incorporated by reference herein).

3.1 Fourth Amended and Restated Certificate of Incorporation of the Registrant (filed as Exhibit 4.1 to the Company's Registration Statement on Form S-8 (File No. 333-24621), which is incorporated by reference herein).

3.2 Fifth Amended and Restated Bylaws of the Registrant (filed as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

3.3 Certain Amendments to the Fifth Amended and Restated Bylaws of the Registrant (filed as Exhibit 3.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1999, which is incorporated by reference herein).

4.1 Form of Class A Common Stock Certificate (included as Exhibit 4.2 to the Company's Registration Statements on Forms S-1 and S-4 (File nos. 33-72892 and 33-72892-01, respectively), which is incorporated by reference herein).

4.2 Form of Class B Common Stock Certificate (included as Exhibit 4.3 to the Company's Registration Statements on Forms S-1 and S-4 (File nos. 33-72892 and 33-72892-01, respectively), which is incorporated by reference herein).

4.3 Rights Agreement dated as of June 1, 1996 by and between the Company and Harris Trust and Savings Bank, as Rights Agent (filed as Exhibit 99.1 to the Company's Registration Statement on Form 8-A (File No. 001-12718), which is incorporated by reference herein).

4.4 First Amendment to the Rights Agreement dated as of October 1, 1996, by and between the Company and Harris Trust and Savings Bank, as Rights Agent (filed as Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 1996, which is incorporated by reference herein).

*10.1 Employment Letter Agreement between the Company and Karin D. Mayhew dated January 22, 1999 (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1999, which is incorporated by reference herein).

*10.2 Employment Letter Agreement between the Company and Ross D. Henderson dated April 29, 1999 (filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1999, which is incorporated by reference herein).

*10.3 Letter Agreement dated June 25, 1998 between B. Curtis Westen and the Company (filed as Exhibit 10.73 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998, which is incorporated by reference herein).

*10.4 Employment Letter Agreement dated July 3, 1996 between Jay M. Gellert and the Company (filed as Exhibit 10.37 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1996, which is incorporated by reference herein).

*10.5 Amended Letter Agreement between the Company and Jay M. Gellert dated as of August 22, 1997 (filed as Exhibit 10.69 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, which is incorporated by reference herein).

*10.6 Employment Letter Agreement between the Company and Dale Terrell dated December 31, 1997 (filed as Exhibit 10.71 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, which is incorporated by reference herein).

*10.7 Employment Letter Agreement between the Company and Steven P. Erwin dated March 11, 1998 (filed as Exhibit 10.72 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, which is incorporated by reference herein).

*10.8 Employment Agreement between the Company and Maurice Costa dated December 31, 1997 (filed as Exhibit 10.71 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, which is incorporated by reference herein).

*10.9 Employment Letter Agreement between the Company and Gary S. Velasquez dated May 1, 1996 (filed as Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.10 Employment Agreement between Foundation Health Corporation and Edward J. Munno dated November 8, 1993 (filed as Exhibit 10.14 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.11 Amendment Number One to Employment Agreement between Foundation Health Corporation and Edward J. Munno dated May 1, 1996 (filed as Exhibit 10.15 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.12 Employment Letter Agreement between the Company and Cora Tellez dated November 16, 1998 (filed as Exhibit 10.16 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.13 Employment Letter Agreement between the Company and Karen Coughlin dated March 12, 1998 (filed as Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.14 Employment Letter Agreement between the Company and J. Robert Bruce dated September 22, 1998 (filed as Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.15 Form of Severance Payment Agreement dated December 4, 1998 by and between the Company and various of its executive officers (filed as Exhibit 10.21 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.16 Severance Payment Agreement, dated as of April 25, 1994, among the Company, QualMed, Inc. and B. Curtis Westen (filed as Exhibit 10.10 to the Company's Annual Report on Form 10-K for the year ended December 31, 1994, which is incorporated by reference herein).

*10.17 Severance Payment Agreement between the Company and J. Robert Bruce dated September 15, 1998 (filed as Exhibit 10.23 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.18 Severance Payment Agreement between the Company and Maurice Costa dated April 6, 1998 (filed as Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.19 Early Retirement Agreement dated August 6, 1998 between the Company and Malik M. Hasan, M.D. (filed as Exhibit 10.77 to

the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998, which is incorporated herein by reference).

*10.20 Waiver and Release of Claims between the Company and Robert Natt (filed as Exhibit 10.20 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.21 Waiver and Release of Claims between the Company and Dale T. Berkbigler, M.D. dated as of July 1, 1999 (filed as Exhibit 10.22 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1999, which is incorporated herein by reference).

*10.22 Deferred Compensation Agreement dated as of March 3, 1995, by and among Malik M. Hasan, M.D., the Company and the Compensation and Stock Option Committee of the Board of Directors of the Company (filed as Exhibit 10.31 to the Company's Annual Report on Form 10-K for the year ended December 31, 1994, which is incorporated by reference herein).

*10.23 Trust Agreement for Deferred Compensation Arrangement for Malik M. Hasan, M.D., dated as of March 3, 1995, by and between the Company and Norwest Bank Colorado N.A. (filed as Exhibit 10.32 to the Company's Annual Report on Form 10-K for the year ended December 31, 1994, which is incorporated by reference herein).

*10.24 The Company's Deferred Compensation Plan effective as of May 1, 1998 (filed as Exhibit 10.66 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.25 The Company's Deferred Compensation Plan Trust Agreement dated as of September 1, 1998 between the Company and Union Bank of California (filed as Exhibit 10.31 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.26 The Company's Second Amended and Restated 1991 Stock Option Plan (filed as Exhibit 10.30 to Registration Statement on Form S-4 (File No. 33-86524), which is incorporated by reference herein).

*10.27 The Company's 1997 Stock Option Plan (filed as Exhibit 10.45 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

*10.28 The Company's 1998 Stock Option Plan (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-8 filed on December 4, 1998, which is incorporated herein by reference).

*10.29 The Company's 1995 Stock Appreciation Right Plan (filed as Exhibit 10.12 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1995, which is incorporated by reference herein).

*10.30 The Company's Second Amended and Restated Non-Employee Director Stock Option Plan (filed as Exhibit 10.31 to Registration Statement on Form S-4 (File No. 33-86524), which is incorporated by reference herein).

*10.31 The Company's Third Amended and Restated Non-Employee Director Stock Option Plan (filed as Exhibit 10.46 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

*10.32 The Company's Employee Stock Purchase Plan (filed as Exhibit 10.33 to the Company's Registration Statements on Forms S-1 and S-4 (File nos. 33-72892 and 33-72892-01, respectively), which is incorporated by reference herein).

*10.33 The Company's Employee Stock Purchase Plan (filed as Exhibit 10.47 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

*10.34 The Company's Performance-Based Annual Bonus Plan (filed as Exhibit 10.35 to Registration Statement on Form S-4 (File No. 33-86524), which is incorporated by reference herein).

*10.35 The Company's Performance-Based Annual Bonus Plan (filed as Exhibit 10.48 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

*10.36 The Company's 401(k) Associate Savings Plan (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-8 filed on March 31, 1998, which is incorporated herein by reference).

*10.37 The Company's Supplemental Executive Retirement Plan effective as of January 1, 1996 (filed as Exhibit 10.65 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998, which is incorporated herein by reference).

*10.38 Managed Health Network, Inc. Incentive Stock Option Plan (filed as Exhibit 4.8 to the Company's Registration Statement on Form S-8 (File No. 333-24621), which is incorporated by reference herein).

*10.39 Managed Health Network, Inc. Amended and Restated 1991 Stock Option Plan (filed as Exhibit 4.9 to the Company's Registration Statement on Form S-8 (File No. 333-24621), which is incorporated by reference herein).

*10.40 1990 Stock Option Plan of Foundation Health Corporation (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-8 (File No. 333-24621), which is incorporated by reference herein).

*10.41 FHC Directors Retirement Plan (filed as an exhibit to FHC's Annual Report on Form 10-K for the year ended June 30, 1994 filed with the Commission on September 24, 1994, which is incorporated by reference herein).

*10.42 FHC's Deferred Compensation Plan, as amended and restated (filed as Exhibit 10.99 to FHC's Annual Report on Form 10-K for the year ended June 30, 1995, filed with the Commission on September 27, 1995, which is incorporated by reference herein).

*10.43 FHC's Supplemental Executive Retirement Plan, as amended and restated (filed as Exhibit 10.100 to FHC's Annual Report on Form 10-K for the year ended June 30, 1995, filed with the Commission on September 27, 1995, which is incorporated by reference herein).

*10.44 FHC's Executive Retiree Medical Plan, as amended and restated (filed as Exhibit 10.101 to FHC's Annual Report on Form 10-K for the year ended June 30, 1995, filed with the Commission on September 27, 1995, which is incorporated by reference herein).

10.45 Stock and Note Purchase Agreement by and between FHC, Jonathan H., Scheff, M.D., FPA Medical Management, Inc., FPA Medical Management of California, Inc. and FPA Independent Practice Association dated as of June 28, 1996 (filed as Exhibit 10.109 to FHC's Annual Report on Form 10-K for the year ended June 30, 1996, which is incorporated by reference herein).

10.46 Participation Agreement dated as of May 25, 1995 among Foundation Health Medical Services, as Construction Agent and Lessee, FHC, as Guarantor, First Security Bank of Utah, N.A., as Owner Trustee, Sumitomo Bank Leasing and Finance, Inc., The Bank of Nova Scotia and NationsBank of

Texas, N.A., as Holders and NationsBank of Texas, N.A., as Administrative Agent for the Lenders; and Guaranty Agreement dated as of May 25, 1995 by FHC for the benefit of First Security Bank of Utah, N.A. (filed as an exhibit to FHC's Form 10-K for the year ended June 30, 1995, filed with the Commission on September 27, 1995, which is incorporated by reference herein).

10.47 Credit Agreement dated July 8, 1997 among the Company, the banks identified therein and Bank of America National Trust and Savings Association in its capacity as Administrative Agent (providing for an unsecured $1.5 billion revolving credit facility) (filed as Exhibit 10.23 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997, which is incorporated by reference herein).

10.48 Guarantee Agreement dated July 8, 1997 between the Company and First Security Bank, National Association (filed as Exhibit 10.24 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1997, which is incorporated by reference herein).

10.49 First Amendment and Waiver to Credit Agreement dated April 6, 1998 among the Company, Bank of America National Trust and Savings Association and the Banks (as defined therein) (filed as Exhibit 10.64 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1998, which is incorporated by reference herein).

10.50 Second Amendment to Credit Agreement dated July 31, 1998 among the Company, Bank of America National Trust and Savings Association and the Banks (as defined therein) (filed as Exhibit 10.65 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998, which is incorporated by reference herein).

10.51 Third Amendment to Credit Agreement, dated November 6, 1998, among the Company, Bank of America National Trust and Savings Association and the Banks (as defined therein) (filed as Exhibit 10.65 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 1998, which is incorporated by reference herein).

10.52 Fourth Amendment to Credit Agreement, dated as of March 26, 1999, among the Company, Bank of America National Trust and Savings Association and the Banks, as defined therein (filed as Exhibit 10.64 to the Company's Form 10-K for the year ended December 31, 1998, which is incorporated by reference herein).

10.53 Form of Credit Facility Commitment Letter, dated March 27, 1998, between the Company and the Majority Banks (as defined therein) (filed as Exhibit 10.70 to the Company's Annual Report on Form 10-K for the year ended December 31, 1997, which is incorporated by reference herein).

10.54 Letter Agreement dated June 1, 1998 between The California Wellness Foundation and the Company (filed as Exhibit 10.75 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998, which is incorporated by reference herein).

10.55 Registration Rights Agreement dated as of March 2, 1995 between the Company and the California Wellness Foundation (filed as Exhibit No. 28.2 to the Company's Current Report on Form 8-K dated March 2, 1995, which is incorporated by reference herein).

10.56 Office Lease, dated as of January 1, 1992, by and between Warner Properties III and Health Net (filed as Exhibit 10.23 to the Company's Registration Statements on Forms S-1 and S-4 (File Nos. 33-72892 and 33-72892-01, respectively), which is incorporated by reference herein).

10.57 Lease Agreement between HAS-First Associates and FHC dated August 1, 1998 and form of amendment thereto (filed as an exhibit to FHC's Registration Statement on Form S-1 (File No. 33-34963), which is incorporated by reference herein).

10.58 Asset Purchase Agreement dated December 31, 1998 by and between the Company and Access Health, Inc. (filed as Exhibit 10.62 to the Company's Form 10-K for the year ended December 31, 1998, which is incorporated by reference herein).

10.59 Purchase Agreement dated February 26, 1999 by and among the Company, Foundation Health Pharmaceutical Services, Inc., Integrated Pharmaceutical Services, Inc., and Advance Paradigm, Inc. (filed as Exhibit 10.63 to the Company's Form 10-K for the year ended December 31, 1998, which is incorporated by reference herein).

10.60	Settlement Agreement and Release dated September 20, 1999 by and between the Company and Per-Se Technologies, Inc. (formerly Medaphis Corporation) (filed as Exhibit 99.1 to the Company's Current Report on Form 8-K dated September 20, 1999, which is incorporated by reference herein).
11.1	Statement relative to computation of per share earnings of the Company (included in Note 2 to the Financial Statements, which is incorporated by reference from pages 25 to 53 of the Annual Report to Stockholders for the year ended December 31, 1999).
+13.1	Selected portions of the 1999 Annual Report to Stockholders, a copy of which portions are filed herewith.
+21.1	Subsidiaries of the Company, a copy of which is filed herewith.
+23.1	Consent of Deloitte & Touche LLP, a copy of which is filed herewith.
+27.1	Financial Data Schedule for 1999, a copy of which has been filed with the EDGAR version of this filing.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 14(c) of Form 10-K.

\+ A copy of the exhibit is being filed with this Annual Report on Form 10-K.

(b) Reports on Form 8-K

No Current Reports on Form 8-K were filed by the Company during the quarterly period ended December 31, 1999.

INDEPENDENT AUDITORS' REPORT ON SCHEDULE

To the Board of Directors and Stockholders of
Foundation Health Systems, Inc.
Woodland Hills, California

We have audited the consolidated financial statements of Foundation Health Systems, Inc. (the "Company") as of December 31, 1999 and 1998 and for each of the three years in the period ended December 31, 1999, and have issued our report thereon dated February 29, 2000, appearing in and incorporated by reference in this Annual Report on Form 10-K of Foundation Health Systems, Inc. for the year ended December 31, 1999. Our audits also included the financial statement schedule of Foundation Health Systems, Inc., listed in Item 14(a)(2). The financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ Deloitte & Touche LLP
Los Angeles, California
February 29, 2000

SUPPLEMENTAL SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)

FOUNDATION HEALTH SYSTEMS, INC.

CONDENSED BALANCE SHEETS

(AMOUNTS IN THOUSANDS)

	DECEMBER 31, 1999	DECEMBER 31, 1998
ASSETS		
Current assets:		
Cash and cash equivalents	$ 108,057	$ 74,767
Investments available for sale	11,756	3,352
Other assets	13,549	6,654
Due from subsidiaries	285,588	597,321
Total current assets	418,950	682,094
Property and equipment, net	21,437	7,854
Investment in subsidiaries	1,584,007	1,459,335
Notes receivable due from subsidiaries	39,385	--
Other assets	59,189	65,881
Total assets	$2,122,968	$2,215,164
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Due to subsidiaries	11,684	72,915
Other current liabilities	177,048	159,484
Total current liabilities	188,732	232,399
Notes payable	1,039,250	1,235,500
Other liabilities	3,787	3,223
Total liabilities	1,231,769	1,471,122
Stockholders' equity:		
Common stock and additional paid-in capital	643,498	641,945
Common stock held in treasury, at cost	(95,831)	(95,831)
Retained earnings	347,601	205,236
Accumulated other comprehensive loss	(4,069)	(7,308)
Total stockholders' equity	891,199	744,042
Total liabilities and stockholders' equity	$2,122,968	$2,215,164

See accompanying note to condensed financial statements.

SUPPLEMENTAL SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)--(CONTINUED)

FOUNDATION HEALTH SYSTEMS, INC.

CONDENSED STATEMENTS OF OPERATIONS

(AMOUNTS IN THOUSANDS)

	YEAR ENDED DECEMBER 31,		
	1999	1998	1997
Revenues:			
Investment and other income	$ 7,379	$ 5,766	$ 6,485
Net gain on sale of businesses and buildings	58,332	5,600	--
Total revenues	65,711	11,366	6,485
Expenses:			
General and administrative	40,961	27,480	17,288
Amortization and depreciation	3,153	2,197	1,315
Interest	90,386	91,717	42,118
Asset impairment, merger, restructuring and other costs	3,746	39,602	42,189
Total expenses	138,246	160,996	102,910
Loss from continuing operations before income taxes and equity in net income of subsidiaries	(72,535)	(149,630)	(96,425)
Income tax benefit	19,393	61,333	39,533
Equity in net income (loss) of subsidiaries	195,819	(76,861)	(10,938)
Income (loss) from continuing operations	142,677	(165,158)	(67,830)
Discontinued operations:			
Loss from operations, net of tax	--	--	(30,409)
Loss from disposition, net of tax	--	--	(88,845)
Income (loss) before cumulative effect of a change in accounting principle	142,677	(165,158)	(187,084)
Cumulative effect of a change in accounting principle, net of tax	(312)	--	--
Net income (loss)	$142,365	$(165,158)	$(187,084)

See accompanying note to condensed financial statements.

SUPPLEMENTAL SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)--(CONTINUED)

FOUNDATION HEALTH SYSTEMS, INC.

CONDENSED STATEMENTS OF CASH FLOWS

(AMOUNTS IN THOUSANDS)

	YEAR ENDED DECEMBER 31,		
	1999	1998	1997
NET CASH FLOWS FROM OPERATING ACTIVITIES	$ 84,743	$ (39,871)	$(521,154)
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sales or maturity of investments available for sale	22,576	8,777	11,400
Purchases of investments available for sale	--	(6,264)	(309)
Sales of property and equipment	170	16,376	--
Purchases of property and equipment	(2,630)	(3,532)	(20,695)
Other assets	7,765	4,771	(130,755)
Proceeds from the sale of businesses and properties	137,728	--	--
Sale of net assets of discontinued operations	--	257,100	--
Acquisition of businesses, net of cash acquired	--	--	(293,625)
Net cash provided by (used in) investing activities	165,609	277,228	(433,984)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from exercise of stock options and employee stock purchases	1,553	13,209	21,506
Proceeds from issuance of notes payable	220,000	155,000	946,000
Principal payments on notes payable	(416,250)	(207,000)	(873)
Stock repurchase	--	--	(111,334)
Cash dividends received from subsidiaries	75,040	2,900	140,994
Capital contributions to subsidiaries	(97,405)	(143,439)	(33,875)
Net cash provided by (used in) financing activities	(217,062)	(179,330)	962,418
Net increase in cash and cash equivalents	33,290	58,027	7,280
Cash and cash equivalents, beginning of period	74,767	16,740	9,460
Cash and cash equivalents, end of period	$ 108,057	$ 74,767	$ 16,740

See accompanying note to condensed financial statements.

SUPPLEMENTAL SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)--(CONTINUED)

FOUNDATION HEALTH SYSTEMS, INC.

NOTE TO CONDENSED FINANCIAL STATEMENTS

NOTE 1--BASIS OF PRESENTATION

Foundation Health Systems, Inc.'s ("FHS") investment in subsidiaries is stated at cost plus equity in undistributed earnings (losses) of subsidiaries. FHS' share of net income (loss) of its unconsolidated subsidiaries is included in consolidated income (loss) using the equity method. This condensed financial information of registrant should be read in conjunction with the consolidated financial statements of Foundation Health Systems, Inc. and subsidiaries.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the Company has duly caused this Report to be signed on its behalf by the undersigned thereunto duly authorized, on the 20th day of March, 2000.

FOUNDATION HEALTH SYSTEMS, INC.

By: /s/ JAY M. GELLERT

Jay M. Gellert
PRESIDENT AND CHIEF EXECUTIVE OFFICER
(PRINCIPAL EXECUTIVE OFFICER)

By: /s/ STEVEN P. ERWIN

Steven P. Erwin
EXECUTIVE VICE PRESIDENT AND
CHIEF FINANCIAL OFFICER
(PRINCIPAL ACCOUNTING AND FINANCIAL
OFFICER)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Report has been signed below by the following persons on behalf of the Company and in the capacities indicated on the 20th day of March, 2000.

SIGNATURE	TITLE	DATE
/s/ J. THOMAS BOUCHARD J. Thomas Bouchard	Director	March 20, 2000
/s/ GEORGE DEUKMEJIAN Gov. George Deukmejian	Director	March 20, 2000
/s/ THOMAS T. FARLEY Thomas T. Farley	Director	March 20, 2000
/s/ PATRICK FOLEY Patrick Foley	Director	March 20, 2000
/s/ EARL B. FOWLER Admiral Earl B. Fowler	Director	March 20, 2000

SIGNATURE	TITLE	DATE
/s/ JAY M. GELLERT Jay M. Gellert	Director	March 20, 2000
/s/ ROGER F. GREAVES Roger F. Greaves	Director	March 20, 2000
/s/ RICHARD W. HANSELMAN Richard W. Hanselman	Director	March 20, 2000
/s/ RICHARD J. STEGEMEIER Richard J. Stegemeier	Director	March 20, 2000
/s/ RAYMOND S. TROUBH Raymond S. Troubh	Director	March 20, 2000

[The following portions of the Foundation Health Systems, Inc. 1999 Annual Report to Stockholders are incorporated by reference into the Foundation Health Systems, Inc. Annual Report on Form 10-K for the year ended December **31, 1999.]**

[Certain statements contained in this report are "forward looking" statements made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Such statements involve risks and uncertainties and actual results may differ materially from those results expressed or implied by such "forward looking" statements. For more information, please refer to the "Cautionary Statements," "Additional Information Concerning the Company's Business" and "Risk Factors" sections of the Company's various filings with the Securities and Exchange Commission and the respective documents incorporated by reference therein.]

FINANCIAL HIGHLIGHTS
Foundation Health Systems, Inc.

Year ended December 31,

(Amounts in thousands, except per share data)	1999	1998(3)	1997(3)	1996(3)	1995(3)
STATEMENT OF OPERATIONS DATA(2):					
REVENUES					
Health plan services premiums	$7,031,055	$7,124,161	$5,482,893	$5,395,125	$4,557,214
Government contracts/Specialty services	1,529,855	1,411,267	1,408,402	1,225,723	489,913
Investment and other income	86,977	93,441	114,300	88,392	66,510
Net gain on sale of businesses and properties	58,332	5,600	-	-	-
Total revenues	8,706,219	8,634,469	7,005,595	6,709,240	5,113,637
EXPENSES					
Health plan services	5,950,002	6,090,472	4,470,816	4,606,574	3,643,463
Government contracts/Specialty services	1,002,893	924,075	990,576	995,820	356,420
Selling, general and administrative	1,301,743	1,413,771	1,185,018	868,196	657,275
Depreciation and amortization	112,041	128,093	98,353	112,916	89,356
Interest	83,808	92,159	63,555	45,372	33,463
Asset impairment, merger, restructuring and other costs	11,724	240,053	286,525	27,408	20,164
Total expenses	8,462,211	8,888,623	7,094,843	6,656,286	4,800,141
Income (loss) from continuing operations before income taxes	244,008	(254,154)	(89,248)	52,954	313,496
Income tax provision (benefit)	96,226	(88,996)	(21,418)	14,124	124,345
Income (loss) from continuing operations	147,782	(165,158)	(67,830)	38,830	189,151
Discontinued operations(2):					
Income (loss) from discontinued operations, net of tax	-	-	(30,409)	25,084	3,028
Gain (loss) on disposition, net of tax	-	-	(88,845)	20,317	-
Income (loss) before cumulative effect of a change in accounting principle	147,782	(165,158)	(187,084)	84,231	192,179

Cumulative effect of a change in accounting principle, net of tax	(5,417)	-	-	-	-
Net income (loss)	$ 142,365	$ (165,158)	$ (187,084)	$ 84,231	$ 192,179
BASIC EARNINGS (LOSS) PER SHARE:					
Continuing operations	$ 1.21	$ (1.35)	$ (0.55)	$ 0.31	$ 1.54
Income (loss) from discontinued operations, net of tax	-	-	(0.25)	0.20	0.02
Gain (loss) on disposition of discontinued operations, net of tax	-	-	(0.72)	0.16	-
Cumulative effect of a change in accounting principle	(0.05)	-	-	-	-
Net	$ 1.16	$ (1.35)	$ (1.52)	$ 0.67	$ 1.56
DILUTED EARNINGS (LOSS) PER SHARE:					
Continuing operations	$ 1.21	$ (1.35)	$ (0.55)	$ 0.31	$ 1.53
Income (loss) from discontinued operations, net of tax	-	-	(0.25)	0.20	0.02
Gain (loss) on disposition of discontinued operations, net of tax	-	-	(0.72)	0.16	-
Cumulative effect of a change in accounting principle	(0.05)	-	-	-	-
Net	$ 1.16	$ (1.35)	$ (1.52)	$ 0.67	$ 1.55
Weighted average shares outstanding:					
Basic	122,289	121,974	123,333	124,453	122,741
Diluted	122,343	121,974	123,333	124,966	123,674
BALANCE SHEET DATA:					
Cash and cash equivalents and investments available for sale	$1,467,142	$1,288,947	$1,112,361	$1,122,916	$ 871,818
Total assets	3,696,481	3,863,269	4,076,350	3,423,776	2,733,765
Notes payable and capital leases - noncurrent	1,039,352	1,254,278	1,308,979	791,618	547,522
Stockholders' equity	891,199	744,042	895,974	1,183,411	1,068,255
OPERATING CASH FLOW	$ 297,128	$ 100,867	$(125,872)	$ (6,666)	$ 51,417

(1) No cash dividends were declared in each of the years presented.

(2) See Note 3 to the Consolidated Financial Statements for discussion of acquisitions during 1997 and dispositions during 1999 impacting the comparability of information. Additionally, the Company's workers' compensation segment sold in 1998 and physician practice management segment sold in 1996 have been accounted for as discontinued operations.

(3) Certain reclassifications have been made to 1998 and 1997 statements of operations data to conform to the 1999 presentation. Comparable information for 1996 and 1995 reclassifications are not available.

1999 FINANCIAL REVIEW

MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

The following table sets forth the high and low sales prices of the Company's Class A Common Stock, par value $.001 per share (the "Class A Common Stock"), on the New York Stock Exchange, Inc. ("NYSE") since January 2, 1998.

	High	Low
Calendar Quarter - 1998		
First Quarter	29 1/16	22 1/4
Second Quarter	32 5/8	25 3/8
Third Quarter	26 7/8	9
Fourth Quarter	15 3/4	5 7/8
Calendar Quarter - 1999		
First Quarter	12 7/16	7 11/16
Second Quarter	20 1/16	10 13/16
Third Quarter	16 15/16	8 7/8
Fourth Quarter	10 1/2	6 1/4
Calendar Quarter - 2000		
First Quarter (through March 17, 2000)	11 11/16	7 7/8

On March 17, 2000, the last reported sales price per share of the Class A Common Stock was $7 15/16 per share.

DIVIDENDS

No dividends have been paid by the Company during the preceding two fiscal years.The Company has no present intention of paying any dividends on its Common Stock.

The Company is a holding company and, therefore, its ability to pay dividends depends on distributions received from its subsidiaries, which are subject to regulatory net worth requirements and certain additional state regulations which may restrict the declaration of dividends by HMOs, insurance companies and licensed managed health care plans. The payment of any dividend is at the discretion of the Company's Board of Directors and depends upon the Company's earnings, financial position, capital requirements and such other factors as the Company's Board of Directors deems relevant.

Under the Credit Agreement entered into on July 8, 1997 (as amended) with Bank of America as agent, the Company cannot declare or pay cash dividends to its stockholders or purchase, redeem or otherwise acquire shares of its capital stock or warrants, rights or options to acquire such shares for cash except to the extent permitted under such Credit Agreement as described elsewhere in the Company's Annual Report on Form 10-K.

HOLDERS

As of March 17, 2000, there were approximately 2,000 holders of record of Class A Common Stock. The California Wellness Foundation (the "CWF") is the only holder of record of the Company's Class B Common Stock, par value $.001 per share (the "Class B Common Stock"), which constitutes under 1% of the Company's aggregate equity. Under the Company's Fourth Amended and Restated Certificate of Incorporation, shares of the Company's Class B Common Stock have the same economic benefits as shares of the Company's Class A Common Stock, but are non-voting. Upon the sale or other transfer of shares of Class B Common Stock by the CWF to an unrelated third party, such shares automatically convert into Class A Common Stock.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Foundation Health Systems, Inc. (together with its subsidiaries, the "Company") is an integrated managed care organization which administers the delivery of managed health care services. The Company's operations, excluding corporate functions, consist of two operating segments: Health Plan Services and Government Contracts/Specialty Services. Through its subsidiaries, the Company offers group, individual, Medicaid and Medicare health maintenance organization ("HMO") and preferred provider organization ("PPO") plans; government sponsored managed care plans; and managed care products related to administration and cost containment, behavioral health, dental, vision and pharmaceutical products and other services.

The Company currently operates within two segments of the managed health care industry: Health Plan Services and Government Contracts/Specialty Services. During 1999, the Health Plan Services segment consisted of four regional divisions: Arizona (Arizona and Utah), California (encompassing only the State of California), Central (Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington) and Northeast (Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia). During 1999, the Company divested its health plans or entered into arrangements to transition the membership of its health plans in the states of Colorado, Idaho, Louisiana, New Mexico, Oklahoma, Texas, Utah and Washington. Effective January 1, 2000, as a result of such divestitures, the Company consolidated and reorganized its Health Plan Services segment into two regional divisions, the Eastern Division (Connecticut, Florida, New Jersey, New York, Ohio, Pennsylvania and West Virginia) and the Western Division (Arizona, California and Oregon). The Company is one of the largest managed health care companies in the United States, with approximately 4 million at-risk and administrative services only ("ASO") members in its Health Plan Services segment.The Company also owns health and life insurance companies licensed to sell insurance in 33 states and the District of Columbia.

The Government Contracts/Specialty Services segment administers large, multi-year managed health care government contracts. This segment subcontracts to affiliated and unrelated third parties the administration and health care risk of parts of these contracts and currently administers health care programs covering approximately 1.5 million eligible individuals under TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS")). Currently, the Company provides these services under three TRICARE contracts that cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon, Texas, Washington and parts of Arizona, Idaho and Louisiana. This segment also offers behavioral health, dental, and vision services as well as managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

This discussion and analysis contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements involve risks and uncertainties detailed from time to time in the Company's filings with the Securities and Exchange Commission (the "Commission") which may cause actual results to differ materially from those projected or implied in these statements. The risks and uncertainties faced by the Company include, but are not limited to, those set forth under "Additional Information Concerning the Company's Business," "Cautionary Statements" in Part I of Form 10-K and other sections within the Company's filings with the Commission.

CONSOLIDATED OPERATING RESULTS

The Company's income from continuing operations for the year ended December 31, 1999 was $147.8 million, or $1.21 per diluted share, compared to a loss from continuing operations for the same period in 1998 of $165.2 million, or $1.35 per diluted share. The Company's loss from continuing operations for the year ended December 31, 1997 was $67.8 million, or $0.55 per diluted share.

During the years ended December 31, 1999, 1998 and 1997, the Company recorded on a pre-tax basis asset impairment, restructuring, merger and other charges totaling $11.7 million (the "1999 Charges"), $240.1 million (the "1998 Charges") and $286.5 million (the "1997 Charges"), respectively. These charges are further described in the "Asset Impairment, Merger, Restructuring and Other Charges" section.

The table below and the discussion that follows summarize the Company's performance in the last three fiscal years. Certain 1998 and 1997 amounts have been reclassified to conform to the 1999 presentation.

(Amounts in thousands)	Year ended December 31, 1999	1998	1997
Total revenues	$8,706,219	$8,634,469	$7,005,595
Expenses:			
Health plan services expenses(1)	5,950,002	6,090,472	4,470,816
Government contracts and specialty services expenses(1)	1,002,893	924,075	990,576
Selling, general and administrative(1)	1,301,743	1,413,771	1,185,018
Amortization and depreciation	112,041	128,093	98,353
Interest	83,808	92,159	63,555
Asset impairment, restructuring, merger, and other charges(1)	11,724	240,053	286,525
Total expenses	8,462,211	8,888,623	7,094,843
Income (loss) from continuing operations before income taxes	$ 244,008	$ (254,154)	$ (89,248)
Overall medical care ratio	81.22%	82.18%	79.25%
Administrative expense ratio	16.02%	17.49%	18.04%
HEALTH PLAN SERVICES SEGMENT:			
Health plan premiums	$7,031,055	$7,124,161	$5,482,893
Health plan medical care ratio	84.62%	85.49%	81.54%
Health plan premiums per member per month	$ 138.76	$ 128.98	$ 129.76
Health plan services per member per month	$ 117.42	$ 110.27	$ 105.81
GOVERNMENT CONTRACTS/SPECIALTY SERVICES SEGMENT:			
Government contracts and specialty services revenues	$1,529,855	$1,411,267	$1,408,402
Government contracts and specialty services expense medical care ratio	65.55%	65.48%	70.33%

(1) Charges of $11.7 million, $240.1 million and $286.5 million in 1999, 1998 and 1997, respectively, are included in asset impairment, restructuring, merger and other charges. Other charges of $170.8 million and $109.4 million in 1998 and 1997, respectively, are included in Health Plan

Services, Government Contracts/Specialty Services and selling, general and administrative expenses.

ENROLLMENT INFORMATION

The table below summarizes the Company's enrollment information for the last three fiscal years.

Year ended December 31, (Amounts in thousands)	1999	1998	Percent Change	1997	Percent Change
Health Plan Services:					
Commercial	3,006	3,287	(8.6)%	3,522	(6.7)%
Medicare Risk	287	326	(12.0)%	308	5.8%
Medicaid	678	586	15.7%	442	32.6%
	3,971	4,199	(5.4)%	4,272	(1.7)%
Government Contracts:					
TRICARE PPO and Indemnity	644	784	(17.9)%	1,090	(28.1)%
TRICARE HMO	852	783	8.8%	801	(2.2)%
	1,496	1,567	(4.5)%	1,891	(17.1)%

REVENUES AND HEALTH CARE COSTS

The Company's total revenues increased by $71.8 million or 1% for the year ended December 31, 1999 as compared to 1998. The decrease in Health Plan Services segment revenues of $93.1 million or 1% was offset by an increase in Government Contracts/Specialty Services segment revenues of $118.6 million or 8%. The decrease in Health Plan Services segment revenues for the year was due to enrollment declines resulting from divestitures of non-core plans and planned membership attrition from pricing actions. Enrollment in the Company's health plans declined by approximately 5% or 228,000 members of which 71,000 members were from divested health plans for the year ended December 31, 1999 as compared to 1998. This membership decrease was offset by premium rate increases as described below. The increase in Government Contracts/Specialty Services segment revenues was due primarily to increases in TRICARE revenues of 11% and continued growth in the Company's behavioral health network, including TRICARE affiliated business, of 21%.

The Company's commercial product lines are profitable. Premium rate increases of 8% in the commercial line of products contributed to revenue increases for the year ended December 31, 1999 as compared to the prior year. These premium rate increases were partially offset by a 9% enrollment decrease from the divestitures of non-core plans and planned membership attrition from pricing actions, resulting in an increase in commercial premium revenue.

The Company's Medicare product lines are profitable. Medicare premium rates have increased 7%, but enrollment has declined by 12% due to the Company exiting certain unprofitable counties, primarily in the Northeast health plans. The Company's Medicaid product lines are profitable. Medicaid premium rates have increased in all markets averaging about 5%. Medicaid enrollment has increased in all divisions resulting in a 16% increase in membership.

Also contributing to the increase in total revenues was a $58.3 million net gain on sale of businesses and properties. During 1999, the Company completed nine divestitures transactions, essentially completing its divestitures program of non-core businesses. See Note 3 - Acquisitions and Dispositions to the consolidated financial statements.

The Company's total revenues increased by $1.6 billion or 23% for the year ended December 31, 1998 as compared to 1997. Growth in the Health Plan Services segment revenues of $1.6 billion or 30% for the year was due primarily to the acquisitions that occurred in the fourth quarter of 1997, including Physicians Health Services, Inc. ("PHS"), FOHP, Inc. ("FOHP") and PACC HMO, Inc. and PACC Health Plans, Inc. (collectively "PACC"). These acquisitions collectively accounted for approximately $1.4 billion of the increase. Excluding these acquisitions, health plan revenues increased by approximately $199 million or 4% for the year ended December 31, 1998. The growth from existing health plan businesses was due to increases in premium rates averaging 4% on a per member per month basis in virtually all markets which were partially offset by a 2% decrease in average membership. See the Enrollment Information section of the previous table for year-end membership information. Growth in the Government Contracts/Specialty Services segment revenues totaled $2.9 million for the year ended December 31, 1998, primarily due to continued growth in the Company's managed behavioral health network.

The overall medical care ratio ("MCR") (medical costs as a percentage of the sum of Health Plan Services and Government Contracts/Specialty Services revenues) for the year ended December 31, 1999 was 81.22% as compared to 82.18% for the year ended December 31, 1998. This resulted from the 8% premium rate increase which exceeded a 7% increase in health care costs on a per member per month basis for the Health Plan Services segment.

The overall MCR for the year ended December 31, 1998 was 82.18% as compared to 79.25% for the year ended December 31, 1997. This resulted primarily from increases in health care costs (4% on a per member per month basis). The increase in health care costs was primarily due to higher pharmacy costs in all divisions, which increased by 18%.

Health Plan Services costs decreased by $140.5 million or 2% for the year ended December 31, 1999 as compared to 1998 primarily as a result of a 5% decrease in enrollment. The Health Plan Services MCR decreased to 84.62% in 1999 from 85.49% in 1998 due to an increased focus on medical management.

Health Plan Services costs increased by $1.6 billion or 36% for the year ended December 31, 1998 as compared to 1997 primarily as a result of enrollment increases in the Northeast Division, Medicaid enrollment growth in the California Division, and pharmacy cost increases in all divisions. The Health Plans Services MCR increased to 85.49% in 1998 from 81.54% in 1997 due to higher medical costs particularly in physician and hospital fee-for-service costs, increases in pharmacy costs and increased utilization.

The Government Contracts/Specialty Services MCR increased slightly to 65.55% for 1999 as compared to 65.48% for 1998. This increase for 1999 was primarily due to the movement of health care services from military treatment facilities to civilian facilities which resulted in higher costs than originally specified in the contract.

The Government Contracts/Specialty Services MCR decreased to 65.48% for 1998 compared to 70.33% for 1997. This decrease for 1998 is primarily due to improved health care and subcontractor performance on the TRICARE contracts which was partially offset by increased pharmacy costs and higher health care claim costs on TRICARE contracts.

SELLING, GENERAL AND ADMINISTRATIVE COSTS

The Company's selling, general and administrative ("SG&A") expenses decreased by $112.0 million or 8% for the year ended December 31, 1999 as compared to 1998. The administrative expense ratio (SG&A and depreciation as a percentage of Health Plan, Government Contracts and Specialty Services revenues) decreased to 16.02% for the year ended December 31, 1999 from 17.49% for the year ended December 31, 1998. This decrease is primarily attributable to the Company's ongoing efforts to control its SG&A expenses and savings associated with the consolidating certain health plans.

The SG&A expenses increased by $228.8 million or 19% for the year ended December 31, 1998 as compared to 1997. The increase in SG&A expenses during 1998 is primarily due to the SG&A expenses associated with the businesses acquired during 1997. The administrative expense ratio decreased to 17.49% for the year ended December 31, 1998 from 18.04% for the year ended December 31, 1997. This decrease is primarily attributable to the Company's ongoing efforts to control its SG&A expenses and savings associated with the integration of its 1997 acquisitions which were partially offset by increased expenditures related to the consolidation and integration of the Company's administrative facilities.

AMORTIZATION AND DEPRECIATION

Amortization and depreciation expense decreased by $16.1 million to $112.0 million in 1999 from $128.1 million in 1998. This decrease was primarily due to a $61.2 million write-down of fixed assets in the fourth quarter of 1998 and impairment charges for goodwill in 1998 which amounted to $30.0 million. See "Asset Impairment, Merger, Restructuring and Other Charges" below and Note 15 to the consolidated financial statements.

Amortization and depreciation expense increased by $29.7 million to $128.1 million in 1998 from $98.4 million in 1997. This increase was due to increases in intangible assets and fixed assets as a result of the acquisitions that occurred primarily in the fourth quarter of 1997 and increased capital expenditures primarily related to the consolidation and integration of the Company's administrative facilities.

INTEREST EXPENSE

Interest expense decreased by $8.4 million to $83.8 million in 1999 from $92.2 million in 1998. This decrease was due to a net decline in the revolving credit borrowings as a result of cash proceeds from divestitures and overall improved financial performance. Interest expense increased by $28.6 million to $92.2 million in 1998 from $63.6 million in 1997. This increase was due to increased borrowings associated with the Company's revolving lines of credit partially offset by lower interest rates.

ASSET IMPAIRMENT, MERGER, RESTRUCTURING AND OTHER CHARGES

This section should be read in conjunction with Notes 14 and 15, and the tables contained therein, to the consolidated financial statements.

1999 CHARGES

The Company initiated during the fourth quarter of 1998 a formal plan to dispose of certain Central Division health plans included in the Company's Health Plan Services segment in accordance with its anticipated divestitures program. In connection with this, the Company announced its plan to close the Colorado regional processing center, terminate employees associated with the support center and transfer these operations to the Company's other administrative facilities. In addition, the Company announced its plans to consolidate certain administrative functions in its Northwest health plan operations. During the quarter ended March 31, 1999, the Company recorded pretax charges for restructuring and other charges of $21.1 million which included $18.5 million for severance and benefit costs related to executives and employees at the Colorado regional processing center and at the Northwest health plans, and $2.6 million for the termination of real estate obligations and other costs to close the Colorado regional processing center. As of December 31, 1999, $1.4 million of the initial reserve was reversed and $8.9 million is expected to require future outlays of cash in 2000. As the closing of the Colorado regional processing center (which is expected to be substantially completed in the first quarter of 2000) was related to the disposition of certain Central Division health plans, management does not expect the closure to have a significant impact on future results of operations or cash flows. During the fourth quarter of 1999, the Company recorded asset impairment costs totaling $6.2 million in connection with pending dispositions

of non-core businesses. These charges included a further adjustment of $4.7 million to adjust the carrying value of the Company's Pittsburgh health plans to fair value for which the Company previously recorded an impairment charge in 1998. The Company also adjusted the carrying value of its subacute operations by $1.5 million to fair value. The revenue and pretax losses attributable to these operations were $66.2 million and $1.4 million, respectively, for the year ended December 31, 1999. The carrying value of these assets as of December 31, 1999 was $16.2 million.

In addition, during 1999, modifications to reduce remaining reserves for the 1998 and 1997 restructuring plans, primarily related to asset impairment, totaling $14.2 million were recorded.

1998 CHARGES

On July 19, 1998, FPA Medical Management, Inc. ("FPA") filed for bankruptcy protection under Chapter 11 of the Federal Bankruptcy Code. FPA, through its affiliated medical groups, provided services to approximately 190,000 of the Company's affiliated members in Arizona and California and also leased health care facilities from the Company. FPA has discontinued its medical group operations in these markets and the Company has made other arrangements for health care services to the Company's affiliated members. The FPA bankruptcy and related events and circumstances caused management to re-evaluate the decision to continue to operate the facilities and management determined to sell the 14 properties, subject to bankruptcy court approval. Management immediately commenced the sale process upon such determination. The estimated fair value of the assets held for disposal was determined based on the estimated sales prices less the related costs to sell the assets.

Management believed that the net proceeds from a sale of the facilities would be inadequate to enable the Company to recover their carrying value. Based on management's best estimate of the net realizable values, the Company recorded charges totaling approximately $84.1 million. These charges were comprised of $63.0 million for real estate asset impairments, $10.0 million impairment adjustment of a note received as consideration in connection with the 1996 sale of the Company's physician practice management business and $11.1 million for other items. These other items included payments made to Arizona physician specialists totaling $3.4 million for certain obligations that FPA had assumed but was unable to pay due to its bankruptcy, advances to FPA to fund certain operating expenses totaling $3.0 million, and other various costs totaling $4.7 million. The carrying value of the assets held for disposal totaled $11.3 million and $24.3 million at December 31, 1999 and 1998, respectively. There has been no further adjustment to the carrying value of the assets held for disposal. As of December 31, 1999, 12 properties have been sold. The remaining properties are expected to be sold during the second half of 2000. The suspension of depreciation on these 12 properties held for disposal has an annual impact of approximately $2.0 million.

During the third quarter ended September 30, 1998, the Company recorded severance and benefit costs totaling $21.2 million related to staff reductions in selected health plans and the centralization and consolidation of corporate functions, and other costs for amounts due from a third-party hospital system that filed for bankruptcy which were not related to the normal business of the Company totaling $18.6 million, and other charges of $3.8 million related to fees for consulting services from one of the Company's former executives and costs related to exiting certain rural Medicare markets.

In addition to the above, other charges totaling $103.3 million were recorded in the third quarter ended September 30, 1998. These charges mostly related to contractual adjustments of $13 million, equitable adjustments relating to government contracts of $17 million, payment disputes with contracted provider groups of $24 million, premium deficiency reserves of $35 million, and other legal and relocation costs of $14.3 million and were primarily included in health care costs within the consolidated statement of operations.

As mentioned previously, during the fourth quarter of 1998, the Company initiated a formal plan to dispose of certain Central Division health plans included in the Company's Health Plan Services segment in accordance with its previously disclosed anticipated divestitures program. The Company sold most of these health plans during 1999. Pursuant to SFAS No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," the Company evaluated the carrying value of the assets for these health plans and the related service center and holding company, and determined that the carrying value of these assets exceeded the estimated fair value of these assets. Estimated fair value was determined by the Company based on the then current stages of sales negotiations, including letters of intent, definitive agreements and sales discussions, net of expected transaction costs. In the case of the service center and holding company operations, buildings, furniture, fixtures, equipment and software development projects were determined by management to have no continuing value to the Company, due to abandoning plans for development of this location and its systems and programs as a centralized operations center. Accordingly, in the fourth quarter of 1998, the Company adjusted the carrying value of these long-lived assets to their estimated fair value, resulting in a non-cash asset impairment charge of approximately $112.4 million. This asset impairment charge of $112.4 million consisted of $40.3 million for write-downs of abandoned furniture, equipment and software development projects, $20.9 million for write-down of buildings and improvements, $30.0 million for write-down of goodwill and $21.2 million for other impairments and other charges. The fair value was

based on expected net realizable value. Revenue and pre-tax income attributable to these plans identified for disposition were $191.3 million and $9.8 million, respectively, for the year ended December 31, 1999. The carrying value of these assets as of December 31, 1999 and 1998 was $22.1 million and $42.8 million, respectively. No subsequent adjustments were made to the carrying value of these assets in 1999 or 1998. As discussed under "1999 Charges," further adjustments to carrying value of $4.7 million were recorded in 1999. The annual impact of suspending depreciation of these assets is $13.0 million.

In addition, the Company recorded additional costs of $48.9 million related to anticipated bad debts totaling $17.4 million, premium deficiency reserves of $22.1 million for certain health plans whose health care costs exceed contractual premium revenues and additional claims reserves and other costs totaling $9.4 million. These costs were recorded in the fourth quarter of 1998. Management assesses the profitability of contracts when operating results or forecasts indicate probable future losses. In preparing forecasts and budgets for the 1999 operating year as well as performing specific year-end analysis on claims reserves, it became probable that losses on certain groups of contracts would not be covered by future premiums. Loss contracts were identified in approximately 12 different operating units as a result of this process. Reserves were recorded in the fourth quarter of 1998 primarily for the Company's Florida health plan as the result of management's assessment of a large provider's likely exposure to insolvency for which the Company carried risk-share receivables. The provider had made payments on the receivables during the year. Conditions worsened in the fourth quarter of 1998 creating a significant risk to the collectibility of the receivables that previously did not exist. The Company also recorded an additional $18.6 million of other charges primarily related to litigation in the normal course of business for non-core operations which were reflected as SG&A expenses on the consolidated statement of operations.

The total 1998 charges recorded by the Company during the second, third and fourth quarters of 1998 were $410.9 million, of which $240.1 million was recorded as asset impairment, merger, restructuring, and other charges on the consolidated statement of operations. During 1999, modifications to the 1998 initial estimates of $12.6 million were recorded. These credits to the 1998 charges resulted from the following: $10.7 million from reductions to asset impairment costs and $1.9 million from reductions to initially anticipated involuntary severance costs and other adjustments. As of December 31, 1999, the 1998 restructuring plans were essentially completed.

1997 CHARGES

The 1997 Charges recorded by the Company were $395.9 million, of which $286.5 million was recorded as asset impairment, merger, restructuring and other charges on the consolidated statement of operations. These charges related to the FHS Combination and the restructuring of the Company's Northeast Division health plans. The principal elements of these charges included (i) restructuring costs of $146.8 million, including $2.7 million of reductions to initial estimates of the 1996 plan, for a workforce reduction, the consolidation of employee benefit plans, the consolidation of facilities in geographic locations where office space is duplicated, the consolidation of overlapping provider networks, and the consolidation of information systems to standardized systems; (ii) $69.6 million in merger-related costs primarily for investment banking, legal, accounting and other costs; (iii) premium deficiency reserves of $57.5 million related to the Company's Gem Insurance Company ("Gem"); and (iv) other charges of $12.6 million related to the loss on the sale of the United Kingdom operations. Additionally, $109.4 million was related to receivable write-offs, loss contract accruals and other termination costs, which were recorded as health care services and SG&A expenses on the consolidated statement of operations. During 1999, modifications to the 1997 initial estimates of $1.6 million were recorded. As of December 31, 1999, the 1997 restructuring plans were essentially completed.

INCOME TAX PROVISION AND BENEFIT

The 1999 tax provision rate of 39.4% on income from continuing operations varied from the 1998 tax benefit rate of 35.0% on losses from continuing operations mainly due to non-deductible impairment charges incurred in 1998. The 1997 tax benefit rate of 24.0% was lower than the 1998 tax benefit rate of 35.0%, resulting primarily from non-deductible merger and restructuring charges incurred in 1997.

DISCONTINUED OPERATIONS

WORKERS' COMPENSATION INSURANCE BUSINESS

In December 1997, the Company adopted a formal plan to sell its workers' compensation segment. In December 1997, the Company estimated the loss on the disposal of the workers' compensation segment would approximate $99.0 million (net of an

income tax benefit of $21.0 million) which included the anticipated results of operations during the phase-out period from December 1997 through the

date of disposal. On December 10, 1998, the Company completed the sale of the workers' compensation segment. The assets sold consisted primarily of investments, premiums and reinsurance receivables. The selling price was $257 million in cash.

IMPACT OF INFLATION AND OTHER ELEMENTS

The managed health care industry is labor intensive and its profit margin is low; hence, 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 have been proposed during recent legislative sessions, and health care reform and similar issues continue to be in the forefront of social and political discussion. If 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, integration of acquired companies, increased cost of individual services, regulatory changes, utilization, new technologies, 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 payments 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 judicial 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 future periods. In light of present facts and current legal interpretations, management believes that adequate provisions have been made for claims and loss reserves.

The Company's HMO subsidiaries contract with providers in California, and to a lesser degree in other areas, primarily through capitation fee arrangements. Under a capitation fee arrangement, the Company's subsidiary pays 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 the Company's HMO subsidiaries, even though such subsidiaries have made their regular payments to the capitated providers. Depending on state law, the Company's HMO subsidiaries may be liable for such claims. In California, the issue of whether HMOs can be liable for unpaid provider claims has not been definitively settled. The Department of Corporations ("DOC") has issued a written statement to the effect that HMOs are not liable for such claims, but there is currently ongoing litigation challenging that ruling.

YEAR 2000

The Company undertook an extensive effort to assess and modify its computer applications and business processes to provide for their continued functionality in light of the "Year 2000" issue.

The "Year 2000" issue is the result of computer programs having been written in a language that used two digits rather than four to define the applicable year. Any of the Company's computer programs that have time-sensitive software and the outdated software language may recognize a date using "00" as the year 1900 rather than the year 2000. This could result in a system failure or miscalculations causing disruptions of operations, including, among other things, a temporary inability to process transactions, prepare invoices or engage in normal business activities. In addition, the Year 2000 problems of the Company's providers and customers, including governmental entities, can affect the Company's operations, which are highly dependent upon information technology for processing claims, determining eligibility and exchanging information.

PROJECT - The Company addressed its Year 2000 issues in several ways. Selected systems were retired with the business functions being converted to Year 2000 compliant systems. The Company closely monitored its systems that utilized packaged software from large vendors to ensure that these systems were Year 2000 compliant. The Company also took advantage of certain updates made available by vendors to ensure Year 2000 compliance of certain software used by the Company. The remaining systems' compliance was addressed by internal technical staff. In addition, the Company completed an assessment of third-party relationships and sought to obtain assurances from all delegated authorities and strategically important providers as to their Year 2000 readiness.

As of March 15, 2000, the Company has not identified any significant disruptions or operational problems resulting from Year 2000 issues. In addition, the Company is not aware of any significant problems experienced by delegated authorities or strategically important third parties that would have a material adverse impact on the Company's operations. There can be no assurance, however, that the Company will not still experience significant disruptions or operational problems related to Year 2000 issues, including as a result of Year 2000 problems experienced by third parties.

COSTS - The total cost for the Company's Year 2000 project was approximately $33.4 million, excluding the costs to accelerate the replacement of hardware or software otherwise required to be purchased by the Company. The percentages of the Company's total expenditures for Year 2000 issues were approximately as follows: 38% for internal costs, 29% for outside consultants and contractors, and 33% for software-related and hardware-related costs. The operating subsidiaries for each line of business of the Company paid for the costs of assessment, planning, remediation, testing and certification of Year 2000 issues for their respective operations.

CONTINGENCY PLANNING - An important part of the Company's Year 2000 project involved identifying worst case scenarios and developing contingency plans. The Company continues to keep the contingency plans in place in the event a significant Year 2000 problem should occur. There can be no assurance, however, that the contingency plans of the Company, if implemented, will adequately address problems that may arise or prevent such problems from having a material adverse effect on the Company's operations.

The information contained herein is intended to be a "Year 2000 Readiness Disclosure" as defined in the Year 2000 Information and Readiness Disclosure Act of 1998 enacted on October 19, 1998.

Forward-looking statements contained in this Year 2000 section should be read in connection with the Company's cautionary statements identifying important risk factors that could cause the Company's actual results to differ materially from those projected in these forward-looking statements, which cautionary statements are contained in the Company's Annual Report on Form 10-K for the year ended December 31, 1999.

LIQUIDITY AND CAPITAL RESOURCES

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. Certain subsidiaries must maintain ratios of current assets to current liabilities of 1:1 pursuant to certain government contracts. The Company believes it is in compliance with these contractual and regulatory requirements in all material respects.

The Company believes that cash from operations, existing working capital and lines of credit 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.

Government health care receivables are best estimates of payments that are ultimately collectible or payable. Since these amounts are subject to government audit and negotiation, amounts ultimately collected may vary significantly from current estimates. Additionally, the timely collection of such receivables is also impacted by government audit and negotiation and could extend for periods beyond a year.

For the year ended December 31, 1999, cash provided by operating activities was $297.1 million compared to cash provided by operating activities of $100.9 million in the prior year. This change was due primarily to the collection of premiums receivable and

timing of payments related to reserves for claims. Net cash provided by investing activities was $163.4 million during 1999 as compared to cash provided by investing activities of $147.0 million during 1998. This increase during 1999 was primarily due to a decrease in the net purchases of fixed assets offset by a decrease in net proceeds from the sale of businesses and buildings. Net cash used in financing activities was $213.9 million in 1999 as compared to cash used in financing activities of $43.3 million during the same period in 1998. The increase in

1999 was due to the increased repayment of funds drawn under the Company's Credit Facility (as defined below), which were partially offset by additional drawings under the Credit Facility.

The Company has a $1.5 billion credit facility (the "Credit Facility"), with Bank of America as Administrative Agent for the Lenders thereto, which was amended by Amendments in April, July, November 1998 and March 1999 with the Lenders (the "Amendments"). All previous revolving credit facilities were terminated and rolled into the Credit Facility on July 8, 1997. At the election of the Company, and subject to customary covenants, loans are initiated on a bid or committed basis and carry interest at offshore or domestic rates, at the applicable LIBOR rate plus margin or the bank reference rate. Actual rates on borrowings under the Credit Facility vary, based on competitive bids and the Company's unsecured credit rating at the time of the borrowing. As of December 31, 1999, the Company was in compliance with the financial covenants of the Credit Facility, as amended by the Amendments. The Credit Facility is available for five years, until July 2002, but it may be extended under certain circumstances for two additional years. The outstanding balance under the Credit Facility has decreased from $1.225 billion at December 31, 1998 to $1.039 billion at December 31, 1999. As of March 14, 2000, the amount outstanding under the Credit Facility totaled $1.039 billion with interest at LIBOR plus 1.50%.

The remaining principal and interest of the promissory notes issued to The California Wellness Foundation in connection with the Health Net conversion to for-profit status was repaid early in 1999. As a result, these notes are no longer outstanding.

On December 31, 1999, the Company sold the capital stock of QualMed Washington Health Plan, Inc., the Company's HMO subsidiary in the state of Washington ("QM-Washington"), to American Family Care ("AFC"). Upon completion of the transaction, AFC assumed control of the health plan license and retained the Medicaid and Basic Health Plan membership of QM-Washington. The Company also entered into definitive agreements with PacifiCare of Washington, Inc. ("PacifiCare-WA") and Premera Blue Cross to transition its commercial membership in Washington to such companies. As part of such agreements, PacifiCare-WA has offered replacement coverage to QM-Washington's HMO and POS groups in western Washington and Premera Blue Cross has offered replacement coverage to substantially all of QM-Washington's HMO and POS group membership in eastern Washington.

In addition, on September 21, 1999, the Company announced that it had executed a definitive agreement with PacifiCare of Colorado, Inc. ("PacifiCare-CO") to transition all of its membership in Colorado to PacifiCare-CO by March 31, 2000. The Company also announced that its previously disclosed letter of intent with WellPoint Health Networks Inc. had expired. Pursuant to the definitive agreement, PacifiCare-CO is offering replacement coverage to substantially all of the Company's Colorado HMO membership and PacifiCare Life Assurance Company ("PLAC") is issuing replacement indemnity coverage to substantially all of the Company's Colorado Point of Service ("POS") membership.

Effective as of September 20, 1999, the Company and Medaphis (which changed its name to Per-Se Technologies, Inc. ("Per-Se")) entered into a Settlement Agreement and Release pursuant to which the Company received net proceeds of approximately $25 million consisting of cash from Per-Se and Per-Se's insurers and proceeds from the sale of both the 976,771 shares of Medaphis (now Per-Se) common stock then owned by the Company and additional shares of Per-Se common stock issued to the Company as part of the settlement. In exchange, the Company and Per-Se terminated the ongoing litigation and granted each other a general release. The gain recognized in the consolidated statement of operations as of December 31, 1999 was immaterial.

The Company's subsidiaries must comply with certain minimum capital requirements under applicable state laws and regulations. During 1999, the Company contributed $97.4 million to its subsidiaries to meet risk-based or other capital requirements of the regulated entities. As of December 31, 1999, the Company's subsidiaries were in compliance with minimum capital requirements.

Legislation has been or may be enacted in certain states in which the Company's subsidiaries operate imposing, or allowing regulators to impose, substantially increased minimum capital and/or statutory deposit requirements for HMOs and insurance companies in such states. Such statutory deposits may only be drawn upon under limited circumstances relating to the protection of policyholders. For example, the Company's HMO subsidiary operating in New Jersey was required to increase its statutory deposits by approximately $51 million in 1998 pursuant to such legislation.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The Company is exposed to interest rate and market risk primarily due to its investing and borrowing activities. Market risk generally represents the risk of loss that may result from the potential change in the value of a financial instrument as a result of fluctuations in interest rates and in equity prices. Interest rate risk is a consequence of maintaining fixed income investments. The Company is exposed to interest rate risks arising from changes in the level or volatility of interest rates, prepayment speeds and/or the shape and slope of the yield curve. In addition, the Company is exposed to the risk of loss related to changes in credit spreads. Credit spread risk arises from the potential that changes in an issuer's credit rating or credit perception may affect the value of financial instruments.

The Company has several bond portfolios to fund reserves. The Company attempts to manage the interest rate risks related to its investment portfolios by actively managing the asset/liability duration of its investment portfolios. The overall goal for the investment portfolios is to provide a source of liquidity and support the ongoing operations of the Company's business units. The Company's philosophy is to actively manage assets to maximize total return over a multiple-year time horizon, subject to appropriate levels of risk. Each business unit has additional requirements with respect to liquidity, current income and contribution to surplus. The Company manages these risks by setting risk tolerances, targeting asset-class allocations, diversifying among assets and asset characteristics, and using performance measurement and reporting.

The Company uses a value-at-risk ("VAR") model, which follows a variance/covariance methodology, to assess the market risk for its investment portfolio. VAR is a method of assessing investment risk that uses standard statistical techniques to measure the worst expected loss in the portfolio over an assumed portfolio disposition period under normal market conditions. The determination is made at a given statistical confidence level.

The Company assumed a portfolio disposition period of 30 days with a confidence level of 95 percent for the 1999 computation of VAR. The computation further assumes that the distribution of returns is normal. Based on such methodology and assumptions, the computed VAR was approximately $2.7 million as of December 31, 1999.

The Company's calculated value-at-risk exposure represents an estimate of reasonably possible net losses that could be recognized on its investment portfolios assuming hypothetical movements in future market rates and are not necessarily indicative of actual results which may occur. It does not represent the maximum possible loss nor any expected loss that may occur, since actual future gains and losses will differ from those estimated, based upon actual fluctuations in market rates, operating exposures, and the timing thereof, and changes in the Company's investment portfolios during the year. The Company, however, believes that any loss incurred would be offset by the effects of interest rate movements on the respective liabilities, since these liabilities are affected by many of the same factors that affect asset performance; that is, economic activity, inflation and interest rates, as well as regional and industry factors.

In addition, the Company has some interest rate market risk due to its borrowings. Notes payable, capital leases and other financing arrangements totaled $1.041 billion at December 31, 1999 with a related average interest rate of 6.78% (which interest rate is subject to change pursuant to the terms of the Credit Facility). See a description of the Credit Facility under "Liquidity and Capital Resources."

The table following presents the expected cash outflows of market risk sensitive debt obligations at December 31, 1999. These cash outflows include both expected principal and interest payments consistent with the terms of the outstanding debt as of December 31, 1999.

(Amounts in thousands)	2000	2001	2002	2003	2004	Beyond	Total
Long-term floating rate borrowings:							
Principal	$ -	$ -	$1,039,250	$ -	$ -	$ -	$1,039,250

Interest	94,302	79,243	39,622	-	-	-	213,167
Total Cash Outflow	$ 94,302	$79,243	$1,078,872	$ -	$ -	$ -	$1,252,417

REPORT OF THE AUDIT COMMITTEE OF THE BOARD OF DIRECTORS OF FOUNDATION HEALTH SYSTEMS INC.

The Board of Directors of the Company addresses its oversight responsibility for the consolidated financial statements through its Audit Committee (the "Committee"). The Committee currently consists of Gov. George Deukmejian, Thomas T. Farley, Earl B. Fowler (Chairman) and Richard J. Stegemeier, each of whom is an independent outside director.

In fulfilling its responsibilities in 1999, the Committee reviewed the overall scope of the independent auditors' audit plan and reviewed the independent auditors' non-audit services to the Company. The Committee also exercised oversight responsibilities over various financial and regulatory matters.

The Committee's meetings are designed to facilitate open communication between the independent auditors and Committee members. To ensure auditor independence, the Committee meets privately with both the independent auditors and also with the chief auditor of the Company's Internal Audit Department, thereby providing for full and free access to the Committee.

/s/ Earl B. Fowler
Earl B. Fowler, Chairman
Audit Committee
February 29, 2000

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors and Stockholders of
Foundation Health Systems, Inc.
Woodland Hills, California

We have audited the accompanying consolidated balance sheets of Foundation Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 1999 and 1998, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 1999. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Foundation Health Systems, Inc. and subsidiaries at December 31, 1999 and 1998, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 1999 in conformity with generally accepted accounting principles.

/s/ Deloitte & Touche LLP
Los Angeles, California
February 29, 2000

CONSOLIDATED BALANCE SHEETS
FOUNDATION HEALTH SYSTEMS, INC.

December 31,

(Amounts in thousands)	1999	1998
ASSETS		
Current Assets:		
Cash and cash equivalents	$1,010,539	$ 763,865
Investments - available for sale	456,603	525,082
Premium receivables, net of allowance for doubtful accounts (1999 - $21,937; 1998 - $28,522)	149,992	230,157
Amounts receivable under government contracts	290,329	321,411
Deferred taxes	209,037	160,446
Reinsurance and other receivables	153,427	147,827
Other assets	77,866	91,096
Total current assets	2,347,793	2,239,884
Property and equipment, net	280,729	345,269
Goodwill and other intangible assets, net	909,586	977,910
Deferred taxes	-	118,759
Other assets	158,373	181,447
Total assets	$3,696,481	$3,863,269
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Reserves for claims and other settlements	$1,138,801	$1,006,799
Unearned premiums	224,381	288,683
Notes payable and capital leases	1,256	1,760
Amounts payable under government contracts	43,843	69,792
Accounts payable and other liabilities	322,048	458,397
Total current liabilities	1,730,329	1,825,431
Notes payable and capital leases	1,039,352	1,254,278
Deferred taxes	5,624	-
Other liabilities	29,977	39,518

Total liabilities	2,805,282	3,119,227
Commitments and contingencies (Note 12)		
Stockholders' equity:		
Preferred stock ($0.001 par value, 10,000 shares authorized, none issued and outstanding)	-	-
Class A common stock ($0.001 par value, 350,000 shares authorized; issued 1999 - 123,429; 1998 - 120,362)	123	120
Class B non-voting convertible common stock ($0.001 par value, 30,000 shares authorized; issued and outstanding 1999 - 2,138; 1998 - 5,048)	2	5
Additional paid-in capital	643,373	641,820
Treasury Class A common stock, at cost (1999 - 3,194 shares; 1998 - 3,194 shares)	(95,831)	(95,831)
Retained earnings	347,601	205,236
Accumulated other comprehensive loss	(4,069)	(7,308)
Total stockholders' equity	891,199	744,042
Total liabilities and stockholders' equity	$3,696,481	$3,863,269

See accompanying notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF OPERATIONS
FOUNDATION HEALTH SYSTEMS, INC.

(Amounts in thousands, except per share data)	Year ended December 31, 1999	1998	1997
REVENUES			
Health plan services premiums	$7,031,055	$7,124,161	$5,482,893
Government contracts/Specialty services	1,529,855	1,411,267	1,408,402
Investment and other income	86,977	93,441	114,300
Net gain on sale of businesses and properties	58,332	5,600	-
Total revenues	8,706,219	8,634,469	7,005,595
EXPENSES			
Health plan services	5,950,002	6,090,472	4,470,816
Government contracts/Specialty services	1,002,893	924,075	990,576
Selling, general and administrative	1,301,743	1,413,771	1,185,018
Depreciation	70,010	78,951	58,100
Amortization	42,031	49,142	40,253
Interest	83,808	92,159	63,555
Asset impairment, merger, restructuring and other costs	11,724	240,053	286,525
Total expenses	8,462,211	8,888,623	7,094,843
Income (loss) from continuing operations before income taxes	244,008	(254,154)	(89,248)
Income tax provision (benefit)	96,226	(88,996)	(21,418)
Income (loss) from continuing operations	147,782	(165,158)	(67,830)
Discontinued operations:			
Loss from discontinued operations, net of tax	-	-	(30,409)
Loss on disposition, net of tax	-	-	(88,845)
Income (loss) before cumulative effect of a change in accounting principle	147,782	(165,158)	(187,084)
Cumulative effect of a change in accounting principle, net of tax	(5,417)	-	-

Net income (loss)	$ 142,365	$ (165,158)	$ (187,084)
Basic and diluted earnings (loss) per share:			
Continuing operations	$ 1.21	$ (1.35)	$ (0.55)
Loss from discontinued operations, net of tax	-	-	(0.25)
Loss on disposition of discontinued operations, net of tax	-	-	(0.72)
Cumulative effect of a change in accounting principle	(0.05)	-	-
Net	$ 1.16	$ (1.35)	$ (1.52)
Weighted average shares outstanding:			
Basic	122,289	121,974	123,333
Diluted	122,343	121,974	123,333

See accompanying notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
FOUNDATION HEALTH SYSTEMS, INC.

(Amounts in thousands)	Common Stock Class A Shares	Class A Amount	Class B Shares	Class B Amount	Additional Paid-in Capital
Balance at January 1, 1997	109,179	$109	19,298	$19	$721,482
Comprehensive loss:					
Net loss					
Change in unrealized depreciation on investments, net					
Total comprehensive loss	-	-	-	-	-
Redemption of common stock			(4,550)	(4)	(111,330)
Retirement of treasury stock, net				(130)	(3,047)
Exercise of stock options including related tax benefit				842	19,310
Conversion of Class B to Class A	4,450	5	(4,450)	(5)	
Employee stock purchase plan				108	2,196
Balance at December 31, 1997	114,449	114	10,298	10	628,611
Comprehensive income (loss):					
Net loss					
Change in unrealized depreciation on investments, net					
Total comprehensive income (loss)	-	-	-	-	-
Exercise of stock options including related tax benefit			497	1	9,584
Conversion of Class B to Class A	5,250	5	(5,250)	(5)	
Employee stock purchase plan				166	3,625
Balance at December 31, 1998	120,362	120	5,048	5	641,820
Comprehensive income:					
Net income					
Change in unrealized depreciation on investments, net					
Total comprehensive income	-	-	-	-	-

Exercise of stock options including related tax benefit		5						
Conversion of Class B to Class A		2,910		3		(2,910)		(3)
Employee stock purchase plan								152
1,553								
Balance at December 31, 1999		123,429		$123		2,138		$2
$643,373								

See accompanying notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (CONTINUED)
FOUNDATION HEALTH SYSTEMS, INC.

(Amounts in thousands)	Common Stock Held in Treasury Shares	Amount	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total
Balance at January 1, 1997	(3,324)	$(98,878)	$557,478	$3,201	$1,183,411
Comprehensive loss:					
Net loss				(187,084)	(187,084)
Change in unrealized depreciation on investments, net				(10,525)	(10,525)
Total comprehensive loss	-	-	(187,084)	(10,525)	(197,609)
Redemption of common stock					(111,334)
Retirement of treasury stock, net		130			3,047
Exercise of stock options including related tax benefit					19,310
Conversion of Class B to Class A					-
Employee stock purchase plan					2,196
Balance at December 31, 1997	(3,194)	(95,831)	370,394	(7,324)	895,974
Comprehensive income (loss):					
Net loss				(165,158)	(165,158)
Change in unrealized depreciation on investments, net				16	16
Total comprehensive income (loss)	-	-	(165,158)	16	(165,142)
Exercise of stock options including related tax benefit					- 9,585
Conversion of Class B to Class A					-
Employee stock purchase plan					3,625
Balance at December 31, 1998	(3,194)	(95,831)	205,236	(7,308)	744,042
Comprehensive income (loss):					
Net income				142,365	142,365
Change in unrealized depreciation on					

investments, net				3,239	3,239
Total comprehensive income	-	-	142,365	3,239	145,604
Exercise of stock options including related tax benefit					-
Conversion of Class B to Class A					-
Employee stock purchase plan					1,553
Balance at December 31, 1999	(3,194)	$(95,831)	$347,601	$(4,069)	$891,199

See accompanying notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOUNDATION HEALTH SYSTEMS, INC.

(Amounts in thousands)	Year ended December 31, 1999	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income (loss)	$ 142,365	$ (165,158)	$ (187,084)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Amortization and depreciation	112,041	128,093	98,353
Net (gain) loss on sale of businesses and properties	(58,332)	(5,600)	12,676
Cumulative effect of a change in accounting principle	5,417	-	-
Impairment of assets	11,724	159,066	8,456
Other changes in net assets of discontinued operations	-	-	(5,395)
Loss on disposition of discontinued operations	-	-	88,845
Loss from discontinued operations	-	-	30,409
Other changes	5,648	15,041	2,525
Changes in assets and liabilities, net of effects of acquisitions and dispositions:			
Premiums receivable and unearned subscriber premiums	(8,973)	38,569	3,105
Other assets	63,902	(69,671)	(112,302)
Amounts receivable/payable under government contracts	5,130	(58,000)	(16,155)
Reserves for claims and other settlements	167,084	(6,416)	(55,450)
Accounts payable and accrued liabilities	(148,878)	64,943	6,145
Net cash provided by (used in) operating activities	297,128	100,867	(125,872)
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sale or maturity of investments	642,150	727,435	597,691
Purchase of investments	(606,350)	(697,472)	(406,818)
Net purchases of property and equipment	(36,592)	(147,782)	(131,669)
Proceeds from notes receivables	-	-	93,011
Sale of net assets of discontinued operations	-	257,100	-
Proceeds from sale of businesses and properties	137,728	-	-
Acquisitions of businesses, net of cash acquired	-	-	(293,625)
Other	26,486	7,682	6,633

Net cash provided by (used in) investing activities	163,422	146,963	(134,777)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from exercise of stock options and employee stock purchases	1,553	13,209	21,506
Proceeds from issuance of notes payable and other financing arrangements	221,276	155,575	566,240
Repayment of debt and other noncurrent liabilities	(436,705)	(212,109)	(144,341)
Stock repurchase	-	-	(111,334)
Net cash provided by (used in) financing activities	(213,876)	(43,325)	332,071
Net increase in cash and cash equivalents	246,674	204,505	71,422
Cash and cash equivalents, beginning of year	763,865	559,360	487,938
Cash and cash equivalents, end of year	$1,010,539	$ 763,865	$ 559,360

See accompanying notes to consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)
FOUNDATION HEALTH SYSTEMS, INC.

(Amounts in thousands)	Year ended December 31, 1999	1998	1997
SUPPLEMENTAL CASH FLOWS DISCLOSURE:			
Interest paid	$ 85,212	$85,981	$ 56,056
Income taxes paid (refunded)	6,106	(87,799)	(3,534)
SUPPLEMENTAL SCHEDULE OF NON-CASH INVESTING AND FINANCING ACTIVITIES:			
Capital lease obligations	$ -	$ 2,530	$ 3,993
Notes and stocks received on sale of businesses	22,909	-	-
Transfer of investments as consideration for PACC acquisition	-	-	14,310
Conversion of FOHP convertible debentures to equity	-	1,197	70,654
ACQUISITION OF BUSINESSES:			
Fair value of assets acquired	-	-	$849,487
Liabilities assumed	-	-	438,448
Cash paid for acquisitions	-	-	411,039
Less: cash acquired in acquisitions	-	-	117,414
Net cash paid for acquisitions	$ -	$ -	$293,625

See accompanying notes to consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 - DESCRIPTION OF BUSINESS

The current operations of Foundation Health Systems, Inc. (the "Company" or "FHS") are a result of the April 1, 1997 merger transaction (the "FHS Combination") involving Health Systems International, Inc. ("HSI") and Foundation Health Corporation ("FHC"). Pursuant to the FHS Combination, FH Acquisition Corp., a wholly-owned subsidiary of HSI ("Merger Sub"), merged with and into FHC and FHC survived as a wholly-owned subsidiary of HSI, which changed its name to "Foundation Health Systems, Inc." and thereby became the Company. Pursuant to the Agreement and Plan of Merger (the "Merger Agreement") that evidenced the FHS Combination, FHC stockholders received 1.3 shares of the Company's Class A Common Stock for every share of FHC common stock held, resulting in the issuance of approximately 76.7 million shares of the Company's Class A Common Stock to FHC stockholders. The shares of the Company's Class A Common Stock issued to FHC's stockholders in the FHS Combination constituted approximately 61% of the outstanding stock of the Company after the FHS Combination and the shares held by the Company's stockholders prior to the FHS Combination (i.e. the prior stockholders of HSI) constituted approximately 39% of the outstanding stock of the Company after the FHS Combination.

The FHS Combination was accounted for as a pooling of interests for accounting and financial reporting purposes. The pooling of interests method of accounting is intended to present, as a single interest, two or more common stockholder interests which were previously independent and assumes that the combining companies have been merged from inception. Consequently, the Company's consolidated financial statements have been prepared and/or restated as though HSI and FHC always had been combined. Although prior to the FHS Combination FHC reported on a fiscal year ended June 30 basis, the consolidated financial statements have been restated to reflect the Company's calendar year basis.

The consolidated financial statements give retroactive effect to the FHS Combination which was accounted for as a pooling of interests and to the sale of the Company's workers' compensation business which was accounted for as discontinued operations (see Note 3).

CONTINUING OPERATIONS

The Company is an integrated managed care organization which administers the delivery of managed health care services. Continuing operations, excluding corporate functions, consist of two segments: Health Plan Services and Government Contracts/Specialty Services. Through its subsidiaries, the Company offers group, individual, Medicaid and Medicare health maintenance organization ("HMO") and preferred provider organization ("PPO") plans; government- sponsored managed care plans; and managed care products related to administration and cost containment, behavioral health, dental, vision and pharmaceutical products and other services.

The Company currently operates within two segments of the managed health care industry: Health Plan Services and Government Contracts/Specialty Services. During 1999, the Health Plan Services segment consisted of four regional divisions: Arizona (Arizona and Utah), California (encompassing only the State of California), Central (Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington) and Northeast (Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia). During 1999, the Company divested its health plans or entered into arrangements to transition the membership of its health plans in the states of Colorado, Idaho, Louisiana, New Mexico, Oklahoma, Texas, Utah and Washington. Effective January 1, 2000, as a result of such divestitures, the Company consolidated and reorganized its Health Plan Services segment into two regional divisions, the Eastern Division (Connecticut, Florida, New Jersey, New York, Ohio, Pennsylvania and West Virginia) and the Western Division (Arizona, California and Oregon). The Company is one of the largest managed health care companies in the United States, with approximately 4 million at-risk and administrative services only ("ASO") members in its Health Plan Services segment. The Company also owns health and life insurance companies licensed to sell insurance in 33 states and the District of Columbia.

The Government Contracts/Specialty Services segment administers large, multi-year managed care government contracts. This segment subcontracts to affiliated and unrelated third parties the administration and health care risk of parts of these contracts and currently administers health care programs covering 1.5 million eligible individuals under TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS")). Currently, there are three TRICARE contracts that cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon, Texas, and Washington, and parts of Arizona, Idaho and Louisiana. This segment also offers behavioral health, dental, vision, and pharmaceutical products and services as well as managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

DISCONTINUED OPERATIONS

WORKERS' COMPENSATION INSURANCE SEGMENT - In December 1997, the Company revised its strategy of maintaining a presence in the workers' compensation risk-assuming insurance business and adopted a formal plan to discontinue and sell this segment through divestiture of its workers' compensation insurance subsidiaries. The Company completed its sale of this segment on December 10, 1998. The consolidated financial statements give retroactive effect to the foregoing (see Note 3).

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

CONSOLIDATION AND BASIS OF PRESENTATION

The consolidated financial statements include the accounts of the Company and its wholly-owned and majority-owned subsidiaries. All significant intercompany transactions have been eliminated in consolidation except for transactions between the Company's continuing operations subsidiaries and the discontinued operations segments discussed in Note 3. The accompanying consolidated financial statements have been restated for the FHS Combination accounted for as a pooling of interests and for the discontinued operations as discussed in Note 1.

RECLASSIFICATIONS

Certain amounts in the 1998 and 1997 consolidated financial statements and notes have been reclassified to conform to the 1999 presentation.

REVENUE RECOGNITION

Health plan services premium revenues include HMO and PPO premiums from employer groups and individuals and from Medicare recipients who have purchased supplemental benefit coverage, which premiums are based on a predetermined prepaid fee, Medicaid revenues based on multi-year contracts to provide care to Medicaid recipients, and revenue under Medicare risk contracts to provide care to enrolled Medicare recipients. Revenue is recognized in the month in which the related enrollees are entitled to health care services. Premiums collected in advance are recorded as unearned premiums.

Government contracts revenues are recognized in the month in which the eligible beneficiaries are entitled to health care services. Government contracts also contain cost and performance incentive provisions which adjust the contract price based on actual performance, and revenue under contracts is subject to price adjustments attributable to inflation and other factors. The effects of these adjustments are recognized on a monthly basis, although the final determination of these amounts could extend significantly beyond the period during which the services were provided. Amounts receivable under government contracts are comprised primarily of estimated amounts receivable under these cost and performance incentive provisions, price adjustments, and change orders for services not originally specified in the contracts.

Specialty services revenues are recognized in the month in which the administrative services are performed or the period that coverage for services is provided.

HEALTH CARE EXPENSES

The cost of health care services is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported. Such costs include payments to primary care physicians, specialists, hospitals, outpatient care facilities and the costs associated with managing the extent of such care. The Company estimates the amount of the provision for service costs incurred but not reported using standard actuarial methodologies based upon historical data including the period between the date services are rendered and the date claims are received and paid, denied claim activity, expected medical cost inflation, seasonality patterns and changes in membership. The estimates for service costs incurred but not reported are made on an accrual basis and adjusted in future periods as required. Any adjustments to the prior period estimates are included in the current period. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims and losses paid are dependent on future developments, management is of the opinion that the recorded reserves are adequate to cover such costs. These liabilities are reduced by estimated amounts recoverable from third parties for subrogation.

The Company generally contracts with various medical groups to provide professional care to certain of its members on a capitation, or fixed per member per month fee basis. Capitation contracts generally include a provision for stop-loss and non-capitated services for which the Company is liable. Professional capitated contracts also generally contain provisions for shared risk, whereby the Company and the medical groups share in the variance between actual costs and predetermined goals. Additionally, the Company contracts with certain hospitals to provide hospital care to enrolled members on a capitation basis. The HMOs also contract with hospitals, physicians and other providers of health care, pursuant to discounted fee-for-service arrangements, hospital per diems, and case rates under which providers bill the HMOs for each individual service provided to enrollees.

The Company assesses the profitability of contracts for providing health care services when operating results or forecasts indicate probable future losses. Contracts are grouped in a manner consistent with the method of determining premium rates. Losses are determined by comparing anticipated premiums to the total of health care related costs less reinsurance recoveries, if any, and the cost of maintaining the contracts. Losses, if any, are recognized in the period the loss is determined and are classified as Health Plan Services.

During 1998, premium deficiency reserves were specifically determined in accordance with this policy for the Louisiana, Oklahoma, and Texas plans, which the Company sold in 1999. See Note 3 - Acquisitions and Dispositions. These future losses were probable as a result of increasing health care costs, on a per member per month basis, driven by a declining membership base.

CASH AND CASH EQUIVALENTS
Cash equivalents include all highly liquid investments with a maturity of three months or less when purchased.

The Company and its consolidated subsidiaries are required to set aside certain funds for restricted purposes pursuant to regulatory requirements. As of December 31, 1999 and 1998, cash and cash equivalent balances of $52.9 million and $65.5 million, respectively, are restricted and included in other noncurrent assets.

INVESTMENTS
Investments classified as available for sale are reported at fair value based on quoted market prices, with unrealized gains and losses excluded from earnings and reported as other comprehensive income, net of income tax effects. The cost of investments sold is determined in accordance with the specific identification method and realized gains and losses are included in investment income.

Certain debt investments are held by trustees or agencies pursuant to state regulatory requirements. These investments totaled $31.8 million in 1999 and $61.8 million in 1998, and are included in other noncurrent assets (see Note 11). Market values approximate carrying value at December 31, 1999 and 1998.

GOVERNMENT CONTRACTS
Amounts receivable or payable under government contracts are based on three TRICARE contracts in five regions which include both amounts billed ($5.1 million and $75.0 million of net receivables at December 31, 1999 and 1998, respectively) and estimates for amounts to be received under cost and performance incentive provisions, price adjustments and change orders for services not originally specified in the contracts. Such estimates are determined based on information available as well as historical performance and collection of which could extend for periods beyond a year. Differences, which may be material, between the amounts estimated and final amounts collected are recorded in the period when determined.

Additionally, the reserves for claims and other settlements includes approximately $189.7 million and $162.4 million relating to health care services provided under these contracts as of December 31, 1999 and 1998, respectively.

PROPERTY AND EQUIPMENT
Property and equipment are stated at historical cost less accumulated depreciation. Depreciation is computed using the straight-line method over the lesser of estimated useful lives of the various classes of assets or the lease term. The useful life for buildings and improvements is estimated at 40 years, and the useful lives for furniture, equipment and software range from three to eight years (see Note 5).

Expenditures for maintenance and repairs are expensed as incurred. Major improvements which increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, the recorded cost and the related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

GOODWILL AND OTHER INTANGIBLE ASSETS
Goodwill and other intangible assets arise primarily as a result of various business acquisitions and consist of identifiable intangible assets acquired and the excess of the cost of the acquisitions over the tangible and intangible assets acquired and liabilities assumed (goodwill). Identifiable intangible assets consist of the value of employer group contracts, provider networks, non-compete agreements and debt issuance costs. Goodwill and other intangible assets are amortized using the straight-line method over the estimated lives of the related assets listed below. In accordance with Accounting Principles Board ("APB") Opinion No. 17, the Company periodically evaluates these estimated lives to determine if events and circumstances warrant revised periods of amortization. The Company further evaluates the carrying value of its goodwill and other intangible assets based on estimated fair value or undiscounted operating cash flows whenever significant events or changes occur which might impair recovery of recorded costs. Fully amortized goodwill and other intangible assets and the related accumulated amortization are removed from the accounts.

Impairment is measured in accordance with Statement of Financial Accounting Standards ("SFAS") No. 121 "Accounting for the Impairment of Long-Lived Assets and Long-Lived Assets to be Disposed Of" and is based on whether the asset will be held and used or held for disposal. An impairment loss on assets to be held and used is measured as the amount by which the carrying amount exceeds the fair value of the asset. Fair value of assets held for disposal would additionally be reduced by costs to sell the asset. For the purposes of analyzing impairment, assets, including goodwill, are grouped at the lowest level for which there are

identifiable independent cash flows, which is generally at the operating subsidiary level. Estimates of fair value are determined using various techniques depending on the event that indicated potential impairment (see Note 15). Impairment charges for goodwill in 1999 and 1998 amounted to $4.7 million and $30.0 million, respectively (see Note 15).

Effective January 1, 1999, the Company adopted Statement of Position 98-5 "Reporting on the Costs of Start-up Activities" and changed its method of accounting for start-up and organization costs. The change involved expensing these costs as incurred, rather than the Company's previous accounting principle of capitalizing and subsequently amortizing such costs.

The change in accounting principle resulted in the write-off of the costs capitalized as of January 1, 1999. The cumulative effect of the write-off was $5.4 million (net of tax benefit of $3.7 million) and has been expensed and reflected in the consolidated statement of operations for the year ended December 31, 1999.

Goodwill and other intangible assets consisted of the following at December 31, 1999 (dollars in thousands):

	Cost	Accumulated Amortization	Net Balance	Amortization Period
Goodwill	$ 981,600	$ 157,924	$ 823,676	9-40 years
Provider network	69,466	15,515	53,951	14-40 years
Employer group contracts	92,900	68,874	24,026	11-23 years
Other	27,002	19,069	7,933	5-7 years
Total	$ 1,170,968	$ 261,382	$ 909,586	

Goodwill and other intangible assets consisted of the following at December 31, 1998 (dollars in thousands):

	Cost	Accumulated Amortization	Net Balance	Amortization Period
Goodwill	$ 1,031,122	$ 152,321	$ 878,801	9-40 years
Provider network	69,466	12,978	56,488	14-40 years
Employer group contracts	92,900	60,724	32,176	11-23 years
Other	27,114	16,669	10,445	5-7 years
Total	$ 1,220,602	$ 242,692	$ 977,910	

CONCENTRATIONS OF CREDIT RISK

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash equivalents, investments and premium receivables. All cash equivalents and investments are managed within established guidelines which limit the amounts which may be invested with one issuer. Concentrations of credit risk with respect to premiums receivable are limited due to the large number of payers comprising the Company's customer base. The Company's 10 largest employer groups accounted for 32% and 17% of receivables and 15% and 12% of premium revenue as of December 31, 1999 and 1998, respectively, and for the years then ended.

EARNINGS PER SHARE

The Company adopted in 1997, SFAS No. 128, "Earnings Per Share." As required by SFAS No. 128, basic EPS excludes dilution and reflects income divided by the weighted average shares of common stock outstanding during the periods presented. Diluted EPS is based upon the weighted average shares of common stock and dilutive common stock equivalents (stock options) outstanding during the periods presented; no adjustment to income was required. Common stock equivalents arising from dilutive stock options are computed using the treasury stock method; in 1999 this amounted to 54,000 shares. Such shares amounting to 207,000 and 488,000 were anti-dilutive in 1998 and 1997, respectively.

Options to purchase an aggregate of 11.4 million, 13.4 million, and 9.6 million shares of common stock during 1999, 1998, and 1997, respectively, were not included in the computation of diluted EPS because the options' exercise price was greater than the average market price of the common stock. These options expire through December 2009.

USE OF ESTIMATES

The preparation of financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Principal areas requiring the use of estimates include the determination of allowances for doubtful accounts, reserves for claims and other settlements, reserves for professional and general liabilities, amounts receivable or payable under government contracts, remaining reserves for restructuring and other charges, and net realizable values for assets where impairment charges have been recorded.

FAIR VALUE OF FINANCIAL INSTRUMENTS

The estimated fair value amounts of cash equivalents, investments available for sale and notes payable approximate their carrying amounts in the financial statements and have been determined by the Company using available market information and appropriate valuation methodologies. The carrying amounts of cash equivalents approximate fair value due to the short maturity of those instruments. The fair values of investments are estimated based on quoted market prices and dealer quotes for similar investments. The fair value of notes payable is estimated based on the quoted market prices for the same or similar issues or on the current rates offered to the Company for debt with the same remaining maturities. Considerable judgment is required to develop estimates of fair value. Accordingly, the estimates are not necessarily indicative of the amounts the Company could have realized in a current market exchange. The use

of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

The fair value estimates are based on pertinent information available to management as of December 31, 1999 and 1998. Although management is not aware of any factors that would significantly affect the estimated fair value amounts, such amounts have not been comprehensively revalued for purposes of these financial statements since that date, and therefore, current estimates of fair value may differ significantly.

STOCK-BASED COMPENSATION

The Financial Accounting Standards Board issued SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123"). As permitted under SFAS 123, the Company has elected to continue accounting for stock-based compensation under the intrinsic value method prescribed in APB Opinion No. 25, "Accounting for Stock Issued to Employees." 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 the Company's stock over the exercise price of the option (see Note 7).

COMPREHENSIVE INCOME

Effective January 1, 1998, the Company adopted SFAS No. 130 "Reporting Comprehensive Income" ("SFAS 130"). SFAS 130 establishes standards for reporting and presenting comprehensive income and its components. Comprehensive income includes all changes in stockholders' equity (except those arising from transactions with stockholders) and includes net income and net unrealized appreciation (depreciation), after tax, on investments available for sale.

RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In June 1998, the Financial Accounting Standards Board issued SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS 133"), which is required to be adopted in fiscal years beginning after June 15, 2000. Management does not anticipate that the adoption of SFAS 133 will have a significant effect on the financial position of the Company or its results of operations.

NOTE 3 - ACQUISITIONS AND DISPOSITIONS

The following summarizes acquisitions, strategic investments, and dispositions by the Company during the three years ended December 31, 1999.

1999 TRANSACTIONS

In connection with its planned divestiture of non-core operations, the Company completed the sale of certain of its non-affiliate pharmacy benefits management operations for net cash proceeds of $65.0 million and recognized a net gain of $60.6 million. In addition, the Company also completed the sale of its HMO operations in Utah, Washington, New Mexico, Louisiana, Texas and Oklahoma, as well as the sale of its two hospitals, a bill review subsidiary, a third-party administrator subsidiary and a PPO network subsidiary. For these businesses, the Company received an aggregate of $60.5 million in net cash proceeds, $12.2 million in notes receivable, $10.7 million in stocks and recognized a net loss of $9.1 million, before taxes. See Note 15 for impairment charges recognized during 1998 on certain of these dispositions.

In connection with the disposition of the HMO operation in Washington, the Company sold the Medicaid and Basic Health Plan membership and retained under a reinsurance and administrative agreement the commercial membership. At the same time, the Company entered into definitive agreements with PacifiCare of Washington, Inc. and Premera Blue Cross to transition the Company's commercial membership in Washington. The Company anticipates substantially completing the transition during the first half of 2000. The Company also entered into a definitive agreement with PacifiCare of Colorado, Inc. to transition the Company's HMO membership in Colorado. The dispositions do not have a material effect on the consolidated financial statements.

1998 TRANSACTIONS

WORKERS' COMPENSATION - In December 1997, the Company adopted a formal plan to sell its workers' compensation segment which was accounted for as discontinued operations. On December 10, 1998, the Company completed the sale of the workers' compensation segment. The net assets sold consisted primarily of investments, premiums and reinsurance receivables, and reserves for claims. The selling price was $257.1 million in cash.

Total revenues for the workers' compensation segment amounted to $560.9 million and $518.7 million in 1997 and 1996, respectively. Net income (loss) amounted to a $30.4 million loss in 1997 and income of $22.2 million in 1996 after applicable income tax benefits of $32.7 million and expense of $1.2 million, respectively.

In December 1997, the Company estimated that the loss on the disposal of the workers' compensation segment would approximate $99.0 million (net of income tax benefit of $21.0 million) which included an anticipated loss

from operations during the phase-out period from December 1997 through the date of disposal. The pre-tax loss in 1998 was an additional $30.2 million. This was offset by an increase in the rate of the tax benefit of the transaction. Accordingly, the accompanying statement of operations for the year ended December 31, 1998 does not reflect any additional net gain or loss from the disposition.

CALL CENTER OPERATIONS - In December 1998, the Company sold the clinical algorithms used in its call center operations for $36.3 million in cash, net of transaction costs, and recorded a gain of $1.2 million. In addition, the Company entered into a long-term services agreement with the buyer to provide such services to its members for a period of 10 years.

1997 TRANSACTIONS

ADVANTAGE HEALTH - On April 1, 1997, the Company completed the acquisition of Advantage Health, a group of managed health care companies based in Pittsburgh, Pennsylvania, for $12.5 million in cash. The acquisition was recorded using purchase accounting and the excess of the purchase price over the fair value of the net liabilities assumed of $19.7 million was recorded as goodwill which was being amortized on a straight-line basis over 40 years. In December 1998, the Company adjusted the carrying value of the goodwill to its estimated fair value (see Note 15). Advantage Health remains a party to long-term provider agreements with the seller.

PACC - On October 22, 1997, the Company completed the acquisitions of PACC HMO and PACC Health Plans (collectively, "PACC"), which are managed health care companies based near Portland, Oregon, for a purchase price of approximately $43.7 million in cash and $14.3 million in investments. The acquisition was recorded using purchase accounting and the excess of the purchase price over the fair value of the assets acquired was recorded as goodwill. The goodwill, in the amount of $30.2 million, is being amortized on a straight-line basis over 40 years.

FOHP - On April 30, 1997, the Company made a $51.7 million investment in FOHP, Inc. ("FOHP"). FOHP was owned by physicians, hospitals and other health care providers and was the sole shareholder of First Option Health Plan of New Jersey, Inc. ("FOHP-NJ"), a managed health care company. The Company's initial investment was in the form of FOHP debentures convertible up to 71 percent of FOHP's outstanding equity at the Company's discretion. As of December 1, 1997, the Company converted these initial FOHP debentures into 71 percent of FOHP's equity. Additionally, effective December 8, 1997, FOHP issued an additional $29.0 million of convertible debentures to the Company which immediately converted approximately $18.9 million of these debentures into an additional 27 percent of FOHP's outstanding equity increasing FHS' equity holding in FOHP to approximately 98 percent. Goodwill of $98.9 million was recorded as a result of these transactions and is being amortized on a straight-line basis over 40 years. On December 31, 1997, the Company purchased nonconvertible debentures in the amount of $24 million from FOHP. On December 31, 1998, the Company converted approximately $1.2 million of its remaining principal amount of convertible debentures of FOHP into common stock of FOHP. Effective July 30, 1999, the Company purchased the remaining .4% minority interests in FOHP.

PHYSICIANS HEALTH SERVICES - On December 31, 1997, the Company completed the acquisition of Physicians Health Services, Inc. ("PHS"), a group of managed health care companies based in Shelton, Connecticut. The Company paid approximately $265 million for the approximately nine million PHS shares then outstanding and caused PHS to cash-out approximately $6 million in PHS employee stock options as part of the acquisition. The acquisition has been recorded using purchase accounting and the excess of the purchase price over the fair value of the assets acquired was recorded as goodwill. The goodwill, in the amount of $218.9 million, is being amortized on a straight-line basis over 40 years.

CHRISTIANIA GENERAL INSURANCE CORPORATION - On May 14, 1997, the Business Insurance Group, Inc., then a subsidiary of the Company, acquired the Christiania General Insurance Corporation of New York ("CGIC") for $12.7 million in cash. The acquisition has been recorded using purchase accounting and the excess of the purchase price over the fair value of the assets acquired was recorded as goodwill. The goodwill, in the amount of $5.2 million, was being amortized on a straight-line basis over 20 years. As previously discussed, the workers' compensation segment is reported as discontinued operations and includes CGIC. The remaining goodwill was reflected in the calculation of the net loss on the sale of this segment.

The following table reflects unaudited pro forma combined results of operations of the Company and Advantage Health, PACC, FOHP, PHS, and CGIC on the basis that the acquisitions had taken place at the beginning of the year ended December 31, 1997 (in thousands, except per share data):

	1997
Total revenues	$8,144,406
Loss from continuing operations	(176,589)
Net loss	(295,746)
Basic and diluted loss per share:	
Continuing operations	(1.43)
Net	(2.39)

NOTE 4 - INVESTMENTS

As of December 31, the amortized cost, gross unrealized holding gains and losses and fair value of the Company's available-for-sale investments were as follows (amounts in thousands):

	1999			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
Asset-backed securities	$116,628	$ 5	$(1,600)	$115,033
U.S. government and agencies	98,998	13	(1,645)	97,366
Obligations of states and other political subdivisions	138,830	10	(833)	138,007
Corporate debt securities	69,602	8	(1,209)	68,401
Other securities	37,808	8	(20)	37,796
	$461,866	$ 44	$(5,307)	$456,603

	1998			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
Asset-backed securities	$135,819	$2,120	$ (39)	$137,900
U.S. government and agencies	59,527	1,385	(48)	60,864
Obligations of states and other political subdivisions	181,464	2,964	(17)	184,411
Corporate debt securities	57,468	1,539	(36)	58,971
Other securities	79,409	209	(23)	79,595
	513,687	8,217	(163)	521,741
Equity securities	22,103	-	(18,762)	3,341
	$535,790	$8,217	$(18,925)	$525,082

At December 31, 1999, the contractual maturities of the Company's available-for-sale investments were as follows (in thousands):

	Cost	Estimated Fair Value
Due in one year or less	$ 101,865	$101,847
Due after one year through five years	252,165	249,068
Due after five years through ten years	56,323	54,846
Due after ten years	51,513	50,842
Total available for sale	$ 461,866	$456,603

Proceeds from sales and maturities of investments available for sale during 1999 were $642.2 million, resulting in realized gains and losses of $.7 million and $.1 million, respectively. Proceeds from sales and maturities of investments available for sale during 1998 were $727.4 million, resulting in realized gains and losses of $3.6 million and $0.3 million, respectively. Proceeds from sales and maturities of investments available for sale during 1997 were $597.7 million, resulting in realized gains and losses of $4.7 million and $0.1 million, respectively.

NOTE 5 - PROPERTY AND EQUIPMENT

Property and equipment comprised the following at December 31 (amounts in thousands):

	1999	1998
Land	$ 20,645	$ 25,195
Construction in progress	18,930	17,824
Buildings and improvements	111,936	157,056
Furniture, equipment and software	473,042	533,897
	624,553	733,972
Less accumulated depreciation	343,824	388,703
	$280,729	$345,269

See Notes 14 and 15 for impairment charges and write-offs recognized during **1998.**

NOTE 6 - NOTES PAYABLE, CAPITAL LEASES AND OTHER FINANCING ARRANGEMENTS

Notes payable, capital leases and other financing arrangements comprised the following at December 31 (amounts in thousands):

	1999	1998
Revolving credit facility, variable interest at LIBOR plus 1.50% at December 31, 1999, unsecured	$1,039,250	$1,225,000
Note payable, due December 2000, interest at 7.95%, unsecured	-	10,500
Note payable to California Wellness Foundation, due quarterly with a balloon payment due 2006, variable interest of 2.5% above 3 year Treasury Note auction rate, 8.16% at December 31, 1998 secured by a cash collateral pledge	-	17,646
Capital leases and other notes payable	1,358	2,892
Total notes payable and capital leases	1,040,608	1,256,038
Notes payable and capital leases-current portion	1,256	1,760
Notes payable and capital leases-noncurrent portion	$1,039,352	$1,254,278

REVOLVING CREDIT FACILITY

The Company established in July 1997, a $1.5 billion credit facility (the "Credit Facility") with Bank of America (as Administrative Agent for the Lenders thereto, as amended in April, July, and November 1998 and March 1999 (the "Amendments")). All previous revolving credit facilities were terminated and rolled into the Credit Facility. At the election of the Company, and subject to customary covenants, loans are initiated on a bid or committed basis and carry interest at offshore or domestic rates, at the applicable LIBOR Rate plus margin or the bank reference rate. Actual rates on borrowings under the Credit Facility vary, based on competitive bids and the Company's unsecured credit rating at the time of the borrowing. These rates were 7.19% and 6.19% at December 31, 1999 and 1998, respectively. Under the Amendments, the Company's public issuer rating becomes the exclusive means of setting the facility fee and borrowing rates under the Credit Facility. In addition, certain covenants including financial covenants were amended. The Credit Facility is available for five years, until July 2002, but it may be extended under certain circumstances for two additional years. The weighted average annual interest rate on the Company's notes payable and capital leases was approximately 6.78%, 6.30% and 6.24% for the years ended December 31, 1999, 1998 and 1997. The maximum amount outstanding under the Credit Facility during 1999 was $1.225 billion and maximum commitment level is $1.369 billion at December 31, 1999.

As of December 31, 1999, the Company was in compliance with the financial covenants of the Credit Facility, as amended in March 1999. The Company may be restricted from paying dividends under certain circumstances from time to time under this Credit Facility.

Scheduled principal repayments on notes payable, capital leases and other financing arrangements for the next five years are as follows (in thousands):

2000	$1,256
2001	19
2002	1,039,333

2003	-
2004	-
Thereafter	-
Total notes payable and capital leases	$1,040,608

NOTE 7 - STOCK OPTION AND EMPLOYEE STOCK PURCHASE PLANS

The Company has various stock option plans which cover certain employees, officers and non-employee directors, and employee stock purchase plans under which substantially all full-time employees of the Company are eligible to participate. The stockholders have approved these plans except for the 1998 Stock Option Plan which was adopted by the Company's Board of Directors.

Under the 1989, 1990, 1991, 1992, 1993, 1997 and 1998 employee stock option plans and the non-employee director stock option plans, the Company grants options at prices at or above the fair market value of the stock on the date of grant. The options carry a maximum term of up to 10 years and in general vest ratably over three to five years. The Company has reserved a total of 23.2 million shares of its Class A Common Stock for issuance under the stock option plans.

Under the 1997 Employee Stock Purchase plans, the Company provides employees with the opportunity to purchase stock through payroll deductions. Eligible employees may purchase on a monthly basis the Company's Class A Common Stock at 85% of the lower of the market price on either the first or last day of each month.

Stock option activity and weighted average exercise prices for the years ended December 31 are presented below:

	1999		1998		1997	
	Number of Options	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
Outstanding at January 1	13,418,473	$20.87	9,636,831	$29.94	7,051,940	$27.75
Granted	785,549	12.62	8,021,018	14.05	3,912,040	32.18
Exercised	(5,000)	14.50	(514,064)	18.64	(830,021)	22.66
Canceled	(1,914,605)	19.93	(3,725,312)	30.28	(497,128)	28.61
Outstanding at December 31	12,284,417	$20.47	13,418,473	$20.87	9,636,831	$29.94
Exercisable at December 31	4,824,708		4,140,362		5,116,533	

The following table summarizes the weighted average exercise price and weighted average remaining contractual life for significant option groups outstanding at December 31, 1999:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$6.63 - $10.84	710,000	9.06	$10.14	69,666	$10.65
11.50 - 12.94	5,775,185	5.10	12.91	428,031	12.91
13.00 - 32.50	4,900,732	6.71	27.35	3,428,511	28.29
34.69 - 52.81	898,500	5.29	39.74	898,500	39.74
$6.63 - $52.81	12,284,417	5.98	$20.47	4,824,708	$28.80

The weighted average fair value for options granted during 1999, 1998 and 1997 was $6.10, $6.00 and $9.95, respectively. The fair values were estimated using the Black-Sholes option-pricing model. The following weighted average assumptions were used in the fair value calculation for 1999, 1998 and 1997, respectively: (i) risk-free interest rate of 6.31%, 4.57% and 5.71%; (ii) expected option lives of 3.9 years, 4.6 years and 3.7 years; (iii) expected volatility for both options and employee purchase rights of 55.7%, 44.5% and 30.0%; and (iv) no expected dividend yield.

The Company applies APB Opinion No. 25 and related Interpretations in accounting for its plans. Accordingly, no compensation cost has been recognized for its stock option or employee stock purchase plans. Had compensation cost for the Company's 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, the Company's net income and earnings per share would have been reduced to the pro forma amounts indicated below for the years ended December 31 (amounts in thousands, except per share data):

		1999	1998	1997
Net income (loss)	As reported	$142,365	$(165,158)	$(187,084)
	Pro forma	132,043	(171,022)	(193,638)
Basic earnings (loss) per share	As reported	1.16	(1.35)	(1.52)
	Pro forma	1.08	(1.40)	(1.57)
Diluted earnings (loss) per share	As reported	1.16	(1.35)	(1.52)
	Pro forma	1.08	(1.40)	(1.56)

On December 4, 1998, options representing approximately 1.9 million shares of stock granted during 1990 through 1997 at exercise prices ranging from $11.70 to $35.25 were exchanged for options representing approximately 1.4 million shares of stock at an exercise price of $12.94, which was the fair market value of the underlying shares on the grant date.

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.

NOTE 8 - CAPITAL STOCK

The Company has two classes of Common Stock. The Company's Class B Common Stock has the same economic benefits as the Company's Class A Common Stock but is non-voting. Upon the sale or transfer of shares of Class B Common Stock by the California Wellness Foundation (the "CWF") to an unrelated third party, such shares automatically convert into Class A Common Stock. The CWF is the only holder of record of the Company's Class B Common Stock.

PUBLIC OFFERING

On May 15, 1996, the Company completed a public offering in which the Company sold 3,194,374 shares of Class A Common Stock and the CWF sold 6,386,510 shares of Class A Common Stock (constituting 6,386,510 shares of Class B Common Stock which automatically converted into shares of Class A Common Stock upon the sale) for a per share purchase price to the public of $30.00 (the "Offering"). The proceeds received by the Company from the sale of the 3,194,374 shares of Class A Common Stock were approximately $92.4 million after deducting underwriting discounts and commissions and estimated expenses of the Offering payable by the Company. The Company used its net proceeds from the Offering to repurchase 3,194,374 shares of Class A Common Stock from certain Class A Stockholders. The Company repurchased these shares of Class A Common Stock from the Class A Stockholders at $30.00 per share less transaction costs associated with the Offering, amounting to $1.08 per share. All of these 3,194,374 shares of Class A Common Stock repurchased are currently held in treasury. The Company did not receive any of the proceeds from the sale of shares of Class A Common Stock in the Offering by the CWF.

On June 27, 1997, the Company redeemed 4,550,000 shares of Class B Common Stock from the CWF at a price of $24.469 per share. The Company provided its consent to permit the CWF to sell 3,000,000 shares of Class B Common Stock to an unrelated third party in June of 1997 and the CWF had the right to sell an additional 450,000 shares of Class B Common Stock to unrelated third parties, which it did throughout August of 1997. On November 6, 1997, the Company also provided its consent to permit the CWF to sell 1,000,000 shares of Class B Common Stock to unrelated third parties. In addition, on June 1, 1998, the Company gave its consent to permit the CWF to sell (and on June 18, 1998, the CWF sold) 5,250,000 shares of Class B Common Stock to unrelated third parties. In 1999, the CWF sold 2,909,600 shares of Class B Common Stock to unrelated third parties. Pursuant to the Company's Certificate of Incorporation, all of such shares of Class B Common Stock automatically converted into shares of Class A Common Stock in the hands of such third parties.

SHAREHOLDER RIGHTS PLAN

On May 20, 1996, the Board of Directors of the Company declared a dividend distribution of one right (a "Right") for each outstanding share of the Company's Class A Common Stock and Class B Common Stock (collectively, the "Common Stock"), to stockholders of record at the close of business on July 31, 1996 (the "Record Date"). The Board of Directors of the Company also authorized the issuance of one Right for each share of Common Stock issued after the Record Date and prior to the earliest of the Distribution Date (as defined below), the redemption of the Rights, and the expiration of the Rights and in certain other circumstances. Rights will attach to all Common Stock certificates representing shares then outstanding and no separate Rights Certificates will be distributed. Subject to certain exceptions contained in the Rights Agreement, the Rights will separate from the Common Stock in the event any person acquires 15% or more of the outstanding Class A Common Stock, the Board of Directors of the Company declares a holder of 10% or more of the outstanding Class A Common Stock to be an "Adverse Person," or any person commences a tender offer for 15% of the Class A Common Stock (each event causing a "Distribution Date").

Except as set forth below and subject to adjustment as provided in the Rights Agreement, each Right entitles its registered holder, upon the occurrence of a Distribution Date, to purchase from the Company one one-thousandth of a share of Series A Junior Participating Preferred Stock, at a price of $170.00 per one-thousandth share. However, in the event any person acquires 15% or more of the outstanding Class A Common Stock, or the Board of Directors of the Company declares a holder of 10% or more of the outstanding Class A Common Stock to be an "Adverse Person," the Rights (subject to certain exceptions contained in the Rights Agreement) will instead become exercisable for Class A Common Stock having a market value at such time equal to

$340.00. The Rights are redeemable under certain circumstances at $.01 per Right and will expire, unless earlier redeemed, on July 31, 2006.

In connection with the FHS Combination, the Company entered into Amendment No. 1 to the Rights Agreement to exempt the FHS Combination and related transactions from triggering the Rights. In addition, the amendment modified certain terms of the Rights Agreement applicable to the determination of certain "Adverse Persons," which modifications became effective upon consummation of the FHS Combination.

NOTE 9 - EMPLOYEE BENEFIT PLANS

DEFINED CONTRIBUTION RETIREMENT PLANS

The Company and certain subsidiaries sponsor defined contribution retirement plans intended to qualify under Section 401(a) and 401(k) of the Internal Revenue Code of 1986, as amended (the "Code"). Participation in the plans is available to substantially all employees who meet certain eligibility requirements and elect to participate. Employees may contribute up to the maximum limits allowed by Sections 401(k) and 415 of the Code, with Company contributions based on matching or other formulas. The Company's expense under the plans totaled $7.8 million, $7.4 million and $4.2 million for the years ended December 31, 1999, 1998 and 1997, respectively.

DEFERRED COMPENSATION PLANS

Effective May 1, 1998, the Company adopted a deferred compensation plan pursuant to which certain management and highly compensated employees are eligible to defer between 5% and 50% of their regular compensation and between 5% and 100% of their bonuses, and non-employee Board members are eligible to defer up to 100% of their directors compensation. The compensation deferred under this plan is credited with earnings or losses measured by the mirrored rate of return on investments elected by plan participants. Each plan participant is fully vested in all deferred compensation and earnings credited to his or her account. At December 31, 1999, the employee deferrals were invested through a trust.

Prior to May 1997, certain members of management, highly compensated employees and non-employee Board members were permitted to defer payment of up to 90% of their compensation under a prior deferred compensation plan (the "Prior Plan"). As part of the FHS Combination, the Prior Plan was frozen in May 1997 at which time each participant's account was credited with three times the 1996 Company match (or a lesser amount for certain participants) and each participant became 100% vested in all such contributions. The current provisions with respect to the form and timing of payments under the Prior Plan remain unchanged. At December 31, 1999 and 1998, the liability under these plans amounted to $20.9 million and $27.9 million, respectively. The Company's expense under this plan totaled $5.6 million, $6.1 million and $7.8 million for the years ended December 31, 1999, 1998 and 1997, respectively.

PENSION AND OTHER POSTRETIREMENT BENEFIT PLANS

RETIREMENT PLANS - In 1992, the Company adopted a non-qualified Supplemental Executive Retirement Plan (the "Prior SERP"). Certain key executives were eligible to participate in the Prior SERP. Under the provisions of the Prior SERP, these executives could elect to credit amounts to the Prior SERP in lieu of compensation. The annual amount so credited was equal to 50% of the premium that would be required to fund a premium variable life insurance policy. The Company then credited the executives SERP account with the remaining 50% premium. The amounts contributed under this plan are credited with earnings or losses measured by the mirrored rate of return on investments elected by plan participants. Upon death, prior to retirement or termination, beneficiaries are entitled to receive the entire death benefit under the policy plus an additional 78.5% of policy benefits. At retirement or termination, the executive is entitled to the cash surrender value of the policy (up to the value of the executive's account) plus an additional 78.5% of the value of the executive's account. The retirement or termination benefit must be paid to the executive in a lump sum. This Prior SERP was discontinued in December 1995.

In 1995, the Company adopted two unfunded non-qualified defined benefit pension plans, a Supplemental Executive Retirement Plan and a Directors' Retirement Plan (collectively, the "FHC SERPs"). The Company has two additional unfunded non-qualified defined benefit pension plans, a Supplemental Executive Retirement Plan (adopted in 1996) and a Directors' Retirement Plan (collectively, the "HSI SERPs"). These plans cover key executives, as selected by the Board of Directors, and non-employee directors. Benefits under the plans are based on years of service and level of compensation.

As part of the FHS Combination, the FHC SERPs were frozen in April 1997 at which time each participant became 100% vested in his or her benefits under the plans which are equal to 90% of the actuarial equivalent of the participant's retirement benefit as of December 31, 1996. All benefits under the FHC SERPs were paid out either in cash, or as a rollover to the FHS deferred compensation plan.

POSTRETIREMENT HEALTH AND LIFE PLANS - Certain subsidiaries of the Company sponsor postretirement defined benefit health care plans that provide postretirement medical benefits to directors, key executives, employees and dependents who meet certain eligibility requirements. Under these plans, the Company pays a percentage of the costs of medical, dental and vision benefits during retirement. The plans include certain cost-sharing features such as deductibles, co-insurance and maximum annual benefit amounts which vary based principally on years of credited service.

On December 31, 1998, the Company adopted SFAS No. 132 "Employers' Disclosures about Pension and Other Postretirement Benefits" ("SFAS No. 132"), which revises employers' disclosures about pension and other postretirement benefit plans. SFAS No. 132 standardizes the disclosure requirements. The Company has chosen to disclose the information required by SFAS No. 132 by aggregating retirement plans into one category and postretirement plans into another category.

The following table sets forth the plans' funded status and amounts recognized in the Company's financial statements (amounts in thousands):

	Pension Benefits		Other Benefits	
	1999	1998	1999	1998
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 15,103	$ 8,078	$ 4,060	$ 5,527
Service cost	1,762	1,525	603	356
Interest cost	989	756	324	252
Plan amendments	-	1,501	-	(777)
Benefits paid	(1,112)	(262)	(94)	(209)
Actuarial loss (gain)	(4,455)	3,505	613	(1,089)
Projected benefit obligation, end of year	$ 12,287	$ 15,103	$ 5,506	$ 4,060
Change in fair value of plan assets:				
Plan assets, beginning of year	$ -	$ -	$ -	$ -
Employer contribution	1,112	262	21	138
Benefits paid	(1,112)	(262)	(21)	(138)
Plan assets, end of year	$ -	$ -	$ -	$ -
Funded status of plans	$(12,287)	$(15,103)	$ (5,506)	$ (4,060)
Unrecognized prior service cost	4,969	5,442	(211)	(217)
Unrecognized (gain) loss	(3,338)	1,220	(1,645)	(2,316)
Net amount recognized	$(10,656)	$ (8,441)	$ (7,362)	$ (6,593)
Amounts recognized in the consolidated balance sheet:				
Accrued benefit liability	$(10,656)	$(10,161)	$ (7,362)	$ (6,593)
Intangible asset	-	1,720	-	-
Net amount recognized	$(10,656)	$ (8,441)	$ (7,362)	$ (6,593)

The components of net periodic benefit costs for the years ended December 31, 1999, 1998 and 1997 are as follows (amounts in thousands):

	Pension Benefits			Other Benefits		
	1999	1998	1997	1999	1998	1997
Service cost	$1,762	$1,525	$1,122	$603	$356	$ -
Interest cost	989	756	418	324	252	86
Amortization of transition obligation	-	-	-	-	-	10
Amortization of prior service cost	474	308	293	(6)	(8)	37
Amortization of unrecognized (gain) loss	103	72	(17)	(58)	(115)	(6)

	3,328	2,661	1,816	863	485	127
Cost of subsidiary plan curtailment	-	1,896	-	-	(13)	531
Net periodic benefit cost	$3,328	$4,557	$1,816	$863	$472	$ 658

The weighted average annual discount rate assumed was 7.75% and 6.75% for the years ended December 31, 1999 and 1998, respectively, for both pension plan benefit plans and other postretirement benefit plans. Weighted average compensation increases of between 2% to 6% for the years ended December 31, 1999 and 1998, respectively, were assumed for the pension benefit plans.

For measurement purposes, depending upon the type of coverage offered, a 6% annual rate of increase in the per capita cost covered health care benefits was assumed for 1999, and 6.25% was assumed for 1998. These rates were assumed to decrease gradually to 4.5% in 2006 for 1999 and between 4.5% and 6.0% in 2005 for 1998.

The Company has multiple postretirement medical benefit plans. The Company acquired PACC effective September 30, 1997, including its frozen postretirement benefit plan. The PACC plan is non-contributory. The FHC plan is contributory by certain participants. The account for the FHC plan anticipates future cost-sharing changes to the plan consistent with the Company's expressed intent to increase retiree contributions at the same rates as the Company's premium increases. The Health Net plan is non-contributory for employees retired prior to December 1, 1995 who have attained the age of 62; employees retiring after December 1, 1995 who have attained age 62 contribute from 25% to 100% of the cost of coverage depending upon years of service.

A one-percentage-point change in assumed health care cost trend rates would have the following effects (amounts in thousands):

	1-percentage point increase	1-percentage point decrease
Effect on total of service and interest cost, 1999	$ 249	$(182)
Effect on postretirement benefit obligation, 12/31/99	1,171	(887)

The Company has no minimum pension liability adjustment to be included in comprehensive income.

PERFORMANCE-BASED ANNUAL BONUS PLAN

In 1998, the Company adopted a Performance-Based Annual Bonus Plan that qualified under Section 162(m) of the Code (the "162(m) Plan"). Under the 162(m) Plan, if the Company achieved greater than $250 million in consolidated income from operations before taxes (as determined under GAAP consistently applied, excluding any non-recurring or extraordinary charges), certain executives were potentially eligible to receive cash bonuses from a pool of $7.5 million based on the executives' salaries in relation to the pool. Amounts payable to such executives from such pool were subject to downward adjustment by the Company's Compensation and Stock Option Committee of the Board of Directors. The $250 million performance goal for the 162(m) Plan was not met for 1999. This existing 162(m) Plan will terminate effective December 31, 1999 in the event stockholder approval of a new Management Incentive Plan is received at the Company's 2000 Annual Stockholders Meeting.

NOTE 10 - INCOME TAXES

Significant components of the provision (benefit) for income taxes are as follows for the years ended December 31 (amounts in thousands):

	1999	1998	1997
Current:			
Federal	$ 29,080	$ 6,346	$(12,894)
State	(6,448)	3,897	3,183
Total current	22,632	10,243	(9,711)

Deferred:			
Federal	52,419	(121,800)	(57,150)
State	21,175	(7,630)	(5,478)
Total deferred	73,594	(129,430)	(62,628)
Total provision (benefit) for income taxes	$ 96,226	$(119,187)	$(72,339)

Income tax expense (benefit) is included in the consolidated financial statements as follows for the years ended December 31 (amounts in thousands):

	1999	1998	1997
Continuing operations	$ 96,226	$ (88,996)	$(21,418)
Discontinued operations	-	(30,191)	(50,921)
Total provision (benefit) for income taxes	$ 96,226	$(119,187)	$(72,339)

A reconciliation of the statutory federal income tax rate and the effective income tax rate on income from continuing operations is as follows for the years ended December 31:

	1999	1998	1997
Statutory federal income tax rate	35%	(35)%	(35)%
State and local taxes, net of federal income tax effect	4	(1)	(3)
Tax exempt interest income	(1)	(1)	(2)
Goodwill amortization	3	6	6
Valuation allowance adjustment	-	-	(2)
Examination settlements	(2)	-	-
Merger transaction costs	-	(3)	8
Other, net	-	(1)	4
Effective income tax rate	39%	(35)%	(24)%

Significant components of the Company's deferred tax assets and liabilities as of December 31 are as follows (amounts in thousands):

	1999	1998
DEFERRED TAX ASSETS:		
Accrued liabilities	$ 52,491	$ 91,993
Insurance loss reserves and unearned premiums	6,144	3,616
Tax credit carryforwards	8,059	-
Accrued compensation and benefits	33,838	31,097
Restructuring reserves	4,025	30,462
Net operating loss carryforwards	165,023	190,913
Other	16,363	5,667
Deferred tax assets before valuation allowance	285,943	353,748
Valuation allowance	(47,092)	(48,452)
Net deferred tax assets	$238,851	$305,296
DEFERRED TAX LIABILITIES:		
Depreciable and amortizable property	$ 35,388	$ 26,077
Other	50	14
Deferred tax liabilities	$ 35,438	$ 26,091

In 1998 and 1997, income tax benefits attributable to employee stock option transactions of $6.3 million and $4.5 million, respectively, were allocated to stockholders' equity. No income tax benefits were allocated to stockholders' equity during 1999.

As of December 31, 1999, the Company had federal and state net operating loss carryforwards of approximately $439.9 million and $246.2 million, respectively. The net operating loss carryforwards expire between 2001 and 2019. Limitations on utilization may apply to approximately $111.2 million and $143.4 million of the federal and state net operating loss carryforwards, respectively. Accordingly, valuation allowances have been provided to account for the potential limitations on utilization of these tax benefits. The valuation allowance decrease of $1.4 million in 1999 was due primarily to utilization of state net operating loss carryforwards. Of the $47.1 million (tax effected) remaining valuation allowance, $45.4 million, pertains primarily to an acquired subsidiary's deferred tax assets. In the event that any portion of the deferred tax assets related to this subsidiary is realized, the future tax benefits will be allocated to reduce the associated goodwill.

NOTE 11 - REGULATORY REQUIREMENTS

All of the Company's health plans as well as its insurance subsidiaries are required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended, California plans must comply with certain minimum capital or tangible net equity requirements. The Company's non-California health plans, as well as its health and life insurance companies, must comply with their respective state's minimum regulatory capital requirements and in certain cases, maintain minimum investment amounts for the restricted use of the regulators which as of December 31, 1999 totaled $84.7 million. Also, under certain government regulations, certain subsidiaries are required to maintain a current ratio of 1:1 and to meet other financial standards.

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. Management believes that as of December 31, 1999, substantially all of the Company's health plans and insurance subsidiaries met their respective regulatory requirements.

NOTE 12 - COMMITMENTS AND CONTINGENCIES

LEGAL PROCEEDINGS

In July 1996, the Company's predecessor, HSI, the owner of 1,234,544 shares of Series F Preferred Stock of Health Data Sciences Corporation ("HDS"), voted its HDS shares in favor of the acquisition of HDS by Medaphis Corporation ("Medaphis"). HSI received as the result of the acquisition 976,771 shares of Medaphis common stock in exchange for its Series F Preferred Stock. In November 1996, HSI filed a lawsuit against Medaphis and its former Chairman and Chief Executive Officer. The Company alleged that Medaphis and certain insiders deceived the Company by presenting materially false financial statements and by failing to disclose that Medaphis would shortly reveal a "write off" of up to $40 million in reorganization costs and would lower its earnings estimate for the following year, thereby more than halving the value of the Medaphis shares received by the Company.

In September 1999, the Company and Medaphis (which changed its name to Per-Se Technologies, Inc. ("Per-Se")) entered into a Settlement Agreement and Release pursuant to which the Company received net proceeds of approximately $25 million consisting of cash from Per-Se and Per-Se's insurers and proceeds from the sale of both the 976,771 shares of Medaphis (now Per-Se) common stock then owned by the Company and additional shares of Per-Se common stock issued to the Company as part of the settlement. In exchange, the Company and Per-Se terminated the ongoing litigation and granted each other a general release. The gain recognized in the consolidated statement of operations as of December 31, 1999 was immaterial.

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 at various times between February 3, 1997 and May 15, 1998. The complaints allege that the Company and certain former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between the Company and FPA, about FPA's business and about the Company's 1997 sale of FPA common stock held by the Company. Based in part on advice from litigation counsel to the Company and upon information presently available, management believes these suits are without merit and intends to vigorously defend the actions.

In November 1999, a complaint was filed seeking certification of a nationwide class action and alleging that cost containment measures used by FHS-affiliated health maintenance organizations, preferred provider organizations and point-of-service health plans violate provisions of the federal Racketeer Influenced and Corrupt Organizations Act and the federal Employee Retirement Income Security Act ("ERISA"). The action seeks unspecified damages and injunctive relief. In January 2000, the court stayed the case pending resolution of matters in an action pending against one of the Company's competitors. Based in part on advice from litigation counsel to the Company and upon information presently available, management believes this suit is without merit and intends to vigorously defend the action.

In September 1983, a lawsuit was filed by Baja, Inc. ("Baja") against a hospital that was subsequently acquired by the Company in October 1992. The lawsuit arose out of a multi-phase written contract for operation of a pharmacy at the hospital during the period September 1978 through September 1983. In August 1993, Baja was awarded $549,532 on a portion of its claim. In July 1995, Baja was awarded an additional $1,015,173 plus interest in lost profits damages. In October 1995, both parties appealed the decision and portions of the judgment were reversed. In January 2000, after further proceedings on the issue of Baja's lost profits, Baja was awarded an additional $4,996,019 plus pre-judgment interest. The Company is in the process of preparing appropriate post-trial motions in this case, and is also considering an appeal of the final judgment. Such costs have been accrued and recorded in the consolidated financial statements.

In December 1999, one of the Company's subsidiaries was sued by the Attorney General of Connecticut on behalf of a group of state residents. The lawsuit is premised on ERISA, and alleges that the Company has violated its duties under that act and seeks to have the Company revamp its formulary system, and to provide patients with written denial notices and instructions on how to appeal. The Company intends to defend the lawsuit vigorously, and has filed a motion to dismiss which asserts that the state residents all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that the Attorney General's office lacks standing to bring the suit, and that the allegations fail to state a claim under ERISA. A decision is expected in the second quarter of 2000.

The Company is involved in various other legal proceedings, which are routine in its business.

Based in part on advice from litigation counsel to the Company and upon information presently available, the resolution of all of the above matters should not have a material adverse effect on the financial position or results of operations of the Company.

OPERATING LEASES

The Company leases administrative and medical office space under various operating leases. Certain medical office space is subleased to participating medical groups doing business with the Company. Certain leases contain renewal options and rent escalation clauses.

In 1995, the Company entered into a $60 million tax retention operating lease with NationsBank of Texas, N.A., as Administrative Agent for the Lenders who are parties thereto, and First Security Bank of Utah, N.A., as Owner Trustee, (the "TROL Agreement") for the construction of health care centers and a corporate facility. Under the TROL Agreement, rental payments commenced upon completion of construction, with a guarantee of 87% to the lessor of the residual value of properties leased at the end of the lease term. After the initial five year noncancelable lease term, the lease may be extended by agreement of the parties or the Company must purchase or arrange for sale of the leased properties. The Company has committed to a maximum guaranteed residual value of $30.8 million under this agreement at December 31, 1999.

Future minimum lease commitments for noncancelable operating leases at December 31, 1999 are as follows (amounts in thousands):

2000	$ 44,440
2001	37,969
2002	23,411
2003	13,349
2004	7,656
Thereafter	6,224
Total minimum lease commitments	$133,049

Rent expense totaled $49.0 million, $50.3 million and $48.7 million in 1999, 1998 and 1997, respectively.

NOTE 13 - RELATED PARTIES

Two current directors of the Company and one prior director are partners in law firms which received legal fees totaling $1.2 million, $1.0 million, and $1.1 million in 1999, 1998, and 1997, respectively. One current director is an officer of IBM which the Company paid $9.0 million and $8.0 million for services in 1999 and 1998, respectively, and one current director is also a director of a temporary staffing company which the Company paid $11.0 million and $20.4 million in 1999 and 1998, respectively. An officer of a contracted hospital was also a member of the Company's Board of Directors until April 1, 1997. Medical costs paid to the hospital totaled $67.1 million in 1997. Such contracted hospital is also an employer group of the Company from which the Company receives premium revenues at standard rates.

A director of the Company was paid an aggregate of $95,000 in consulting fees in 1999 and 2000 due to various services provided to the Company in connection with the closing of its operations in Pueblo,Colorado (see Note 15). In addition, two of this director's law firm partners purchased a building from the Company in Pueblo,Colorado, for $405,000 in 1999.

During 1998, three executive officers of the Company, in connection with their hire or relocation, received one-time loans from the Company aggregating $775,000 which ranged from $125,000 to $400,000 each. The loans accrue interest at the prime rate and each is payable upon demand by the Company in the event of a voluntary termination of employment of the respective officer or termination for cause. During 1999, three executive officers of the Company, in connection with their hire or relocation, received one-time loans from the Company aggregating $550,000 which ranged from $100,000 to $300,000 each. The loans accrue interest at the prime rate and each is payable upon demand by the Company in the event of a voluntary termination of employment of the respective officer or termination for cause.

The principal and interest of the loans will be forgiven by the Company at varying times between one and five years after the date of hire or relocation of the respective officers. As of December 31, 1999 a portion of a loan to one executive officer was forgiven for $83,000 and the aggregate outstanding principal balance of the six loans was $1,242,000.

NOTE 14 - ASSET IMPAIRMENT, MERGER, RESTRUCTURING AND OTHER CHARGES

The following sets forth the principal components of asset impairment, merger, restructuring and other costs for the years ended December 31 (amounts in millions):

	1999	1998	1997
Severance and benefit related costs	$17.2	$ 21.2	$ 61.4
Provider network consolidation costs	-	-	36.2
Real estate lease termination costs	0.8	-	7.9
Asset impairments and other charges related to FPA Medical Management	-	84.1	-
Asset impairment and other costs	6.2	112.4	44.0
Merger related costs	-	-	69.6
Gem costs	-	-	57.5
Other costs	1.7	22.4	12.6
	25.9	240.1	289.2
Modifications to prior year restructuring plans	(14.2)	-	(2.7)
Total	$11.7	$ 240.1	$286.5

1999 CHARGES

The following tables summarize the 1999 charges by quarter and by type (amounts in millions):

	1999 Charges	1999 Modifications to Estimate	Net 1999 Charges	1999 Activity Cash Payments	1999 Activity Non-Cash	Balance at December 31, 1999	Expected Future Cash Outlays
Severance and benefit related costs	$18.5	$(1.3)	$17.2	$ (8.6)	-	$8.6	$ 8.6
Asset impairment costs	6.2	-	6.2	-	$ (6.2)	-	-
Real estate lease termination costs	0.8	-	0.8	(0.8)	-	-	-
Other costs	1.8	(0.1)	1.7	(1.4)	-	0.3	0.3
Total	$27.3	$(1.4)	$25.9	$(10.8)	$ (6.2)	$8.9	$8.9
First Quarter 1999 Charge	$21.1	$(1.4)	$19.7	$(10.8)	-	$8.9	$ 8.9
Fourth Quarter 1999 Charge	6.2	-	6.2	-	(6.2)	-	-
Total	$27.3	$(1.4)	$25.9	$(10.8)	$ (6.2)	$8.9	$ 8.9

The Company initiated during the fourth quarter of 1998 a formal plan to dispose of certain Central Division health plans included in the Company's Health Plan Services segment in accordance with its anticipated divestitures program. In this connection, the Company announced in 1999 its plan to close the Colorado regional processing center, terminate employees and transfer its operations to the Company's other administrative facilities. In addition, the Company also announced its plans to consolidate certain administrative functions in its Northwest health plan operations. During the first and fourth quarters ended March 31, 1999 and December 31, 1999, the Company recorded pretax charges for restructuring and other charges of $21.1 million (the "1999 Charges") and $6.2 million, respectively.

SEVERANCE AND BENEFIT RELATED COSTS - The 1999 Charges included $18.5 million for severance and benefit costs related to executives and operations employees at the Colorado regional processing center and operations employees at the Northwest health plans. The operations functions include premium accounting, claims, medical management, customer service, sales and other related departments. The 1999 Charges included the termination of a total of 773 employees. As of December 31, 1999, 457 employees had been terminated and $8.6 million had been paid. Termination of the remaining 316 employees is expected to be completed during the first half of 2000. Modifications to the initial estimate of $1.3 million were recorded during 1999.

ASSET IMPAIRMENT COSTS - During the fourth quarter ended December 31, 1999, the Company recorded asset impairment costs totaling $6.2 million related to impairment of certain long-lived assets held for disposal (see Note 15).

REAL ESTATE LEASE TERMINATION AND OTHER COSTS - The 1999 Charges included $2.6 million related to termination of real estate obligations and other costs to close the Colorado regional processing center.

1998 CHARGES

The following tables summarize the 1998 charges by quarter and by type (amounts in millions):

	Activity during 1998				1999 Activity				
	1998 Charges	Cash Payments	Non-Cash	Balance at Dec. 31, 1998	Cash Payments	Non-Cash	1999 Modifications to Estimate	Balance at Dec.31, 1999	Expected Future Cash Outlays
Severance and benefit related costs	$ 21.2	$ (13.2)	$ (1.9)	$ 6.1	$ (5.0)	$ -	$ (1.0)	$ 0.1	$ 0.1
Asset impairment and other charges related to FPA	84.1	(11.0)	(63.5)	9.6	(5.6)	(3.4)	(0.6)	-	-
Asset impairment and other	112.4	-	(97.8)	14.6	(0.8)	(3.1)	(10.7)	-	-
Other costs	22.4	(2.1)	(9.6)	10.7	(1.4)	(9.0)	(0.3)	-	-
Total	$ 240.1	$ (26.3)	$ (172.8)	$ 41.0	$ (12.8)	$(15.5)	$ (12.6)	$ 0.1	$ 0.1
Second Quarter 1998 Charge	$ 50.0	$ (4.5)	$ (41.1)	$ 4.4	$ (4.4)	$ -	$ -	$ -	$ -
Third Quarter 1998 Charge	71.7	(17.1)	(33.9)	20.7	(6.6)	(12.1)	(1.9)	0.1	0.1
Fourth Quarter 1998 Charge	118.4	(4.7)	(97.8)	15.9	(1.8)	(3.4)	(10.7)	-	-
Total	$ 240.1	$ (26.3)	$ (172.8)	$ 41.0	$ (12.8)	$(15.5)	$ (12.6)	$ 0.1	$ 0.1

SEVERANCE AND BENEFIT RELATED COSTS - During the third quarter ended September 30, 1998, the Company recorded severance costs of $21.2 million related to staff reductions in selected health plans and the corporate centralization and consolidation. This plan includes the termination of 683 employees in seven geographic locations primarily relating to corporate finance and human resources functions and California operations. As of December 31, 1999, termination of employees had been completed and $20.1 million had been recorded as severance under this plan.

FPA MEDICAL MANAGEMENT - On July 19, 1998, FPA Medical Management, Inc. ("FPA") filed for bankruptcy protection under Chapter 11 of the Federal Bankruptcy Code. FPA, through its affiliated medical groups, provided services to approximately 190,000 of the Company's affiliated members in Arizona and California and also leased health care facilities from the Company. FPA has discontinued its medical group operations in these markets and the Company has made other arrangements for health care services to the Company's affiliated members. The FPA bankruptcy and related events and circumstances caused management to re-evaluate the decision to continue to operate the facilities and management determined to sell the 14 properties, subject to bankruptcy court approval. Management immediately commenced the sale process upon such determination. The

estimated fair value of the assets held for disposal was determined based on the estimated sales prices less the related costs to sell the assets. Management believed that the net proceeds from a sale of the facilities would be inadequate to enable the Company to recover their carrying value. Based on management's best

estimate of the net realizable values, the Company recorded charges totaling approximately $84.1 million. These charges were comprised of $63.0 million for real estate asset impairments, $10.0 million impairment adjustment of a note received as consideration in connection with the 1996 sale of the Company's physician practice management business and $11.1 million for other items. These other items included payments made to Arizona physician specialists totaling $3.4 million for certain obligations that FPA had assumed but was unable to pay due to its bankruptcy, advances to FPA to fund certain operating expenses totaling $3.0 million, and other various costs totaling $4.7 million. The carrying value of the assets held for disposal totaled $11.3 million at December 31, 1999. There have been no further adjustments to the carrying value of these assets held for disposal. As of December 31, 1999, 12 properties have been sold which has resulted in net gains of $5.0 million during 1999 and $3.6 million in 1998 which are included in net gains on sale of businesses and buildings. The remaining properties are expected to be sold during 2000. The suspension of real estate depreciation has an annual impact of approximately $2.0 million. The results of operations attributable to FPA real estate assets were immaterial during 1998 and 1999.

ASSET IMPAIRMENT AND OTHER CHARGES - During the fourth quarter ended December 31, 1998, the Company recorded impairment and other charges totaling $118.4 million. Of this amount, $112.4 million related to impairment of certain long-lived assets held for disposal (see Note 15) and $6 million related to the FPA bankruptcy.

OTHER COSTS - The Company recorded other costs of $22.4 million which included the adjustment of amounts due from a third-party hospital system that filed for bankruptcy which were not related to the normal business of the Company totaling $18.6 million, and $3.8 million related to other items such as fees for consulting services from one of the Company's prior executives and costs related to exiting certain rural Medicare markets.

During 1999, modifications of $12.6 million to the initial estimates were recorded. These credits to the 1998 charges included: $10.7 million from reductions to asset impairment costs and $1.9 million from reductions to initially anticipated involuntary severance costs and other adjustments.

In addition, other charges totaling $103.3 million were recorded in the third quarter ended September 30, 1998. These charges mostly related to contractual adjustments, equitable adjustments relating to government contracts, payment disputes with contracted provider groups and premium deficiency reserves and were primarily included in health care costs within the consolidated statement of operations. The Company also recorded in the fourth quarter ended December 31, 1998, $67.5 million of other charges primarily related to litigation in the normal course of business for non-core operations totaling $18.6 million and other charges totaling $48.9 million primarily related to bad debts, claims and premium deficiency reserves for certain health plans whose health care costs exceeded the contractual premiums. These charges are included as part of health plan services and SG&A expenses within the consolidated statement of operations.

1997 CHARGES

The following tables summarize the 1997 charges by quarter and by type (amounts in millions):

				Activity during 1997 and 1998	
	1997 Charge	1997 Modifications to Estimate	Net 1997 Charges	Cash Payments	Non-Cash
Severance and benefit related costs	$ 71.1	$ (9.7)	$ 61.4	$ (51.9)	$ (6.6)
Provider network consolidation costs	44.3	(8.1)	36.2	(27.7)	-
Asset impairment costs	46.0	(2.0)	44.0	(5.4)	(35.2)
Real estate lease termination costs	30.1	(22.2)	7.9	(5.0)	-
Total restructuring costs	191.5	(42.0)	149.5	(90.0)	(41.8)

Merger related costs	73.2	(3.6)	69.6	(64.8)	(4.8)
Gem costs	57.5	-	57.5	(54.0)	(3.5)
Other costs	12.6	-	12.6	-	(12.6)
Total	$ 334.8	$ (45.6)	$ 289.2	$ (208.8)	$ (62.7)
Second Quarter 1997 Charge	$ 328.8	$ (45.6)	$ 283.2	$ (205.0)	$ (60.5)
Fourth Quarter 1997 Charge	6.0	-	6.0	(3.8)	(2.2)
Total	$ 334.8	$ (45.6)	$ 289.2	$ (208.8)	$ (62.7)

	Balance at Dec. 31, 1998	1999 Activity		1999 Modifications to Estimate	Balance at Dec.31, 1999	Expected Future Cash Outlays
		Cash Payments	Non-Cash			
Severance and benefit related costs	$ 2.9	$ (2.4)	$ -	$ (0.5)	$ -	$ -
Provider network consolidation costs	8.5	(7.0)	(0.7)	(0.8)	-	-
Asset impairment costs	3.4	-	(3.3)	(0.1)	-	-
Real estate lease termination costs	2.9	(2.7)	-	(0.2)	-	-
Total restructuring costs	17.7	(12.1)	(4.0)	(1.6)	-	-
Merger related costs	-	-	-	-	-	-
Gem costs	-	-	-	-	-	-
Other costs	-	-	-	-	-	-
Total	$ 17.7	$ (12.1)	$ (4.0)	$ (1.6)	$ -	$ -
Second Quarter 1997 Charge	$ 17.7	$ (12.1)	$ (4.0)	$ (1.6)	$ -	$ -
Fourth Quarter 1997 Charge	-	-	-	-	-	-
Total	$ 17.7	$ (12.1)	$ (4.0)	$ (1.6)	$ -	$ -

RESTRUCTURING COSTS - The Company adopted a restructuring plan during the quarter ended June 30, 1997 related to the merger of Foundation Health Corporation and Health Systems International, Inc. (the "FHS Combination"), which created the Company (the "June 1997 Plan"). The principal elements of the June 1997 Plan included a workforce reduction, the consolidation of employee benefit plans, the consolidation of facilities in geographic locations where office space was duplicated, the consolidation of overlapping provider networks as required in obtaining regulatory approval for the FHS Combination, and the consolidation of information systems at all locations to standardized systems. The June 1997 Plan is substantially completed as of December 31, 1999.

During December 1997, the Company adopted a restructuring plan (the "December 1997 Plan") and recorded a $6.0 million restructuring charge related to the Company's Northeast Division health plans. The plan relates to the integration of the Company's Eastern Division operations in connection with its acquisition of PHS and FOHP in 1997.

SEVERANCE AND BENEFIT RELATED COSTS - Severance and benefit related costs of $61.4 million included a termination benefits plan and contractually required change of control payments to senior executives. The two restructuring plans during 1997 included the termination of 1,235 employees in 13 geographic locations, primarily related to duplicative claims processing functions and sale forces. As of December 31, 1999, the termination of employees had been completed and $54.3 million had been paid in severance and related benefits under these plans. Also included are changes in benefit plan costs that were primarily related to the loss incurred on curtailment and settlement of the Supplemental Executive Retirement Plan of FHC and the expense for amounts credited to participants' accounts in connection with the termination of future benefits under the FHC deferred compensation plan (see Note 9). These benefit plan actions were effected pursuant to the change of control of FHC in connection with the FHS Combination.

PROVIDER NETWORK COSTS - Asset Provider network consolidation costs of $36.2 million relate to the requirement to re-contract with many of the Company's providers in conjunction with obtaining regulatory approval from the State of California for the FHS Combination. The Company was required to resolve disputed claims with certain providers for contract releases in order to comply with the regulatory conditions of approval imposed on the Company; these costs totaled $36.2 million. Real estate lease termination costs include facilities consolidation costs primarily in geographic regions where there was overlapping office space usage.

ASSET IMPAIRMENT CHARGES - Asset impairment costs totaling $44.0 million are primarily a result of the Company's plan to be on common operating systems and hardware platforms. These costs are primarily related to software development projects that were abandoned totaling $24.6 million, hardware totaling $4.8 million, various FHC provider receivables totaling $8.8 million that the Company determined not to pursue as a result of certain regulatory approval conditions related to the FHS Combination, and various other assets totaling $5.8 million. These assets were written off since management determined that they would not be used in operations. Of the total costs of $44.0 million, approximately $31.4 million was related to the Health Plans segment, $3.8 million was related to the Government Contracts/Specialty Services segment and the remaining $8.8 million was related to Corporate functions.

The restructuring credits to the June 1997 Plan of $42.0 million were subsequently recorded in 1997 and resulted from the following: $22.2 million from the Company's determination to continue to operate certain facilities originally identified for lease termination; $9.7 million from reductions to initially anticipated involuntary severance costs; $8.1 million from reductions to certain anticipated provider network consolidation and other contract termination costs; and $2.0 million in reductions to asset impairment costs primarily related to the reclassification of workers' compensation insurance subsidiaries related charges to discontinued operations. During 1999, modifications to initial estimates of $1.6 million were recorded.

MERGER COSTS - In connection with the June 1997 Plan, $69.6 million in merger costs were recorded. The significant components of the charge include the following: $22.6 million of transaction costs, primarily consisting of investment banking, legal, accounting, filing and printing fees; $22.7 million of merger consulting costs; $5.9 million of former senior executive consulting costs; $2.4 million of directors and officers liability coverage required by the merger agreement; $9.6 million in costs related to the early retirement of FHC public debt; and $6.4 million of other merger related costs.

GEM COSTS - The Company established a premium deficiency of $57.5 million related to the Company's Gem Insurance Company ("Gem") during the year ended December 31, 1997. During the quarter ended June 30, 1997, the Company had reached a definitive agreement regarding a reinsurance transaction with The Centennial Life Insurance Company ("Centennial"). Pursuant to this agreement, Centennial was to reinsure and manage Gem's accident and health, life and annuity policies in exchange for a

reinsurance premium. The cost of the reinsurance along with the write-down of certain Gem assets that were not recoverable based on the terms of the agreement totaled $57.5 million. These costs were recorded and disclosed as reinsurance costs. During the quarter ended September 30, 1997, the transac-

tion was not ultimately consummated due to the unanticipated failure to satisfy certain closing conditions, including the failure to receive certain regulatory approvals. As a result, Gem established a reserve for the estimated premium deficiency related to these policies for the intervening period. These losses were determined by projecting premiums, health care costs and expenses by state separately for group and individual contracts (including state insurance department mandated renewals). Actual premium and health care costs were used as the basis of the projection. Expenses were projected using historically adjusted costs as a percentage of premium or per member basis. This method is consistent with the Company's manner of acquiring, servicing and measuring the profitability of its insurance contracts.

OTHER COSTS - During the quarter ended June 30, 1997, the Company recorded $12.6 million for the loss on sale of the United Kingdom operations. In addition, during the two quarters ended June 30 and December 31, 1997, $77.1 million and $32.3 million, respectively, in other costs were recorded. The significant components of the charge included the following: $30.5 million for receivables related to provider contracts that will not be renewed; $17.2 million for government receivables related to prior contracts and adjustments on current contracts being negotiated with the Department of Defense; $15.1 million for litigation settlement estimates primarily related to former FHC subsidiaries; $16.1 million for loss contract accruals, including $10.1 million related to the Company's health plans in Texas, Louisiana and Oklahoma; $7.7 million related to contract termination costs; $8.2 million in other receivables; and $14.6 million of other costs. Approximately $53.8 million was recorded as health plan services, $38.4 million as SG&A and $17.2 million as government health care services in the consolidated statement of operations. In addition, $2.7 million in credits related to modifications of the Company's 1996 restructuring plan were recorded in 1997.

NOTE 15 - IMPAIRMENT OF LONG-LIVED ASSETS

During 1998, the Company initiated a formal plan to dispose of certain Central Division health plans included in the Company's Health Plan Services segment in accordance with its previously disclosed anticipated divestitures program. Pursuant to SFAS No. 121, the Company evaluated the carrying values of the assets for these health plans and the related service center and holding company, and determined that the carrying value of these assets exceeded the estimated fair values of these assets. Estimated fair value is determined by the Company based on the current stages of sales negotiation, including letters of intent, definitive agreements, and sales discussions, net of expected transaction costs.

In the case of the service center and holding company operations, buildings, furniture, fixtures, equipment and software development projects were determined by management to have no continuing value to the Company, due to the Company abandoning plans for the development of this location and its systems and programs as a centralized operations center.

Accordingly, in the fourth quarter of 1998, the Company adjusted the carrying value of these long-lived assets to their estimated fair value, resulting in a non-cash asset impairment charge of approximately $112.4 million (see Note 14). This asset impairment charge of $112.4 million consists of $40.3 million for write-downs of abandoned furniture, equipment and software development projects; $20.9 million write-down of buildings and improvements; $30.0 million for write-down of goodwill; and $21.2 million for other impairments and other charges. The fair value is based on expected net realizable value. Revenue and pretax income attributable to these Central Division plans were $191.3 million and $9.8 million for the year ended December 31, 1999 and revenue and pretax loss were $346.8 million and $36.1 million for the year ended December 31, 1998. The carrying value of these assets as of December 31, 1999 and 1998 was $22.1 million and $42.8 million, respectively. No subsequent adjustments were made to these assets in 1998. Further adjustments to carrying value of $4.7 million were recorded in 1999. The annual impact of suspending depreciation is approximately $13.0 million.

During the fourth quarter of 1999, the Company recorded asset impairment costs totaling $6.2 million in connection with pending dispositions of non-core businesses. These charges included a further adjustment of $4.7 million to adjust the carrying value of the Company's Pittsburgh health plans to fair value. The Company also adjusted the carrying value of its subacute operations by $1.5 million to fair value. The revenue and pretax losses attributable to these operations were $66.2 million and $1.4 million for the year ended December 31, 1999. The carrying value of these assets as of December 31, 1999 was $16.2 million.

NOTE 16 - SEGMENT INFORMATION

As of December 31, 1998, the Company adopted SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS 131"). SFAS 131 establishes annual and interim reporting standards for an enterprise's reportable segments and related disclosures about its products, services, geographic areas and major customers. Under SFAS 131, reportable segments are to be defined on a basis consistent with reports used by management to assess performance and allocate resources. The Company's reportable segments are business units that offer different products to different classes of customers. The Company has two reportable segments: Health Plan Services and Government Contracts/Specialty Services. The Health Plan Services segment provides a comprehensive range of health care services through HMO and PPO networks. The Government Contracts/Specialty Services segment administers large, multi-year managed care government contracts and also offers behavioral, dental, vision, and pharmaceutical products and services.

The Company evaluates performance and allocates 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, except intersegment transactions are not eliminated.

Presented below are segment data for the three years in the period ended December 31 (amounts in thousands):

1999	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(1)	Total
Revenues from external sources	$7,031,055	$1,529,855	$ -	$8,560,910
Intersegment revenues	7,921	346,845	-	354,766
Investment and other income	81,342	8,241	(2,606)	86,977
Interest expense	5,624	103	78,081	83,808
Depreciation and amortization	71,186	14,960	25,895	112,041
Asset impairment, merger, restructuring, and other costs	13,045	(2,743)	1,422	11,724
Segment profit (loss)	179,786	132,326	(68,104)	244,008
Segment assets	2,598,582	1,168,961	(71,062)	3,696,481

1998	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(1)	Total
Revenues from external sources	$7,124,161	$1,411,267	$ -	$8,535,428
Intersegment revenues	7,448	355,488	-	362,936
Investment and other income	69,760	18,110	5,571	93,441
Interest expense	11,937	805	79,417	92,159

Depreciation and amortization	87,579	15,104	25,410	128,093
Asset impairment, merger, restructuring, and other costs	142,703	5,200	92,150	240,053
Segment profit (loss)	(154,546)	113,833	(213,441)	(254,154)
Segment assets	2,780,783	800,767	281,719	3,863,269

1997	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(1)	Total
Revenues from external sources	$5,482,893	$1,408,402	$ -	$6,891,295
Intersegment revenues	28,487	346,551	-	375,038
Investment and other income	72,351	19,248	22,701	114,300
Interest expense	8,474	1,443	53,638	63,555
Depreciation and amortization	67,952	9,648	20,753	98,353
Asset impairment, merger, restructuring, and other costs	127,365	23,199	135,961	286,525
Segment profit (loss)	110,027	186,959	(386,234)	(89,248)

(i) Includes intersegment eliminations.

NOTE 17 - QUARTERLY INFORMATION (UNAUDITED)

The following interim financial information presents the 1999 and 1998 results of operations on a quarterly basis (in thousands, except per share data) (see Note 1). Certain revenue amounts have been reclassified to conform to the fourth quarter of 1999 presentation:

	March 31	June 30	September 30	December 31
1999:				
Total revenues	$2,218,942	$2,125,661	$2,164,375	$2,197,241
Income from continuing operations before income taxes	78,779	46,549	58,341	60,339
Income before cumulative effect of a change in accounting principle, net of tax	47,338	27,969	35,089	37,386
Net income	41,921	27,969	35,089	37,386
BASIC AND DILUTED EARNINGS PER SHARE(i)				
Income before cumulative effect of a change in accounting principle, net of tax	0.39	0.23	0.29	0.31
Net income	0.34	0.23	0.29	0.31

	March 31	June 30	September 30	December 31
1998:				
Total revenues	$2,113,708	$2,167,380	$2,138,464	$2,214,917
Income (loss) from continuing operations before income taxes	43,262	1,529	(127,572)	(171,373)
Net income (loss)	26,238	956	(88,619)	(103,733)
BASIC AND DILUTED EARNINGS (LOSS) PER SHARE(i)				
Net income (loss)	0.22	0.01	(0.73)	(0.85)

(i) The sum of the quarterly earnings (loss) per share amounts may not equal the year-to-date earnings (loss) per share amounts due to rounding.

SUBSIDIARIES OF FOUNDATION HEALTH SYSTEMS, INC.

Foundation Health Systems, Inc. (DE)*
- -QualMed, Inc. (DE)
  - -QualMed Plans for Health of Colorado, Inc. (CO)
    - -San Luis Valley Physicians Service Corp., Ltd. (CO Limited Partnership)(1)
  - -QualMed Oregon Health Plan, Inc. (OR)
- -Health Net (CA) (2)
  - -Health Net Life Insurance Company (CA)
- - HSI Advantage Health Holdings, Inc. (DE)
  - -QualMed Plans for Health of Ohio and West Virginia, Inc. (OH)
  - -QualMed Plans for Health of Western Pennsylvania, Inc. (PA)
  - -Pennsylvania Health Care Plan, Inc. (PA)
- -National Pharmacy Services, Inc. (DE)
  - -Integrated Pharmacy Systems, Inc. (PA) (3)
- - HSI Eastern Holdings, Inc. (PA)
  - -Greater Atlantic Health Service, Inc. (DE)
    - -QualMed Plans for Health, Inc. (PA)
    - -Greater Atlantic Preferred Plus, Inc. (PA)
    - -Employ Better Care, Inc. (PA)
- -Foundation Health Corporation (DE)
  - -FH-Arizona Surgery Centers, Inc. (AZ)
  - -FH Surgery Limited, Inc. (CA)
  - -FH Surgery Centers, Inc. (CA)
  - -Foundation Health Facilities, Inc. (CA)
  - -FH Assurance Company (Cayman Islands)
  - -Foundation Health Warehouse Company (CA)
  - -Memorial Hospital of Gardena, Inc. (CA)
    - -East Los Angeles Doctors Hospital, Inc. (CA)
  - -Foundation Health Vision Services (CA)
  - -Denticare of California, Inc. (CA)
  - -Managed Alternative Care, Inc. (CA)
  - -American VitalCare, Inc. (CA)
    - -Foundation Health Federal Services, Inc. (DE)
    - -Catalina Professional Recruiters, Inc. (AZ)
  - -FHPS, Inc. (CA)
  - -Health Benchmarks, Inc. (DE)
  - -Integrated Pharmaceutical Services (CA)
  - -Foundation Health, A Florida Health Plan, Inc. (FL)
  - -Intercare, Inc. (AZ)
  - -Intergroup Health Plan, Inc. (AZ)
  - -Intergroup Prepaid Health Services of Arizona, Inc. (AZ)
  - -Interlease of Arizona, Inc. (AZ)
  - -Managed Health Network, Inc. (DE)
    - -Health Management Center, Inc. of Wisconsin (WI)
- -FHS Life Holdings Company Inc. (DE)
  - -Foundation Health Systems Life & Health Insurance Company (CO)

-HMC PPO, Inc. (MA)
-Managed Health Network (CA)
-MHN Reinsurance Company of Arizona (AZ)
-MHN Services (CA)
--MHN Services IPA, Inc. (NY)
-Employer & Occupational Services Group, Inc. (CA)
-Foundation Health Medical Resource Management (CA)
-Foundation Integrated Risk Management Solutions, Incorporated (CA)
-AXIS Integrated Resources, Inc. (DE)
-Gem Holding Corporation (UT) (4)
-Gem Insurance Company (UT)
-MedEmpower, Inc. (DE)
-MedUnite, Inc. (DE)
-QualMed Plans for Health of Pennsylvania, Inc. (PA)
-Physicians Health Services, Inc. (DE)
-FOHP, Inc. (NJ)
-Physicians Health Services of New Jersey, Inc. (NJ)
-First Option Health Plan of Pennsylvania, Inc. (PA)
-FOHP Agency, Inc. (NJ)
-Physicians Health Services (Bermuda) Ltd. (Bermuda)
-Physicians Health Services of Connecticut, Inc. (CT)
-Physicians Health Services of New York, Inc. (NY)
-Physicians Health Services Insurance of New York, Inc. (NY)
-Physicians Health Insurance Services, Inc. (CT)
-PHS Insurance of Connecticut, Inc. (CT)
-PHS Real Estate, Inc. (DE)
-PHS Real Estate II, Inc. (DE)

*All subsidiaries wholly owned unless otherwise indicated.

(1) A limited partnership in which QualMed Plans for Health of Colorado, Inc. is an 83.4% limited partner.

(2) Foundation Health Systems, Inc. owns approximately 86% of the outstanding common stock; Foundation Health Corporation owns approximately 14% of the outstanding common stock.

(3) National Pharmacy Services, Inc. owns approximately 90% of the outstanding common stock.

(4) Foundation Health Corporation owns approximately 99.99% of the outstanding common stock.

EXHIBIT 23.1

INDEPENDENT AUDITORS' CONSENT

To the Board of Directors and Stockholders of
Foundation Health Systems, Inc.
Woodland Hills, California

We consent to the incorporation by reference in Registration Statements on Forms S-8 (i) filed on December 4, 1998 and on March 31, 1998, and (ii) No. 333-35193, No. 333-24621, No. 33-74780 and No. 33-90976 of our report dated February 29, 2000, appearing in and incorporated by reference in this Annual Report on Form 10-K of Foundation Health Systems, Inc. (the "Company") for the year ended December 31, 1999.

/s/ Deloitte & Touche LLP

Los Angeles, California
February 29, 2000

THIS SCHEDULE CONTAINS SUMMARY FINANCIAL INFORMATION EXTRACTED FROM CONSOLIDATED BALANCE SHEETS AND CONSOLIDATED STATEMENTS OF OPERATIONS AND IS QUALIFIED IN ITS ENTIRETY BY REFERENCE TO SUCH FINANCIAL STATEMENTS

PAYABLE AND CAPITAL LEASES