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

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**FORM 10-Q**

(Mark One)

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

For the quarterly period ended: **September 30, 2001**

OR

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

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

Commission file number: **1-12718**

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**HEALTH NET, INC.**

(Exact name of registrant as specified in its charter)

**Delaware**

(State or other jurisdiction of  
incorporation or organization)

**95-4288333**

(I.R.S. Employer Identification No.)

**21650 Oxnard Street, Woodland Hills, CA**

(Address of principal executive offices)

**91367**

(Zip Code)

**(818) 676-6000**

Registrant's telephone number, including area code

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

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

The number of shares outstanding of the registrant's Class A Common Stock as of November 13, 2001 was 123,564,218 (excluding 3,194,374 shares held as treasury stock) and no shares of Class B Common Stock were outstanding as of such date.

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**PART I—FINANCIAL INFORMATION**

**Item 1. Financial Statements**

**HEALTH NET, INC.  
CONDENSED CONSOLIDATED BALANCE SHEETS**

**(Amounts in thousands)**

**(Unaudited)**

	<u>September 30, 2001</u>	<u>December 31, 2000</u>
<b>ASSETS</b>		
Current Assets:		
Cash and cash equivalents . . . . .	\$1,144,598	\$1,046,735
Investments—available for sale . . . . .	565,922	486,902
Premiums receivable, net . . . . .	198,554	174,654
Amounts receivable under government contracts . . . . .	127,086	334,187
Reinsurance and other receivables . . . . .	147,511	141,140
Deferred taxes . . . . .	116,924	141,752
Other assets . . . . .	<u>77,198</u>	<u>74,184</u>
Total current assets . . . . .	2,377,793	2,399,554
Property and equipment, net . . . . .	250,141	296,009
Goodwill and other intangible assets, net . . . . .	811,875	863,419
Other noncurrent assets . . . . .	<u>142,460</u>	<u>111,134</u>
Total Assets . . . . .	<u>\$3,582,269</u>	<u>\$3,670,116</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current Liabilities:		
Reserves for claims and other settlements . . . . .	\$1,295,820	\$1,242,389
Unearned premiums . . . . .	215,309	238,571
Amounts payable under government contracts . . . . .	3,342	972
Accounts payable and other liabilities . . . . .	<u>280,241</u>	<u>329,149</u>
Total current liabilities . . . . .	1,794,712	1,811,081
Revolving credit facilities and capital leases . . . . .	225,264	766,450
Senior notes payable . . . . .	398,643	—
Deferred taxes . . . . .	11,513	8,635
Other noncurrent liabilities . . . . .	<u>44,206</u>	<u>22,819</u>
Total Liabilities . . . . .	<u>2,474,338</u>	<u>2,608,985</u>
Commitments and contingencies		
Stockholders' Equity:		
Common stock and additional paid-in capital . . . . .	659,568	649,292
Retained earnings . . . . .	541,760	511,224
Treasury Class A common stock, at cost . . . . .	(95,831)	(95,831)
Accumulated other comprehensive income (loss) . . . . .	<u>2,434</u>	<u>(3,554)</u>
Total Stockholders' Equity . . . . .	<u>1,107,931</u>	<u>1,061,131</u>
Total Liabilities and Stockholders' Equity . . . . .	<u>\$3,582,269</u>	<u>\$3,670,116</u>

See accompanying notes to condensed consolidated financial statements.

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

	Third Quarter Ended September 30,	
	2001	2000
<b>REVENUES</b>		
Health plan services premiums . . . . .	\$2,078,628	\$1,847,400
Government contracts/Specialty services . . . . .	447,862	414,279
Investment and other income . . . . .	18,449	26,136
Total revenues . . . . .	2,544,939	2,287,815
<b>EXPENSES</b>		
Health plan services . . . . .	1,772,020	1,575,723
Government contracts/Specialty services . . . . .	322,782	283,306
Selling, general and administrative . . . . .	329,339	310,576
Depreciation . . . . .	15,279	16,423
Amortization . . . . .	9,426	9,675
Interest . . . . .	12,735	22,736
Net gain on sale of properties . . . . .	—	(1,068)
Asset impairment, restructuring and other costs . . . . .	79,667	—
Total expenses . . . . .	2,541,248	2,217,371
Income before income taxes . . . . .	3,691	70,444
Income tax provision . . . . .	1,365	25,797
Net income . . . . .	\$ 2,326	\$ 44,647
<b>Basic and diluted earnings per share:</b>		
Basic . . . . .	\$ 0.02	\$ 0.36
Diluted . . . . .	\$ 0.02	\$ 0.36
<b>Weighted average shares outstanding:</b>		
Basic . . . . .	123,315	122,477
Diluted . . . . .	124,965	124,188

See accompanying notes to condensed consolidated financial statements.

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

	Nine Months Ended September 30,	
	2001	2000
<b>REVENUES</b>		
Health plan services premiums . . . . .	\$6,257,828	\$5,430,967
Government contracts/Specialty services . . . . .	1,253,651	1,211,813
Investment and other income . . . . .	68,287	73,970
Total revenues . . . . .	7,579,766	6,716,750
<b>EXPENSES</b>		
Health plan services . . . . .	5,355,613	4,628,738
Government contracts/Specialty services . . . . .	898,117	810,663
Selling, general and administrative . . . . .	1,001,641	944,558
Depreciation . . . . .	48,339	50,375
Amortization . . . . .	28,265	28,979
Interest . . . . .	43,581	66,003
Net loss (gain) on sale of businesses and properties . . . . .	76,072	(1,068)
Asset impairment, restructuring and other costs . . . . .	79,667	—
Total expenses . . . . .	7,531,295	6,528,248
Income before income taxes . . . . .	48,471	188,502
Income tax provision . . . . .	17,935	71,105
Net income . . . . .	\$ 30,536	\$ 117,397
<b>Basic and diluted earnings per share:</b>		
Basic . . . . .	\$ 0.25	\$ 0.96
Diluted . . . . .	\$ 0.24	\$ 0.96
<b>Weighted average shares outstanding:</b>		
Basic . . . . .	123,065	122,435
Diluted . . . . .	125,084	122,625

See accompanying notes to condensed consolidated financial statements.

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

	<b>Nine Months Ended September 30,</b>	
	<b>2001</b>	<b>2000</b>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Net income . . . . .	\$ 30,536	\$ 117,397
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Amortization and depreciation . . . . .	76,604	79,354
Net loss (gain) on sale of businesses and buildings . . . . .	76,072	(1,068)
Asset impairments . . . . .	27,760	—
Other changes . . . . .	2,663	8,885
Changes in assets and liabilities, net of the effects of dispositions:		
Premiums receivable . . . . .	(23,919)	(2,313)
Unearned premiums . . . . .	(22,002)	(149,373)
Other assets . . . . .	(12,857)	47,748
Amounts receivable/payable under government contracts . . . . .	209,471	(109,133)
Reserves for claims and other settlements . . . . .	89,896	29,704
Accounts payable and other liabilities . . . . .	(6,900)	(48,077)
Net cash provided by (used in) operating activities . . . . .	<u>447,324</u>	<u>(26,876)</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Sales or maturities of investments . . . . .	596,019	209,518
Purchases of investments . . . . .	(673,030)	(153,495)
Net purchases of property and equipment . . . . .	(53,498)	(50,364)
Cash (paid) received from the sale of businesses and buildings, net of cash disposed . . . . .	(58,997)	3,505
Other . . . . .	(21,503)	(24,076)
Net cash used in investing activities . . . . .	<u>(211,009)</u>	<u>(14,912)</u>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>		
Proceeds from exercise of stock options and employee stock purchases . . . . .	7,962	1,233
Proceeds from issuance of notes and other financing arrangements . . . . .	601,102	155,032
Repayment of debt . . . . .	(747,516)	(248,738)
Net cash used in financing activities . . . . .	<u>(138,452)</u>	<u>(92,473)</u>
Net increase (decrease) in cash and cash equivalents . . . . .	97,863	(134,261)
Cash and cash equivalents, beginning of period . . . . .	<u>1,046,735</u>	<u>1,010,539</u>
Cash and cash equivalents, end of period . . . . .	<u>\$1,144,598</u>	<u>\$ 876,278</u>

See accompanying notes to condensed consolidated financial statements.

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

**1. BASIS OF PRESENTATION**

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

We are responsible for the unaudited financial statements included in this document. The financial statements include all normal and recurring adjustments that are considered necessary for the fair presentation of our financial position and operating results in accordance with GAAP. In accordance with GAAP, we make certain estimates and assumptions that affect the reported amounts. Actual results could differ from estimates. As these are condensed financial statements, one should also read our 2000 consolidated financial statements and notes included in our Form 10-K filed in March 2001.

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

**2. COMPREHENSIVE INCOME**

Our comprehensive income for the third quarter and nine months ended September 30 is as follows (amounts in thousands):

	<u>Third Quarter</u> <u>Ended September 30,</u>		<u>Nine Months</u> <u>Ended September 30,</u>	
	<u>2001</u>	<u>2000</u>	<u>2001</u>	<u>2000</u>
Net income . . . . .	\$2,326	\$44,647	\$30,536	\$117,397
Other comprehensive income, net of tax:				
Net change in unrealized appreciation on investments				
available for sale . . . . .	<u>2,457</u>	<u>1,878</u>	<u>5,988</u>	<u>2,105</u>
Comprehensive income . . . . .	<u>\$4,783</u>	<u>\$46,525</u>	<u>\$36,524</u>	<u>\$119,502</u>

**3. EARNINGS PER SHARE**

Basic earnings per share excludes dilution and reflects net income or loss divided by the weighted average shares of common stock outstanding during the periods presented. Diluted earnings per share is based upon the weighted average shares of common stock and dilutive common stock equivalents (all of which are comprised of stock options) outstanding during the periods presented. Common stock equivalents arising from dilutive stock options are computed using the treasury stock method. There were 1,650,000 and 2,019,000 shares of dilutive common stock equivalents for the third quarter and nine months ended September 30, 2001, respectively, and 1,711,000 and 190,000 shares of dilutive common stock equivalents for the third quarter and nine months ended September 30, 2000, respectively.

Options to purchase an aggregate of 6,925,000 and 6,849,000 shares of common stock during the third quarter and nine months ended September 30, 2001, respectively, and an aggregate of 4,230,000 and 8,609,000 shares of common stock during the third quarter and nine months ended September 30,

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

**3. EARNINGS PER SHARE (Continued)**

2000, respectively, were not included in the computation of diluted earnings per share because the options' exercise prices were greater than the average market price of the common stock for each respective period.

**4. SEGMENT INFORMATION**

Our segment information for the third quarter and nine months ended September 30, 2001 and 2000 is as follows (amounts in thousands):

	Health Plan Services	Government Contracts/ Specialty Services	Corporate and Other	Total
<b>Third Quarter Ended September 30, 2001</b>				
Revenues from external sources . . . . .	\$2,078,628	\$ 447,862	—	\$2,526,490
Intersegment revenues . . . . .	—	30,252	—	30,252
Asset impairment, restructuring and other costs . . . . .	40,677	17,205	\$ 21,785	79,667
Income (loss) before income taxes . . . . .	41,047	(9,493)	(27,863)	3,691
<b>Third Quarter Ended September 30, 2000</b>				
Revenues from external sources . . . . .	\$1,847,400	\$ 414,279	—	\$2,261,679
Intersegment revenues . . . . .	—	20,171	—	20,171
Asset impairment, restructuring and other costs . . . . .	—	—	—	—
Income (loss) before income taxes . . . . .	76,120	29,315	\$ (34,991)	70,444
<b>Nine Months Ended September 30, 2001</b>				
Revenues from external sources . . . . .	\$6,257,828	\$1,253,651	—	\$7,511,479
Intersegment revenues . . . . .	—	77,033	—	77,033
Asset Impairment, restructuring and other costs . . . . .	40,677	17,205	\$ 21,785	79,667
Loss on sale of Florida health plan and related corporate facility building . . . . .	—	—	76,072	76,072
Income (loss) before income taxes . . . . .	192,313	12,487	(156,329)	48,471
<b>Nine Months Ended September 30, 2000</b>				
Revenues from external sources . . . . .	\$5,430,967	\$1,211,813	—	\$6,642,780
Intersegment revenues . . . . .	—	53,765	—	53,765
Asset impairment, restructuring and other costs . . . . .	—	—	—	—
Income (loss) before income taxes . . . . .	216,974	78,495	\$(106,967)	188,502

We made certain reclassifications to the 2000 amounts to conform to the 2001 presentation.

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

**5. ASSET IMPAIRMENT, RESTRUCTURING AND OTHER COSTS**

The following table summarizes the restructuring charges we recorded during the third quarter ended September 30, 2001:

	<u>2001 Charges</u>	<u>Cash Payments</u>	<u>Non-cash</u>	<u>Balance at September 30, 2001</u>	<u>Expected Future Cash Outlays</u>
	(amounts in millions)				
Severance and benefit related costs . . .	\$43.3	\$(15.7)	\$ —	\$27.6	\$27.6
Asset impairment costs . . . . .	27.9	—	(27.9)	—	—
Real estate lease termination costs . . . .	5.1	—	—	5.1	5.1
Other costs . . . . .	<u>3.4</u>	<u>—</u>	<u>(2.3)</u>	<u>1.1</u>	<u>1.1</u>
Total restructuring charges . . . . .	\$79.7	\$(15.7)	\$(30.2)	\$33.8	\$33.8

As part of our ongoing selling, general and administrative expense reduction efforts, during the third quarter of 2001, we finalized a formal plan to reduce operating and administrative expenses for all business units within the Company (the 2001 Plan). In connection with the 2001 Plan, we decided on enterprise-wide staff reductions and consolidations of certain administrative, financial and technology functions. We recorded pretax restructuring charges of \$79.7 million during the third quarter ended September 30, 2001 (2001 Charge). Of the total 2001 Charge, approximately \$49.5 million will result in cash outlays. We plan to use cash flows from operations to fund these payments.

**SEVERANCE AND BENEFIT RELATED COSTS**

During the third quarter ended September 30, 2001, we recorded severance and benefit related costs of \$43.3 million related to enterprise-wide staff reductions, which costs were included in the 2001 Charge. These reductions include the elimination of approximately 1,500 positions throughout all functional groups, divisions and corporate offices within the Company. As of September 30, 2001, 769 positions have been eliminated and \$15.7 million of the severance and benefit related costs have been paid out. We expect that an additional \$12.6 million will be paid out during the fourth quarter of 2001 with the remaining balance to be paid during 2002. Elimination of the remaining 748 positions will be completed over the next twelve months.

**ASSET IMPAIRMENT COSTS**

Pursuant to Statement of Financial Accounting Standards (SFAS) No. 121, we evaluated the carrying value of certain long-lived assets that were affected by the 2001 Plan. The affected assets were primarily comprised of information technology systems and equipment, software development projects and leasehold improvements. We determined that the carrying value of these assets exceeded their estimated fair values. The fair values of these assets were determined based on market information available for similar assets. For certain of the assets, we determined that they had no continuing value to us due to our abandoning certain plans and projects in connection with our workforce reductions.

Accordingly, we recorded asset impairment charges of \$27.9 million consisting entirely of non-cash write-downs of equipment, building improvements and software application and development costs, which charges were included in the 2001 Charge. The carrying value of these assets was \$36.2 million as of September 30, 2001.

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

**5. ASSET IMPAIRMENT, RESTRUCTURING AND OTHER COSTS (Continued)**

The asset impairment charges of \$27.9 million consists of \$10.8 million for write-downs of assets related to the consolidation of four data centers, including all computer platforms, networks and applications into a single processing facility at our Hazel Data Center; \$16.3 million related to abandoned software applications and development projects resulting from the workforce reductions, migration of certain systems and investments to more robust technologies; and \$0.8 million for write-downs of leasehold improvements.

**REAL ESTATE LEASE TERMINATION COSTS**

The 2001 Charge included charges of \$5.1 million related to termination of lease obligations and non-cancelable lease costs for excess office space resulting from streamlined operations and consolidation efforts. Approximately \$0.1 million of the termination obligations will be paid during the fourth quarter of 2001 with the remainder to be paid during 2002 and throughout the respective lease terms.

**OTHER COSTS**

The 2001 Charge included charges of \$3.4 million related to costs associated with consolidating certain data center operations and systems and other activities which are expected to be completed in the first quarter of 2002. Approximately \$0.6 million of these costs will be paid by the end of 2001 with the remainder to be paid during the first quarter of 2002.

**6. DIVESTITURES AND OTHER INVESTMENTS**

Effective August 1, 2001, we sold our Florida health plan, known as Foundation Health, a Florida Health Plan, Inc., to Florida Health Plan Holdings II, LLC. In connection with the sale, we received approximately \$49 million which consists of \$23 million in cash and approximately \$26 million in a secured six-year note bearing eight percent interest per annum. We also sold the corporate facility building used by our Florida health plan to DGE Properties, LLC for \$15 million, payable by a secured five-year note bearing eight percent interest per annum. We estimated and recorded a \$76.1 million pre-tax loss on the sales of our Florida health plan and the related corporate facility building during the second quarter ended June 30, 2001. As part of the Florida sale agreement, there will be a series of true up processes that will take place during 2001 and 2002 that could result in additional loss or gain recognition.

The Florida health plan, excluding the \$76.1 million loss on sale, had premium revenues of \$45.8 million and a net loss of \$2.3 million for the third quarter ended September 30, 2001, and premium revenues of \$339.7 million and a net loss of \$11.5 million for the nine months ended September 30, 2001. The effect of the suspension of the depreciation on the corporate facility building was immaterial for the third quarter and nine months ended September 30, 2001.

During the third quarter ended September 30, 2000, we sold property in California and received cash proceeds of \$3.5 million and recognized a gain of \$1.1 million before taxes.

Throughout 2000 and the nine months ended September 30, 2001, we have provided funding in the aggregate amount of approximately \$10.0 million to MedUnite, Inc., an independent company, funded and organized by seven major managed health care companies. MedUnite, Inc. is designed to provide

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

**6. DIVESTITURES AND OTHER INVESTMENTS (Continued)**

on-line internet provider connectivity services including eligibility information, referrals, authorizations, claims submission and payment. The funded amounts are included in other noncurrent assets.

During 2000, we secured an exclusive e-business connectivity services contract from the Connecticut State Medical Society IPA, Inc. (CSMS-IPA) for \$15.0 million. CSMS-IPA is an association of medical doctors providing health care primarily in Connecticut. The amounts paid to CSMS-IPA for this agreement are included in other noncurrent assets.

**7. LEGAL PROCEEDINGS**

**SUPERIOR NATIONAL INSURANCE GROUP, INC.**

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

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

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

Superior seeks \$300 million in compensatory damages, unspecified punitive damages and the costs of the action, including attorneys' fees.

On August 1, 2000, a motion filed by us and FHC to remove the lawsuit from the jurisdiction of the Bankruptcy Court to the United States District Court for the Central District of California was granted. The lawsuit is now pending in the District Court under case number SACV00-0658 GLT. The parties are currently engaged in discovery.

We intend to defend ourselves vigorously in this litigation.

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

**7. LEGAL PROCEEDINGS (Continued)**

**FPA MEDICAL MANAGEMENT, INC.**

Since May 1998, several complaints have been filed in federal and state courts seeking an unspecified amount of damages on behalf of an alleged class of persons who purchased shares of common stock, convertible subordinated debentures and options to purchase common stock of FPA Medical Management, Inc. (FPA) at various times between February 3, 1997 and May 15, 1998. The complaints name as defendants FPA, certain of FPA's auditors, us and certain of our former officers. The complaints allege that we and such former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between us and FPA, about FPA's business and about our 1997 sale of FPA common stock held by us. All claims against our former officers were voluntarily dismissed from the consolidated class actions in both federal and state court. We have filed a motion to dismiss all claims asserted against us in the consolidated federal class actions but have not formally responded to the other complaints. We intend to vigorously defend the actions.

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

Physicians Health Services, Inc. (PHS), a subsidiary of ours, was sued on December 14, 1999 in the United States District Court in Connecticut by the Attorney General of Connecticut, Richard Blumenthal, acting on behalf of a group of state residents. The lawsuit was premised on ERISA, and alleged that PHS violated its duties under ERISA by managing its prescription drug formulary in a manner that served its own financial interest rather than those of plan beneficiaries. The suit sought to have PHS revamp its formulary system, and to provide patients with written denial notices and instructions on how to appeal. PHS filed a motion to dismiss which asserted that the state residents the Attorney General purported to represent all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that his office lacked standing to bring the suit and that the allegations failed to state a claim under ERISA. On July 12, 2000, the court granted PHS' motion and dismissed the action. The State of Connecticut has appealed the dismissal and argument on the appeal was held before the United States Court of Appeals for the Second Circuit on May 1, 2001. We intend to vigorously defend the action.

**IN RE MANAGED CARE LITIGATION**

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

*Subscriber Track*

The subscriber track includes the following actions involving us: *Pay v. Foundation Health Systems, Inc.* (filed in the Southern District of Mississippi on November 22, 1999), *Romero v. Foundation Health Systems, Inc.* (filed in the Southern District of Florida on June 23, 2000 as an amendment to a suit filed in the Southern District of Mississippi), *State of Connecticut v. Physicians Health Services of Connecticut, Inc.* (filed in the District of Connecticut on September 7, 2000), and *Albert v. CIGNA Healthcare of*

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

**7. LEGAL PROCEEDINGS (Continued)**

*Connecticut, Inc., et al.* (including Physicians Health Services of Connecticut, Inc. and Foundation Health Systems, Inc.) (filed in the District of Connecticut on September 7, 2000). The *Pay* and *Romero* actions seek certification of nationwide class actions, unspecified damages and injunctive relief, and allege that cost containment measures used by our 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 *Albert* suit also alleges violations of ERISA and seeks certification of a nationwide class and unspecified damages and injunctive relief. The *State of Connecticut* action asserts claims against our subsidiary, Physicians Health Services of Connecticut, Inc., and us that are similar, if not identical, to those asserted in the previous lawsuit that was dismissed, as discussed above, on July 12, 2000.

We filed a motion to dismiss the lead subscriber track case, *Romero v. Foundation Health Systems, Inc.*, and on June 12, 2001, the court entered an order dismissing all claims in that suit brought against Health Net with leave for the plaintiffs to re-file an amended complaint. On this same date, the court stayed discovery until after the court rules upon motions to dismiss the amended complaints and any motions to compel arbitration. On June 29, 2001, the plaintiffs in *Romero* filed a third amended class action complaint which re-alleges causes of action under RICO, ERISA, common law civil conspiracy and common law unjust enrichment. The third amended class action complaint seeks unspecified compensatory and treble damages and equitable relief. On July 24, 2001, the court heard oral argument on class certification issues. On August 17, 2001, we filed a motion to dismiss the third amended complaint in *Romero*.

*Provider Track*

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

On August 17, 2000, a complaint was filed in the United States District Court for the Southern District of Florida in *Shane*, the lead provider track action in MDL 1334. The complaint seeks certification of a nationwide class action on behalf of physicians and alleges that the defendant managed care companies' methods of reimbursing physicians violate provisions of RICO, ERISA, certain federal regulations and various state laws. The action seeks unspecified damages and injunctive relief.

On September 22, 2000, we filed a motion to dismiss, or in the alternative to compel arbitration in *Shane*. On December 11, 2000, the court granted in part and denied in part our motion to compel arbitration. Under the court's December arbitration order, plaintiff Dennis Breen, the single named

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

**7. LEGAL PROCEEDINGS (Continued)**

plaintiff to allege a direct contractual relationship with us in the August complaint, was compelled to arbitrate his direct claims against us. We have filed an appeal in the United States Court of Appeals for the 11<sup>th</sup> Circuit seeking to overturn the portion of the district court's December ruling that did not order certain claims to arbitration. On April 26, 2001, the court modified its December arbitration order and is now retaining jurisdiction over certain direct claims of plaintiff Breen relating to a single contract. On March 2, 2001, the District Court for the Southern District of Florida issued an order in *Shane* granting the dismissal of certain claims with prejudice and the dismissal of certain other claims without prejudice, and denying the dismissal of certain claims.

On March 26, 2001, a consolidated amended complaint was filed in *Shane* against managed care companies, including us. This consolidated complaint adds new plaintiffs, including Leonard Klay and the California Medical Association (who, as set forth below, had previously filed claims against the Company), and has, in addition to revising the pleadings of the original claims, added a claim under the California Business and Professions Code. On May 1, 2001, we filed a motion to compel arbitration in *Shane* of the claims of all individual plaintiffs that allege to have treated persons insured by us. On that same date, we filed a motion to dismiss this action. Preliminary discovery and briefing regarding the plaintiffs' motion for class certification has taken place. On May 7, 2001, the court heard oral argument on class certification issues in *Shane*. On May 9, 2001, the court entered a scheduling order permitting further discovery. On May 14, 2001, Health Net joined in a motion for stay of proceedings in *Shane v. Humana, Inc., et al.* (including Foundation Health Systems, Inc.) (00-1334-MD) in the United States District Court for the Southern District of Florida pending appeal in the 11th Circuit Court of Appeals. On June 17, 2001, the district court stayed discovery until after the district court rules upon motions to dismiss and motions to compel arbitration. This order staying discovery also applies to other actions transferred to the district court by the Judicial Panel on Multidistrict Litigation, namely *California Medical Association v. Blue Cross of California, Inc. et al.*, *Klay v. Prudential Ins. Co. of America, et al.*, *Connecticut State Medical Society v. Physicians Health Services of Connecticut, Inc.*, and *Lynch v. Physicians Health Services of Connecticut, Inc.* On June 25, 2001, the 11th Circuit Court of Appeals entered an order staying proceedings in the district court pending resolution of the appeals relating to the district court's ruling on motions to compel arbitration. The Eleventh Circuit has scheduled oral argument on the arbitration issues for the week of January 7, 2002.

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

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

The *CSMS* case was originally brought in Connecticut state court against Physicians Health Services of Connecticut, Inc. alleging violations of the Connecticut Unfair Trade Practices Act. The complaint alleges that PHS-CT engaged in conduct that was designed to delay, deny, impede and

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

**7. LEGAL PROCEEDINGS (Continued)**

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

The *Lynch* case was also originally filed in Connecticut state court. This case was purportedly brought on behalf of physicians members of the Connecticut State Medical Society who provide health care services to PHS-CT health plan members pursuant to provided service contracts. The complaint alleges that PHS-CT engaged in improper, unfair and deceptive practices by denying, impeding and/or delaying lawful reimbursement to physicians. The complaint, similar to the complaint referred to above filed against PHS-CT on the same day by the Connecticut State Medical Society, seeks declaratory and injunctive relief, and damages. On March 13, 2001, we removed this action to federal court. Before this case was transferred to MDL 1334, the plaintiffs moved to remand the action to state court and the District Court of Connecticut consolidated this action and *CSMS v. Physicians Health Services of Connecticut, Inc.*, along with similar actions against Aetna, CIGNA and Anthem, into one case entitled *CSMS v. Aetna Health Plans of Southern New England, et al.* PHS-CT has not yet responded to the complaint.

As noted above, on June 17, 2001, the district court entered an order which applies to the *Shane, CMA, Klay, CSMS* and *Lynch* actions and stays discovery until after the court rules upon motions to dismiss and motions to compel arbitration.

**MISCELLANEOUS PROCEEDINGS**

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

**8. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS**

The Financial Accounting Standards Board (FASB) issued the following Statements of Financial Accounting Standards (SFAS) that are effective in 2001:

- In October 2001, the FASB issued SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" (SFAS No. 144). SFAS No. 144 supersedes SFAS No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of," and some provisions of Accounting Principles Board (APB) Opinion 30. SFAS No. 144 sets new criteria for determining when an asset can be classified as held-for-sale as well as modifying the financial statement presentation requirements of operating losses from discontinued operations. SFAS

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

**8. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS (Continued)**

No. 144 is effective for fiscal years beginning after December 15, 2001. We are currently evaluating the provisions of SFAS 144.

- In August 2001, the FASB issued SFAS No. 143, "Accounting for Asset Retirement Obligations" (SFAS No. 143). SFAS No. 143 provides accounting standards for closure or removal-type costs similar to the costs of nuclear decommissioning, but it applies to other industries and assets as well. SFAS No. 143 is effective for fiscal years beginning after June 15, 2002, however, earlier application is encouraged. We do not expect the adoption of SFAS No. 143 to have a material effect on our consolidated financial position or results of operations.
- In July 2001, the FASB issued two new pronouncements: SFAS No. 141, Business Combinations, and SFAS No. 142, Goodwill and Other Intangible Assets. SFAS No. 141 is effective as follows: a) use of the pooling-of-interest method is prohibited for business combinations initiated after June 30, 2001; and b) the provisions of SFAS No. 141 also apply to all business combinations accounted for by the purchase method that are completed after June 30, 2001 (that is, the date of the acquisition is July 2001 or later). There are also transition provisions that apply to business combinations completed before July 1, 2001, that were accounted for by the purchase method. SFAS No. 142 is effective for fiscal years beginning after December 15, 2001 for all goodwill and other intangible assets recognized in an entity's statement of financial position at that date, regardless of when those assets were initially recognized. We are currently evaluating the provisions of SFAS No. 141 and SFAS No. 142.

**9. SENIOR NOTES AND CREDIT FACILITIES**

On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent Senior Notes due in April 2011 at a discount of \$1.4 million. The proceeds, net of discount and other issuance costs, of \$395.1 million from the Senior Notes were used to repay outstanding borrowings under our then-existing revolving credit facility. Effective October 4, 2001, we completed an exchange offer for the senior notes in which the outstanding Senior Notes were exchanged for an equal aggregate principal amount of new 8.375 percent Senior Notes due 2011 that have been registered under the Securities Act of 1933, as amended.

On June 28, 2001, we entered into credit agreements for two new revolving syndicated credit facilities with Bank of America, N.A. as administrative agent, that replaced our previous credit facility. The new facilities, providing for an aggregate of \$700 million in borrowings, consist of a \$175 million 364-day revolving credit facility and a \$525 million five-year revolving credit and competitive advance facility.

As of September 30, 2001, the net carrying value of the Senior Notes and the credit facilities were \$398.6 million and \$225.0 million, respectively. The \$225.0 million outstanding under the credit facilities is under the five-year facility.

## **ITEM 2: MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS**

Health Net, Inc. (formerly named Foundation Health Systems, Inc., together with its subsidiaries, referred to herein as the Company, we, us or our) is an integrated managed care organization which administers through its subsidiaries the delivery of managed health care services. Through our subsidiaries, we offer group, individual, Medicaid and Medicare health maintenance organization (HMO), point of service (POS) 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.

We currently operate within two segments: Health Plan Services and Government Contracts/Specialty Services. Our Health Plan Services segment operates in two regional areas: Eastern (consisting of Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia) and Western (consisting of Arizona, California and Oregon).

In 2000, we decided to exit the Ohio, West Virginia and Western Pennsylvania markets and provided notice of our intention to withdraw from these service areas to the appropriate regulators. As of February 2001, we no longer had any members in these markets. As of September 30, 2001, we still have 3,000 commercial members in Washington to be transitioned out as part of the Washington health plan sale in 1999.

Effective August 1, 2001, we completed the sale of our Florida health plan, known as Foundation Health, a Florida Health Plan, Inc., to Florida Health Plan Holdings II, LLC. In connection with the sale, we received approximately \$49 million which consists of \$23 million in cash and approximately \$26 million in a secured six-year note bearing eight percent interest per annum. We also sold the corporate facility building used by our Florida health plan to DGE Properties, LLC for \$15 million, payable by a secured five-year note bearing eight percent interest per annum. We estimated and recorded a \$76.1 million pre-tax loss on the sales of our Florida health plan and the related corporate facility building during the second quarter ended June 30, 2001. As part of the Florida sale agreement, there will be a series of true up processes that will take place during 2001 and 2002 that could result in additional loss or gain recognition.

Our Florida health plan, excluding the \$76.1 million loss on net assets held for sale had premium revenues of \$45.8 million and a net loss of \$2.3 million for the third quarter ended September 30, 2001, and premium revenues of \$339.7 million and a net loss of \$11.5 million for the nine months ended September 30, 2001. The effect of the suspension of depreciation on the corporate facility building was immaterial for the third quarter and nine months ended September 30, 2001.

Throughout 2000 and the nine months ended September 30, 2001, we have provided funding in the aggregate amount of approximately \$10.0 million to MedUnite, Inc., an independent company, funded and organized by seven major managed health care companies. MedUnite, Inc. is designed to provide on-line internet provider connectivity services including eligibility information, referrals, authorizations, claims submission and payment. The funded amounts are included in other noncurrent assets.

We are one of the largest managed health care companies in the United States, with approximately 4.1 million at-risk and administrative services only (ASO) members in our Health Plan Services segment. We also own health and life insurance companies licensed to sell PPO, POS and indemnity products, as well as certain auxiliary non-health products such as life and accidental death and disability insurance in 35 states and the District of Columbia.

Our Government Contracts/Specialty Services segment administers large multi-year managed health care government contracts. Certain components of these contracts, including administrative and assumption of health care risk, are subcontracted to affiliated and unrelated third parties. We administer health care programs covering approximately 1.5 million eligible individuals under

TRICARE. We have three TRICARE contracts that cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon, Washington and parts of Arizona, Idaho, Louisiana and Texas. The Department of Defense extended all three contracts in 2000 for periods up to two years. Through this segment, we also offer behavioral health, dental and vision services as well as employee and occupational services comprising managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

This discussion and analysis and other portions of this Form 10-Q contain “forward-looking statements” within the meaning of Section 21E of the Securities Exchange Act of 1934, as amended, and Section 27A of the Securities Act of 1933, as amended, that involve risks and uncertainties. All statements other than statements of historical information provided or incorporated by reference herein may be deemed to be forward-looking statements. Without limiting the foregoing, the words “believes,” “anticipates,” “plans,” “expects” and similar expressions are intended to identify forward-looking statements. Factors that could cause actual results to differ materially from those reflected in the forward-looking statements include, but are not limited to, the matters described in the “Cautionary Statements” section and other portions of our Annual Report on Form 10-K for the fiscal year ended December 31, 2000 and the risks discussed in our other filings with the SEC. You should not place undue reliance on these forward-looking statements, which reflect management’s analysis, judgment, belief or expectation only as of the date hereof. Except as required by law, we undertake no obligation to publicly revise these forward-looking statements to reflect events or circumstances that arise after the date of this report.

#### **CONSOLIDATED OPERATING RESULTS**

Our net income for the third quarter ended September 30, 2001 was \$2.3 million, or \$0.02 per basic share and diluted share, compared to net income for the same period in 2000 of \$44.6 million or \$0.36 per basic share and diluted share. Our net income for the nine months ended September 30, 2001 was \$30.5 million, or \$0.25 per basic share and \$0.24 per diluted share, compared to net income for the same period in 2000 of \$117.4 million or \$0.96 per basic share and diluted share.

Included in our results for the third quarter and nine months ended September 30, 2001, are costs of \$79.7 million related to our 2001 restructuring plan. Included in our results for the nine months ended September 30, 2001, is a loss of \$76.1 million on the sales of our Florida health plan and related corporate facility building. See Notes to Condensed Consolidated Financial Statements.

The table below and the discussions that follows summarize our financial performance for the third quarter and nine months ended September 30, 2001 and 2000, respectively.

	Third Quarter Ended September 30,		Nine Months Ended September 30,	
	2001	2000	2001	2000
(Amounts in thousands, except per member per month data)				
<b>Revenues:</b>				
Health plan services premiums . . . . .	\$2,078,628	\$1,847,400	\$6,257,828	\$5,430,967
Government contracts/Specialty services . . . . .	447,862	414,279	1,253,651	1,211,813
Investment and other income . . . . .	18,449	26,136	68,287	73,970
Total revenues . . . . .	<u>2,544,939</u>	<u>2,287,815</u>	<u>7,579,766</u>	<u>6,716,750</u>
<b>Expenses:</b>				
Health plan services . . . . .	1,772,020	1,575,723	5,355,613	4,628,738
Government contracts/Specialty services . . . . .	322,782	283,306	898,117	810,663
Selling, general and administrative . . . . .	329,339	310,576	1,001,641	944,558
Depreciation . . . . .	15,279	16,423	48,339	50,375
Amortization . . . . .	9,426	9,675	28,265	28,979
Interest . . . . .	12,735	22,736	43,581	66,003
Net (gain) loss on sale of businesses and properties . . . . .	—	(1,068)	76,072	(1,068)
Asset impairment, restructuring and other costs . . . . .	79,667	—	79,667	—
Total expenses . . . . .	<u>2,541,248</u>	<u>2,217,371</u>	<u>7,531,295</u>	<u>6,528,248</u>
Income before income taxes . . . . .	3,691	70,444	48,471	188,502
Income tax provision . . . . .	1,365	25,797	17,935	71,105
Net income . . . . .	<u>\$ 2,326</u>	<u>\$ 44,647</u>	<u>\$ 30,536</u>	<u>\$ 117,397</u>
Health plan services medical care ratio (MCR) . . . . .	85.2%	85.3%	85.6%	85.2%
Government contracts/Specialty services MCR . . . . .	72.1%	68.4%	71.6%	66.9%
Administrative (SG&A + Depreciation) ratio . . . . .	13.6%	14.5%	14.0%	15.0%
Health plan premiums per member per month . . . . .	\$ 167.21	\$ 158.55	\$ 167.69	\$ 155.35
Health plan services per member per month . . . . .	\$ 145.31	\$ 138.21	\$ 146.32	\$ 135.34

## Enrollment Information

The table below summarizes our enrollment information at September 30, 2001 and 2000.

	<u>September 30,</u>		<u>Percent</u> <u>Change</u>
	<u>2001</u>	<u>2000</u>	
	(Enrollees in Thousands)		
Health Plan Services:			
Commercial . . . . .	3,035	2,801	8.4%
Medicare . . . . .	224	223	0.4%
Medicaid . . . . .	763	614	24.3%
Continuing plans . . . . .	4,022	3,638	10.6%
Discontinued plans . . . . .	7	174	(96.0)%
Total Health Plan Services . . . . .	<u>4,029</u>	<u>3,812</u>	5.7%
Government Contracts:			
TRICARE PPO and Indemnity . . . . .	519	567	(8.5)%
TRICARE HMO . . . . .	949	896	5.9%
Total Government Contracts . . . . .	<u>1,468</u>	<u>1,463</u>	0.3%
ASO . . . . .	<u>79</u>	<u>84</u>	(6.0)%

The following discussion on enrollment changes relates to our continuing plans only and excludes our discontinued plans. Discontinued plans included Colorado, Florida and Washington. As of September 30, 2001, we had membership in Florida and Washington. We no longer had any membership in Colorado as of September 30, 2001. Membership in these plans is expected to decline due to completion of divestitures or as the operations in these plans continue to wind down.

Commercial membership increased 8.4% to 3.0 million members at September 30, 2001 compared to 2.8 million members at September 30, 2000 primarily due to the following:

- 15.9% increase in California primarily in individual sales of POS products and small business and individual/family plan PPO products,
- 7.3% increase in New York primarily in small group POS and HMO products, and
- 34.1% increase in New Jersey primarily in small group POS and HMO products.

Medicare membership remained at a constant level across all markets at September 30, 2001 compared to September 30, 2000.

Medicaid membership increased 24.3% to 763,000 members at September 30, 2001 compared to 614,000 members at September 30, 2000 primarily due to increased sales of children's health programs in California, particularly the Healthy Families program.

Government contracts covered approximately 1.5 million eligible individuals under the TRICARE program at September 30, 2001 and 2000. Dependents of active-duty military personnel and retirees and their dependents are automatically eligible to receive benefits under the TRICARE program. Any changes in the enrollment reflect the timing of when the individuals become eligible.

### *Health Plan Services Premiums*

Health Plan Services premiums increased \$231.2 million or 12.5% for the third quarter ended September 30, 2001 and \$826.9 million or 15.2% for the nine months ended September 30, 2001 as compared to the same periods in 2000 primarily due to the following:

- 5.5% and 7.9% increases in per member per month (PMPM) premiums due to rate increases for the third quarter and nine months ended September 30, 2001, respectively, and
- 5.7% increase in net membership as compared to September 30, 2000.

The Florida health plan, excluding the \$76.1 million loss on sale, had premium revenues of \$45.8 million and a net loss of \$2.3 million for the third quarter ended September 30, 2001, and premium revenues of \$339.7 million and a net loss of \$11.5 million for the nine months ended September 30, 2001.

### *Government Contracts/Specialty Services Revenues*

Government Contracts/Specialty Services revenues increased \$33.6 million or 8.1% for the third quarter ended September 30, 2001 and \$41.8 million or 3.5% for the nine months ended September 30, 2001, as compared to the same periods in 2000 primarily due to the following:

- Increase in revenues from the new TRICARE for Life Program,
- Other TRICARE contracts from higher health care costs resulting in higher risk share revenues from the government and increased change orders, offset by
- Decrease in revenues from the mental health portion of the TRICARE contracts shifting from fee-for-service to ASO.

### *Investment and Other Income*

Investment and other income decreased \$7.7 million, or 29.4%, and \$5.7 million, or 7.7%, for the third quarter and nine months ended September 30, 2001, respectively as compared to the same periods in 2000. The decrease in investment income is due to a decrease in the average yield which was partially offset by higher invested assets during the third quarter and nine months ended September 30, 2001, as compared to the same periods in 2000. The decrease in the average yield for the third quarter ended September 30, 2001 is reflective of the Federal Reserve's continued lowering of interest rates. Additionally, other income decreased due to certain one-time payments associated with the sale of membership in our discontinued plans which were received in the third quarter ended September 30, 2000.

### *Health Plan Services Medical Care Ratio (MCR)*

Health Plan Services costs rose 5.1% on PMPM basis for the third quarter ended September 30, 2001 and 8.1% on PMPM basis for the nine months ended September 30, 2001 as compared to the same periods in 2000. This increase in the third quarter ended September 30, 2001 as compared to the same period in 2000 includes a 7.5% increase in hospital costs, a 6.2% increase in physician costs and a 4.9% increase in pharmacy costs on a PMPM basis.

The MCR for the third quarter ended September 30, 2001 decreased to 85.2% from 85.3% compared to the same period in 2000. The MCR for the nine months ended September 30, 2001 increased to 85.6% from 85.2% as compared to the same period in 2000.

### *Government Contracts/Specialty Services MCR*

Government Contracts/Specialty Services MCR increased to 72.1% and 71.6% for the third quarter and nine months ended September 30, 2001, respectively, as compared to 68.4% and 66.9% for the same periods in 2000, respectively. The increases are primarily due to the following:

- The mental health portion of the TRICARE contracts shifting from fee-for-service to ASO, and
- Increased benefit payments from our behavioral health care subsidiary due to parity provisions requiring behavioral health service providers to offer the same level of services to all current health plan members as well as increased benefit levels on new businesses.

### *Selling, General and Administrative (SG&A) Expenses*

The administrative expense ratio (SG&A and depreciation as a percentage of Health Plan premiums and Government Contracts/Specialty Services revenues) decreased to 13.6% and 14.0% for the third quarter and nine months ended September 30, 2001, respectively, from 14.5% and 15.0% for the same periods in 2000, respectively. This decrease is primarily attributable to our ongoing efforts to control our SG&A expenses. We continue to focus efforts on ways to adopt technology to our business processes to improve efficiencies.

See “Asset Impairment, Restructuring and Other Costs” for discussion on impact to future SG&A expenses.

### *Amortization and Depreciation*

Amortization and depreciation expense for the third quarter and nine months ended September 30, 2001 decreased by \$1.4 million or 5.3% and \$2.8 million or 3.5%, respectively, as compared to the same periods in 2000. The decrease is primarily due to various leasehold improvements, personal computer equipment and software being completely depreciated prior to or during the third quarter ended September 30, 2001.

The effect of the suspension of the depreciation on the corporate facility building in Florida was immaterial for the third quarter and nine months ended September 30, 2001.

### *Interest Expense*

Interest expense decreased by \$10.0 million or 44.0% for the third quarter ended September 30, 2001 and by \$22.4 million or 34.0% for the nine months ended September 30, 2001, as compared to the same periods in 2000. This decrease reflects the \$322.5 million decline in long-term debt to \$623.9 million from \$946.4 million as of September 30, 2000. During the first quarter ended March 31, 2001, we used the net proceeds of \$284.0 million, after certain payments to vendors, from our global settlement of the outstanding TRICARE receivables to pay down our long-term debt.

### *Income Tax Provision*

The effective income tax rate was 37.0% for the third quarter and nine months ended September 30, 2001, as compared with 36.6% and 37.7% for the third quarter and nine months ended September 30, 2000, respectively. The year-to-date rate declined primarily due to tax minimization strategies.

The effective tax rate of 37.0% for the third quarter and nine months ended September 30, 2001, differed from the statutory federal tax rate of 35.0% due primarily to state income taxes, goodwill amortization, and tax-exempt investment income.

## ASSET IMPAIRMENT, RESTRUCTURING AND OTHER COSTS

The following table summarizes the restructuring charges we recorded during the third quarter ended September 30, 2001:

	2001 Charges	Cash Payments	Non-cash	Balance at September 30, 2001	Expected Future Cash Outlays
	(amount in millions)				
Severance and benefit related costs . . .	\$43.3	\$(15.7)	\$ —	\$27.6	\$27.6
Asset impairment costs . . . . .	27.9	—	(27.9)	—	—
Real estate lease termination costs . . . .	5.1	—	—	5.1	5.1
Other costs . . . . .	3.4	—	(2.3)	1.1	1.1
Total restructuring charges . . . . .	<u>\$79.7</u>	<u>\$(15.7)</u>	<u>\$(30.2)</u>	<u>\$33.8</u>	<u>\$33.8</u>

As part of our ongoing selling, general and administrative (SG&A) expense reduction efforts, during the third quarter of 2001, we finalized a formal plan to reduce operating and administrative expenses for all business units within the Company (the 2001 Plan). In connection with the 2001 Plan, we decided on enterprise-wide staff reductions and consolidations of certain administrative, financial and technology functions. We recorded pretax restructuring charges of \$79.7 million during the third quarter ended September 30, 2001 (2001 Charge). Of the total 2001 Charge, approximately \$49.5 million will result in cash outlays. We plan to use cash flows from operations to fund these payments. We estimate a minimum annual pretax cost savings in SG&A expenses of approximately \$10 million as a result of the initiatives to improve our cost structure net of investments in technology, process redesign, business transformation and economic uncertainties.

### SEVERANCE AND BENEFIT RELATED COSTS

During the third quarter ended September 30, 2001, we recorded severance and benefit related costs of \$43.3 million related to enterprise-wide staff reductions, which costs were included in the 2001 Charge. These reductions include the elimination of approximately 1,500 positions throughout all functional groups, divisions and corporate offices within the Company. As of September 30, 2001, 769 positions have been eliminated and \$15.7 million of the severance and benefit related costs have been paid out. We expect that an additional \$12.6 million will be paid out during the fourth quarter of 2001 with the remaining balance to be paid during 2002. Elimination of the remaining 748 positions will be completed over the next twelve months.

### ASSET IMPAIRMENT COSTS

Pursuant to SFAS No. 121, we evaluated the carrying value of certain long-lived assets that were affected by the 2001 Plan. The affected assets were primarily comprised of information technology systems and equipment, software development projects and leasehold improvements. We determined that the carrying value of these assets exceeded their estimated fair values. The fair values of these assets were determined based on market information available for similar assets. For certain of the assets, we determined that they had no continuing value to us due to our abandoning certain plans and projects in connection with our workforce reductions.

Accordingly, we recorded asset impairment charges of \$27.9 million consisting entirely of non-cash write-downs of equipment, building improvements and software application and development costs, which charges were included in the 2001 Charge. The carrying value of these assets was \$36.2 million as of September 30, 2001.

The asset impairment charges of \$27.9 million consists of \$10.8 million for write-downs of assets related to the consolidation of four data centers, including all computer platforms, networks and applications into a single processing facility at our Hazel Data Center; \$16.3 million related to abandoned software applications and development projects resulting from the workforce reductions, migration of certain systems and investments to more robust technologies; and \$0.8 million for write-downs of leasehold improvements.

#### **REAL ESTATE LEASE TERMINATION COSTS**

The 2001 Charge included charges of \$5.1 million related to termination of lease obligations and non-cancelable lease costs for excess office space resulting from streamlined operations and consolidation efforts. Approximately \$0.1 million of the termination obligations will be paid during the fourth quarter of 2001 with the remainder to be paid during 2002 and throughout the respective lease terms.

#### **OTHER COSTS**

The 2001 Charge included charges of \$3.4 million related to costs associated with consolidating certain data center operations and systems and other activities which are expected to be completed in the first quarter of 2002. Approximately \$0.6 million of these costs will be paid by the end of 2001 with the remainder to be paid during the first quarter of 2002.

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

The managed health care industry is labor intensive and its profit margin is low, so 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 us.

Federal and state legislators continue to propose various legislative initiatives regarding the health care industry, including federal “patients’ bill of rights” legislation. See “Item 5—Recent Developments—Legislation.” If federal or state legislatures enact further health care reform or similar legislation, the legislation could affect us. Management cannot at this time predict the specifics of any of these initiatives, whether federal or state legislatures will enact any of these initiatives or, if enacted, how any of these initiatives will financially impact us.

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

Our 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 and are based on various assumptions. External forces such as changes in the rate of inflation, the regulatory environment, medical costs and other factors may affect reserves. Establishment of appropriate reserves is an inherently uncertain process. There can be no certainty that currently established reserves will prove adequate in light of subsequent actual experience. Reserve estimates in the past have been, and in the future may be, too high or too low. 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.

Our California HMO subsidiary contracts with providers in California primarily through capitation fee arrangements. Our HMO subsidiaries in other areas contract with providers, to a lesser degree, through capitation fee arrangements. Under a capitation fee arrangement, our 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 our HMO subsidiaries, even though such subsidiaries have made their regular payments to the capitated providers. Depending on state law, our HMO subsidiaries may or may not be liable for such claims. In California, the issue of whether HMOs are liable for unpaid provider claims has not been definitively settled. The California agency that until July 1, 1999 acted as regulator of HMOs had issued a written statement to the effect that HMOs are not liable for such claims. However, there is currently ongoing litigation on the subject among providers and HMOs, including our California HMO subsidiary.

## **LIQUIDITY AND CAPITAL RESOURCES**

Certain of our subsidiaries must comply with minimum capital and surplus requirements under applicable state laws and regulations, and must have adequate reserves for claims. Certain of our subsidiaries must maintain ratios of current assets to current liabilities pursuant to certain government contracts. We believe we are in compliance with these contractual and regulatory requirements in all material respects.

We believe 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.

We regularly evaluate cash requirements for current operations and commitments, and for capital acquisitions and other strategic transactions. We may elect to raise additional funds for these purposes through additional debt or equity, the sale of investment securities or otherwise.

Effective August 1, 2001, we completed the sale of our Florida health plan, known as Foundation Health, a Florida Health Plan, Inc., to Florida Health Plan Holdings II, LLC. In connection with the sale, we received approximately \$49 million which consists of \$23 million in cash and approximately \$26 million in a secured six-year note bearing eight percent interest per annum. We also sold the corporate facility building used by our former Florida health plan to DGE Properties, LLC for \$15 million, payable by a secured five-year note bearing eight percent interest per annum. We recorded a \$76.1 million pre-tax loss on the sales of our Florida health plan and the related corporate facility building for the nine months ended September 30, 2001. As part of the Florida sale agreement, there will be a series of true up processes that will take place during 2001 and 2002 that could result in additional loss or gain recognition.

On June 28, 2001, we completed the refinancing of our credit facility maturing in July 2002. The previous credit facility was refinanced with two new credit facilities, a 364-day \$175.0 million revolving credit facility and a five-year \$525.0 million revolving credit and competitive advance facility.

On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent (or all-in cost rate of 8.54%) Senior Notes due in April 2011. The net proceeds of \$395.1 million from the Senior Notes were used to repay outstanding borrowings under our then-existing revolving credit facility. Effective October 4, 2001, we completed an exchange offer for the senior notes in which the outstanding Senior Notes were exchanged for an equal aggregate principal

amount of new 8.375 percent Senior Notes due 2011 that have been registered under the Securities Act of 1933, as amended.

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

In December 2000, our subsidiary, Health Net Federal Services, Inc., and the Department of Defense agreed to a settlement of approximately \$389 million for outstanding receivables related to our three TRICARE contracts and for the completed contract for the Civilian Health and Medical Program of the Uniformed Services Reform Initiative. Approximately \$60 million of the settlement amount was received in December 2000. The majority of the remaining settlement that was received on January 5, 2001 was used to reduce the amounts receivable under government contracts. The receivable items settled by this payment include change orders, bid price adjustments, equitable adjustments and claims. These receivables developed as a result of TRICARE health care costs rising faster than the forecasted health care cost trends used in the original contract bids, data revisions on formal contract adjustments, and routine contract changes for benefits. Net proceeds of \$284 million, after paying vendors, providers and amounts owed back to the government, were applied to the continuing operating needs of the three TRICARE contracts and to reducing the outstanding balance of the notes payable.

#### *Operating Cash Flows*

Net cash provided by operating activities was \$447.3 million for the nine months ended September 30, 2001 compared to net cash used in operating activities of \$26.9 million for the same period in 2000. This change was primarily due to the effect of timing of Medicare payments on our unearned premiums and net proceeds of \$284 million, after certain payments to vendors, from our global settlement of the outstanding TRICARE receivables.

In July and August 2001, we paid approximately \$21.0 million to certain former minority shareholders of a current subsidiary in connection with a merger involving that subsidiary in 1999. We are obligated to pay up to an additional \$12.7 million to former minority shareholders in connection with the merger, approximately \$6 million of which is contingent on our New Jersey health plan meeting certain financial performance criteria. These amounts totaling \$33.7 million were recorded as a current liability as of December 31, 2000. See “Item 5—Recent Developments—FOHP” for a more complete description.

#### *Investing Activities*

Net cash used in investing activities was \$211.0 million for the nine months ended September 30, 2001 as compared to net cash used in investing activities of \$14.9 million during the same period in 2000. This change was primarily due to net cash outflows resulting from the sale of our Florida Plan and increased purchases of investments net of reinvested proceeds from the sales and maturities of investments.

Throughout 2000 and the nine months ended September 30, 2001, we provided funding in the amount of approximately \$10.0 million to MedUnite, Inc., an independent company, funded and organized by seven major managed health care companies. MedUnite, Inc. is designed to provide on-line internet provider connectivity services including eligibility information, referrals, authorizations, claims submission and payment. The funded amounts are included in other noncurrent assets.

During 2000, we secured an exclusive e-business connectivity services contract from the Connecticut State Medical Society IPA, Inc. (CSMS-IPA) for \$15.0 million. CSMS-IPA is an association

of medical doctors providing health care primarily in Connecticut. The amounts paid to CSMS-IPA for this agreement are included in other noncurrent assets.

### *Financing Activities*

Net cash used in financing activities was \$138.5 million for the nine months ended September 30, 2001 as compared to \$92.5 million during the same period in 2000. The change was due to an increase in the repayment of funds drawn under our then \$1.5 billion credit facility, which was primarily funded by the TRICARE settlement amount received in January 2001.

On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent Senior Notes due in April 2011 at a discount of \$1.4 million. The net cash proceeds of \$395.1 million from the Senior Notes were used to repay outstanding borrowings under the then-existing revolving credit facility. Effective October 4, 2001, we completed an exchange offer for the senior notes in which the outstanding Senior Notes were exchanged for an equal aggregate principal amount of new 8.375 percent Senior Notes due 2011 that have been registered under the Securities Act of 1933, as amended.

On June 28, 2001, we refinanced our previous \$1.5 billion revolving credit facility with credit agreements for two new revolving syndicated credit facilities, with Bank of America, N.A. as administrative agent, that replaced our \$1.5 billion credit facility. The new facilities, providing for an aggregate of \$700 million in borrowings, consist of a \$175 million 364-day revolving credit facility and a \$525 million five-year revolving credit and competitive advance facility. At our election, 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 alternative base rate. Actual rates on borrowings under the credit facility vary, based on competitive bids and our unsecured credit rating at the time of the borrowing. As of September 30, 2001, we were in compliance with the financial covenants of the credit facilities. See “Item 5—Recent Developments—Credit Agreements.”

As of September 30, 2001, the maximum commitment level under the 364-day credit facility agreement was \$175.0 million of which approximately \$175.0 million remained available. The 364-day credit facility expires in June 2002. As of September 30, 2001, the maximum commitment level under the five-year credit facility agreement was \$525.0 million, of which approximately \$300.0 million remained available. The five-year credit facility expires in June 2006.

### **STATUTORY CAPITAL REQUIREMENTS**

Our subsidiaries must comply with certain minimum capital requirements under applicable state laws and regulations. As necessary, we make contributions to our subsidiaries to meet risk-based capital requirements under state laws and regulations. We contributed \$6.2 million and \$56.0 million to certain of our subsidiaries to meet capital requirements during the third quarter and nine months ended September 30, 2001, respectively. As of September 30, 2001, our subsidiaries were in compliance with all minimum capital requirements. Of the capital contributions made, \$22.3 million were to our Florida health plan during the nine months ended September 30, 2001. In October 2001, we made no contributions to our subsidiaries to meet statutory capital requirements. We intend to further strengthen our statutory capital through 2001 by allowing some earnings to be retained by our regulated subsidiaries.

Effective January 1, 2001, certain of the states in which our regulated subsidiaries operate adopted the codification of statutory accounting principles. This means that the amount of capital contributions required to meet risk-based capital and minimum capital requirements may change. Any reduction in the statutory surplus as a result of adopting the codification of statutory accounting principles may require us to contribute additional capital to our subsidiaries to satisfy minimum statutory net worth requirements. As of September 30, 2001, the adoption of the codification of statutory accounting

principles did not have a material impact on the amount of capital contributions required to meet risk-based capital and other minimum capital requirements.

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

As a result of the above requirements and other regulatory requirements, certain subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to the parent company. Such restrictions, unless amended or waived, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends which can be paid by our insurance company subsidiaries to us without prior approval of the insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. We believe that as of September 30, 2001, all of our health plans and insurance subsidiaries met their respective regulatory requirements.

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

In 2000 and 2001, the Department of Health and Human Services (DHHS) issued final regulations under the administrative simplification provisions of HIPAA relating to “Standards for Electronic Transactions and Code Sets” (with an implementation date of October 16, 2002) and “Standards for Privacy of Individually Identifiable Health Information” (with a compliance date by April 14, 2003). The new regulations require health plans, clearinghouses and providers to (a) comply with various requirements and restrictions related to the use, storage and disclosure of private health information (PHI), (b) adopt rigorous internal procedures to protect PHI, (c) enter into specific written agreements with business associates to whom PHI is disclosed and (d) accept nine transactions electronically, in a specified format, using specified code sets. The regulations establish significant criminal penalties and civil sanctions for non-compliance. In addition, the regulations could expose us to additional liability for, among other things, violations of the regulations by our business associates. We believe that the costs required to comply with the regulations will be significant and may have a material adverse impact on our business or results of operations.

### **ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK**

We are exposed to interest rate and market risk primarily due to our 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. We are 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, we are 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.

We have several bond portfolios to fund reserves. We attempt to manage the interest rate risks related to our investment portfolios by actively managing the asset/liability duration of our investment portfolios. The overall goal of the investment portfolios is to provide a source of liquidity and to support the ongoing operations of our business units. Our 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 will have additional requirements with respect to liquidity, current income and contribution to surplus. We manage these risks by setting risk tolerances, targeting asset-class allocations, diversifying among assets and asset characteristics, and using performance measurement and reporting.

We use 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.

We assumed a portfolio disposition period of 30 days with a confidence level of 95 percent for the 2001 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 \$1.7 million as of September 30, 2001.

Our 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 our investment portfolios during the year. However, we believe 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, we have some interest rate market risk due to our credit facility borrowings. Notes payable and other financing arrangements totaled \$624.3 million at September 30, 2001 and the related average interest rate on the floating rate borrowings was 5.0% (which interest rate is subject to change pursuant to the terms of the Credit Facility). See a description of the Credit Facility under “Item 5—Recent Developments—Credit Agreements.” The table below presents the expected cash outflows of market risk sensitive instruments at September 30, 2001 and the \$400 million senior notes offering completed on April 12, 2001. These cash outflows include both expected principal and interest payments consistent with the terms of the outstanding debt as of September 30, 2001.

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>Beyond</u>	<u>Total</u>
Long-term floating borrowings:							
Interest . . . . .	\$29,938	\$11,406	\$11,406	\$11,406	\$11,406	\$ 5,703	\$ 81,265
Principal . . . . .						225,000	225,000
Fixed-rate borrowings:							
Interest . . . . .	16,750	33,500	33,500	33,500	33,500	184,250	335,000
Principal . . . . .						400,000	400,000
Total cash outflows . . . . .	<u>\$46,688</u>	<u>\$44,906</u>	<u>\$44,906</u>	<u>\$44,906</u>	<u>\$44,906</u>	<u>\$814,953</u>	<u>\$1,041,265</u>

## **PART II. OTHER INFORMATION**

### **ITEM 1. LEGAL PROCEEDINGS**

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

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

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

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

Superior seeks \$300 million in compensatory damages, unspecified punitive damages and the costs of the action, including attorneys' fees.

On August 1, 2000, a motion filed by us and FHC to remove the lawsuit from the jurisdiction of the Bankruptcy Court to the United States District Court for the Central District of California was granted. The lawsuit is now pending in the District Court under case number SACV00-0658 GLT. The parties are currently engaged in discovery.

We intend to defend ourselves vigorously in this litigation.

#### **FPA MEDICAL MANAGEMENT, INC.**

Since May 1998, several complaints have been filed in federal and state courts seeking an unspecified amount of damages on behalf of an alleged class of persons who purchased shares of common stock, convertible subordinated debentures and options to purchase common stock of FPA Medical Management, Inc. (FPA) at various times between February 3, 1997 and May 15, 1998. The complaints name as defendants FPA, certain of FPA's auditors, us and certain of our former officers. The complaints allege that we and such former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between us and FPA, about FPA's business and about our 1997 sale of FPA common stock held by us. All claims against our former officers were voluntarily dismissed from the consolidated class actions in both federal and state court. We have filed a motion to dismiss all claims asserted against us in the consolidated federal

class actions but have not formally responded to the other complaints. We intend to vigorously defend the actions.

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

Physicians Health Services, Inc. (PHS), a subsidiary of ours, was sued on December 14, 1999 in the United States District Court in Connecticut by the Attorney General of Connecticut, Richard Blumenthal, acting on behalf of a group of state residents. The lawsuit was premised on ERISA, and alleged that PHS violated its duties under ERISA by managing its prescription drug formulary in a manner that served its own financial interest rather than those of plan beneficiaries. The suit sought to have PHS revamp its formulary system, and to provide patients with written denial notices and instructions on how to appeal. PHS filed a motion to dismiss which asserted that the state residents the Attorney General purported to represent all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that his office lacked standing to bring the suit and that the allegations failed to state a claim under ERISA. On July 12, 2000, the court granted PHS' motion and dismissed the action. The State of Connecticut has appealed the dismissal and argument on the appeal was held before the United States Court of Appeals for the Second Circuit on May 1, 2001. We intend to vigorously defend the action.

#### IN RE MANAGED CARE LITIGATION

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

##### *Subscriber Track*

The subscriber track includes the following actions involving us: *Pay v. Foundation Health Systems, Inc.* (filed in the Southern District of Mississippi on November 22, 1999), *Romero v. Foundation Health Systems, Inc.* (filed in the Southern District of Florida on June 23, 2000 as an amendment to a suit filed in the Southern District of Mississippi), *State of Connecticut v. Physicians Health Services of Connecticut, Inc.* (filed in the District of Connecticut on September 7, 2000), and *Albert v. CIGNA Healthcare of Connecticut, Inc., et al.* (including Physicians Health Services of Connecticut, Inc. and Foundation Health Systems, Inc.) (filed in the District of Connecticut on September 7, 2000). The *Pay* and *Romero* actions seek certification of nationwide class actions, unspecified damages and injunctive relief, and allege that cost containment measures used by our 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 *Albert* suit also alleges violations of ERISA and seeks certification of a nationwide class and unspecified damages and injunctive relief. The *State of Connecticut* action asserts claims against our subsidiary, Physicians Health Services of Connecticut, Inc., and us that are similar, if not identical, to those asserted in the previous lawsuit that was dismissed, as discussed above, on July 12, 2000.

We filed a motion to dismiss the lead subscriber track case, *Romero v. Foundation Health Systems, Inc.*, and on June 12, 2001, the court entered an order dismissing all claims in that suit brought against Health Net with leave for the plaintiffs to re-file an amended complaint. On this same date, the court stayed discovery until after the court rules upon motions to dismiss the amended complaints and any motions to compel arbitration. On June 29, 2001, the plaintiffs in *Romero* filed a third amended class action complaint which re-alleges causes of action under RICO, ERISA, common law civil conspiracy

and common law unjust enrichment. The third amended class action complaint seeks unspecified compensatory and treble damages and equitable relief. On July 24, 2001, the court heard oral argument on class certification issues. On August 17, 2001, we filed a motion to dismiss the third amended complaint in *Romero*.

#### *Provider Track*

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

On August 17, 2000, a complaint was filed in the United States District Court for the Southern District of Florida in *Shane*, the lead provider track action in MDL 1334. The complaint seeks certification of a nationwide class action on behalf of physicians and alleges that the defendant managed care companies' methods of reimbursing physicians violate provisions of RICO, ERISA, certain federal regulations and various state laws. The action seeks unspecified damages and injunctive relief.

On September 22, 2000, we filed a motion to dismiss, or in the alternative to compel arbitration in *Shane*. On December 11, 2000, the court granted in part and denied in part our motion to compel arbitration. Under the court's December arbitration order, plaintiff Dennis Breen, the single named plaintiff to allege a direct contractual relationship with us in the August complaint, was compelled to arbitrate his direct claims against us. We have filed an appeal in the United States Court of Appeals for the 11th Circuit seeking to overturn the portion of the district court's December ruling that did not order certain claims to arbitration. On April 26, 2001, the court modified its December arbitration order and is now retaining jurisdiction over certain direct claims of plaintiff Breen relating to a single contract. On March 2, 2001, the District Court for the Southern District of Florida issued an order in *Shane* granting the dismissal of certain claims with prejudice and the dismissal of certain other claims without prejudice, and denying the dismissal of certain claims.

On March 26, 2001, a consolidated amended complaint was filed in *Shane* against managed care companies, including us. This consolidated complaint adds new plaintiffs, including Leonard Klay and the California Medical Association (who, as set forth below, had previously filed claims against the Company), and has, in addition to revising the pleadings of the original claims, added a claim under the California Business and Professions Code. On May 1, 2001, we filed a motion to compel arbitration in *Shane* of the claims of all individual plaintiffs that allege to have treated persons insured by us. On that same date, we filed a motion to dismiss this action. Preliminary discovery and briefing regarding the plaintiffs' motion for class certification has taken place. On May 7, 2001, the court heard oral argument on class certification issues in *Shane*. On May 9, 2001, the court entered a scheduling order permitting further discovery. On May 14, 2001, Health Net joined in a motion for stay of proceedings in *Shane v. Humana, Inc., et al.* (including Foundation Health Systems, Inc.) (00-1334-MD) in the United States District Court for the Southern District of Florida pending appeal in the 11th Circuit Court of Appeals. On June 17, 2001, the district court stayed discovery until after the district court rules upon motions to dismiss and motions to compel arbitration. This order staying discovery also applies to other actions transferred to the district court by the Judicial Panel on Multidistrict Litigation, namely *California Medical Association v. Blue Cross of California, Inc. et al., Klay v. Prudential Ins. Co. of*

*America, et al., Connecticut State Medical Society v. Physicians Health Services of Connecticut, Inc.*, and *Lynch v. Physicians Health Services of Connecticut, Inc.* On June 25, 2001, the 11th Circuit Court of Appeals entered an order staying proceedings in the district court pending resolution of the appeals relating to the district court's ruling on motions to compel arbitration. The Eleventh Circuit has scheduled oral argument on the arbitration issues for the week of January 7, 2002.

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

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

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

The *Lynch* case was also originally filed in Connecticut state court. This case was purportedly brought on behalf of physicians members of the Connecticut State Medical Society who provide health care services to PHS-CT health plan members pursuant to provider service contracts. The complaint alleges that PHS-CT engaged in improper, unfair and deceptive practices by denying, impeding and/or delaying lawful reimbursement to physicians. The complaint, similar to the complaint referred to above filed against PHS-CT on the same day by the Connecticut State Medical Society, seeks declaratory and injunctive relief, and damages. On March 13, 2001, we removed this action to federal court. Before this case was transferred to MDL 1334, the plaintiffs moved to remand the action to state court and the District Court of Connecticut consolidated this action and *CSMS v. Physicians Health Services of Connecticut, Inc.*, along with similar actions against Aetna, CIGNA and Anthem, into one case entitled *CSMS v. Aetna Health Plans of Southern New England, et al.* PHS-CT has not yet responded to the complaint.

As noted above, on June 17, 2001, the district court entered an order which applies to the *Shane*, *CMA*, *Klay*, *CSMS* and *Lynch* actions and stays discovery until after the court rules upon motions to dismiss and motions to compel arbitration.

#### MISCELLANEOUS PROCEEDINGS

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

## **ITEM 2. CHANGES IN SECURITIES**

On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent Senior Notes due in 2011. We completed a registered exchange offer for the Senior Notes on October 4, 2001. These transactions are described in Item 5 under “Recent Developments—Debt Offering.” The new Senior Notes issued in the exchange offer are identical in all material respects to the terms of the old Senior Notes, except that the new Senior Notes have been registered under the Securities Act of 1933, as amended (the “Securities Act”), do not bear restrictive legends restricting their transfer under the Securities Act, are not entitled to registration rights and do not contain provisions relating to an increase in the applicable interest rate under circumstances related to the timing of the exchange offer.

On May 3, 2001, our board of directors approved an amendment to our Rights Agreement. The amendment provides that certain passive institutional investors that beneficially own less than 17.5% of the outstanding shares of our common stock shall not be deemed to be “Acquiring Persons,” as defined in the Rights Agreement. The amendment also provides, among other things, for the appointment of Computershare Investor Services, L.L.C. as the Rights Agent. The full text of the amendment is included as Exhibit 3 to our Current Report on Form 8-K dated May 3, 2001 and filed with the SEC on May 9, 2001.

On May 7, 2001, we filed a Fifth Amended and Restated Certificate of Incorporation which eliminated the separation of our Board of Directors into three separate classes and replaced it with a Board of Directors elected on an annual basis, and eliminated provisions relating to the removal of directors. Our stockholders approved these changes to our Certificate of Incorporation at our Annual Meeting of Stockholders on May 3, 2001. We filed a corrected Fifth Amended and Restated Certificate of Incorporation on July 3, 2001, the full text of which is included as Exhibit 3.1 to our Registration Statement on Form S-4 filed with the SEC on August 10, 2001.

## **ITEM 3. DEFAULTS UPON SENIOR SECURITIES**

Not applicable.

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

No matters were submitted to a vote of our security holders during the quarter ended September 30, 2001.

## **ITEM 5. OTHER INFORMATION**

### **RECENT DEVELOPMENTS**

**DEBT OFFERING.** On April 12, 2001, we completed our offering of \$400 million aggregate principal amount of 8.375 percent Senior Notes due in April 2011. The net proceeds of \$395.1 million from the Senior Notes have been used to repay outstanding borrowings under our then-existing revolving credit facility. On October 4, 2001, we completed an exchange offer for the Senior Notes in which the outstanding Senior Notes were exchanged for an equal aggregate principal amount of new 8.375 percent Senior Notes due in 2011 that have been registered under the Securities Act of 1933, as amended.

**FLORIDA OPERATIONS.** Effective August 1, 2001, we completed the sale of our Florida health plan to Florida Health Plan Holdings II, LLC for approximately \$49 million, consisting of \$23 million in cash and approximately \$26 million in a secured six-year note bearing 8% interest per annum. In addition, we sold our Florida corporate facility building to DGE Properties, LLC for \$15 million, payable by a secured 5-year note bearing 8% interest per annum.

**KPC ORGANIZATION.** Our California HMO subsidiary, Health Net of California, Inc. (HN California), was contracted with KPC Medical Management, Inc. (together with its affiliates, the “KPC Organization”), one of the largest provider organizations in Southern California, to provide health care services to approximately 66,000 of its members. During 2000, as the KPC Organization experienced continuing financial difficulties, HN California and other health plans made loans and other financial accommodations to the KPC Organization. The aggregate principal amount of such loans allocated to HN California is \$8.5 million, and certain of such loans are secured by real estate. Notwithstanding such financial accommodations, the KPC Organization continued to incur losses. In late November 2000, the KPC Organization filed a petition seeking reorganization under Chapter 11 of the Bankruptcy Code. All of HN California’s membership previously assigned to the KPC Organization has now been reassigned to other provider organizations. However, the KPC Organization left unpaid significant provider claims which are unlikely to be discharged to any substantial degree through distribution of proceeds of the bankruptcy estate. Accordingly, there is the possibility that HN California will be at risk for the unpaid portion of those provider claims. We are not able at this time to assess the extent of such unpaid claims and whether the providers will seek to hold us liable for them. We are also unable to assess at this time the probability that we will be held liable in any litigation arising from these provider claims.

**CREDIT AGREEMENTS.** We have two credit facilities with Bank of America, N.A., as administrative agent, each governed by a separate credit agreement dated as of June 28, 2001. The credit facilities, providing for an aggregate of \$700 million in borrowings, consist of:

- a \$175 million 364-day revolving credit facility; and
- a \$525 million five-year revolving credit and competitive advance facility.

We established the credit facilities to refinance our then-existing credit facility and to finance any lawful general corporate purposes, including acquisitions and working capital. The credit facilities allow us to borrow funds:

- by obtaining committed loans from the group of lenders as a whole on a pro rata basis;
- by obtaining under the five-year facility loans from individual lenders within the group by way of a bidding process;
- by obtaining under the five-year facility swingline loans in an aggregate amount of up to \$50 million that may be requested on an expedited basis; and
- by obtaining under the five-year facility letters of credit in an aggregate amount of up to \$200 million.

*Repayment.* The 364-day credit facility expires on June 27, 2002. We must repay all borrowings under the 364-day credit facility by June 27, 2004. The five-year credit facility expires in June 2006, and we must repay all borrowings under the five-year credit facility by, June 28, 2006, unless the five-year credit facility is extended. The five-year credit facility may, at our request and subject to approval by lenders holding two-thirds of the aggregate amount of the commitments under the five-year credit facility, be extended for up to two twelve-month periods to the extent of the commitments made under the five-year credit facility by such approving lenders. Swingline loans under the five-year credit facility are subject to repayment within no more than seven days.

*Covenants.* The credit agreements contain negative covenants, including financial covenants, that impose restrictions on our operations. The financial covenants in the credit agreements provide that

- for any period of four consecutive fiscal quarters, the consolidated leverage ratio, which is the ratio of (i) our consolidated funded debt to (ii) our consolidated net income before interest, taxes, depreciation, amortization and other specified items (consolidated EBITDA), must not exceed 3 to 1;

- for any period of four consecutive fiscal quarters, the consolidated fixed charge coverage ratio, which is the ratio of (i) our consolidated EBITDA plus consolidated rental expense minus consolidated capital expenditures to (ii) our consolidated scheduled debt payments, (defined as the sum of scheduled principal payments, interest expense and rent expense) must be at least 1.5 to 1; and
- we must maintain our consolidated net worth at a level equal to at least \$945 million (less the sum of a pre-tax charge associated with our sale of Florida Health Plan and specified pre-tax charges relating to the write-off of goodwill) plus 50% of our consolidated net income and 100% of our net cash proceeds from equity issuances.

The other covenants in the credit agreements include, among other things, limitations on incurrence of indebtedness by subsidiaries of Health Net, Inc. and on our ability to

- incur liens;
- extend credit and make investments;
- merge, consolidate, dispose of stock in subsidiaries, lease or otherwise dispose of assets and liquidate or dissolve;
- engage in transactions with affiliates;
- substantially alter the character or conduct of the business of Health Net, Inc. or any of its “significant subsidiaries” within the meaning of Rule 1-02 under Regulation S-X promulgated by the SEC;
- make restricted payments, including dividends and other distributions on capital stock and redemptions of capital stock; and
- become subject to other agreements or arrangements that restrict (i) the payment of dividends by any Health Net, Inc. subsidiary, (ii) the ability of Health Net, Inc. subsidiaries to make or repay loans or advances to us, (iii) the ability of any subsidiary of Health Net, Inc. to guarantee our indebtedness or (iv) the creation of any lien on our property.

*Interest and fees.* Committed loans under the credit facilities bear interest at a rate equal to a base rate plus a margin that depends on our senior unsecured credit rating. Loans obtained through the bidding process bear interest at a rate determined in the bidding process. Swingline loans under the five-year credit facility bear interest equal to, at our option, either a base rate plus a margin that depends on our senior unsecured credit rating or a rate quoted to us by the swingline lender. We pay fees on outstanding letters of credit and a facility fee, computed as a percentage of the lenders’ commitments under the credit facilities, which varies from 0.130% to 0.320% per annum for the 364-day credit facility and from 0.155% to 0.375% per annum for the five-year credit facility, depending on our senior unsecured credit rating.

*Events of Default.* The credit agreements provide for acceleration of repayment of indebtedness under the credit facilities upon the occurrence of customary events of default.

**LEGISLATION.** On June 2, 2001, the United States Senate passed legislation, sometimes referred to as “patients’ rights” or “patients’ bill of rights” legislation, that seeks, among other things, to hold health plans liable for claims regarding health care delivery and improper denial of care. The United States House of Representatives passed similar legislation on August 2, 2001. Congress will attempt to reconcile the two bills in a conference committee. Although both bills provide for independent review of decisions regarding medical care, the bills differ on the circumstances under which lawsuits may be brought against managed care organizations and the scope of their liability. If patients’ bill of rights legislation is enacted into law we would be subject to significant additional

litigation risk and regulatory compliance costs, which could be costly to us and could have a significant effect on our results of operations. Although we could attempt to mitigate our ultimate exposure to litigation and regulatory compliance costs through, among other things, increases in premiums, there can be no assurance that we would be able to mitigate or cover the costs stemming from litigation arising under patients' bill of rights legislation or the other costs that we could incur in connection with complying with patients' bill of rights legislation.

**FOHP.** Effective July 30, 1999, a wholly-owned subsidiary of ours merged with and into FOHP, Inc., a then-majority owned subsidiary of ours, which, as a result of the merger, became a wholly-owned subsidiary of Health Net, Inc. In connection with the merger, the former minority shareholders of FOHP were entitled to receive either \$.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 and other conditions are met. Also in connection with the merger, certain holders of payment rights will also be entitled to receive additional consideration of \$2.25 per payment right ("Bonus Consideration") if our New Jersey health plan achieves certain annual returns on common equity and the participation conditions are met. In July and August 2001, based on the satisfaction of certain participation and other conditions by the former minority shareholders of FOHP, FOHP made aggregate payments of approximately \$21.0 million to certain holders of payment rights. FOHP will make up to an additional \$6.7 million in payments to additional holders of payment rights, subject to such holders submitting appropriate documentation. A determination on the satisfaction of the conditions for payment of the Bonus Consideration will be made in 2002.

**DISASTER RECOVERY.** We are in the process of updating our disaster recovery plans including maintaining fully redundant systems for our operations at an alternate site. Before these plans are fully updated, a disaster such as fire, flood, earthquake, tornado, power loss, virus, telecommunications failure, break-in or similar event could severely damage or interrupt our systems and operations, result in loss of data, and/or delay or impair our ability to service our members and providers. Even after the plans are updated, there can be no assurance that such adverse effects will not occur in the event of a disaster. In addition, a substantial part of our operations are located in the State of California. Due to the limited availability of electricity in California, certain locations in California have experienced sporadic periods of electricity outages. A substantial or sustained interruption in the power supplied to our facilities and systems could significantly and negatively impact our ability to conduct our business. Any such disaster, power loss or similar event could have a material adverse effect on our business, financial condition and results of operations.

**TERRORIST AND OTHER MALICIOUS ACTIVITY.** We are in the process of updating and implementing our procedures dealing with potential terrorist related activity such as the September 11, 2001 attack, recent anthrax cases and other potential future events involving malicious activity. Even after we update our procedures, there can be no assurance that such events will not occur or that such events will not materially or negatively effect the Company, including through adverse effects on general economic conditions or industry and company specific economic conditions, the price and availability of products or services, the availability or morale of employees, the general operation of the Company or its facilities, or the demand for the Company's products or services.

**ASSET IMPAIRMENT, RESTRUCTURING AND OTHER CHARGES.** As part of our ongoing selling, general and administrative expense reduction efforts, during the third quarter of 2001, we initiated a formal plan to reduce operating and administrative expenses for all business units within the Company (the "2001 Plan"). In connection with the 2001 Plan, we decided on enterprise-wide staff reductions and consolidations of certain administrative and technology functions, and in connection therewith the Company recorded pretax restructuring charges of \$79.7 million during the quarter (the "2001 Charge").

The 2001 Charge included severance and benefit related costs of \$43.3 million related to enterprise-wide staff reductions. These reductions include the elimination of approximately 1,500 positions throughout all functional groups, divisions and corporate offices within the Company. As of September 30, 2001, 769 positions have been eliminated through these reductions, and we expect that elimination of the remaining positions will be completed over the next twelve months.

The 2001 Charge also included: asset impairment charges of \$27.9 million consisting entirely of non-cash write downs of equipment, building improvements and software application and development costs; charges of \$5.1 million related to the termination of lease obligations and non-cancelable lease costs for excess office space resulting from streamlined operations and consolidation efforts; and charges of \$3.4 million related to costs associated with consolidating certain information technology systems and functions and other activities which are expected to be completed in the first quarter of 2002.

Please refer to Part I of this Quarterly Report on Form 10-Q for additional information related to the 2001 Charge.

## **OTHER POTENTIAL DIVESTITURES**

**CERTAIN OTHER OPERATIONS.** We continue to evaluate the profitability realized or likely to be realized by our existing businesses and operations. We are reviewing from a strategic standpoint which of such businesses or operations, if any, should be divested.

## **ITEM 6. EXHIBITS AND REPORTS ON FORM 8-K**

### **(a) EXHIBITS**

The following exhibits are filed as part of this Quarterly Report on Form 10-Q 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 herein by reference).
- 3.1 Fifth Amended and Restated Certificate of Incorporation of the Company (filed as Exhibit 3.1 to the Company's Registration Statement on Form S-4 filed with the SEC on August 10, 2001, which is incorporated herein by reference).
- 3.2 Seventh Amended and Restated Bylaws of the Company (filed as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2001, which is incorporated herein by reference).
- 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 herein by reference).
- 4.2 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).
- 4.3 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 2 to the Company's Form 8-A/A dated May 9, 2001, which is incorporated herein by reference).

- 4.4 Second Amendment to Rights Agreement dated as of May 3, 2001, by and among the Company, Harris Trust and Savings Bank, and Computershare Investor Services, L.L.C. (filed as Exhibit 3 to the Company's Form 8-A/A dated May 9, 2001, which is incorporated herein by reference).
- 4.5 Indenture dated as of April 12, 2001 by and between the Company and U.S. Bank Trust National Association as Trustee (filed as Exhibit 4.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2001, which is incorporated herein by reference).
- 4.6 Exchange and Registration Rights Agreement dated April 12, 2001 by and among the Company, JP Morgan, a division of Chase Securities Inc., Banc of America Securities LLC, Fleet Securities, Inc., Mizuho International plc, Salomon Smith Barney Inc. and Scotia Capital (USA) Inc. (filed as Exhibit 4.6 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2001, which is incorporated herein by reference).
- 4.7 Form of 8 $\frac{3}{4}$ % Senior Note due 2001 (included in Exhibit 4.5).
- 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 herein by reference).
- 10.2 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 herein by reference).
- 10.3 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 herein by reference).
- 10.4 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 herein by reference).
- 10.5 Letter Agreement between the Company and Jay M. Gellert dated as of March 22, 2000 (filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2000, which is incorporated herein by reference).
- 10.6 Employment Letter Agreement between the Company and Jeffrey J. Bairstow dated as of January 29, 1998 (filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2000, which is incorporated herein by reference).
- 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 herein by reference).
- 10.8 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).
- 10.9 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).
- 10.10 Employment Letter Agreement between the Company and Timothy J. Moore, M.D. dated March 12, 2001 (filed as Exhibit 10.10 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2001, which is incorporated herein by reference).

- 10.11 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).
- 10.12 Form of Agreement amending Severance Payment Agreement by and between the Company and various of its executive officers (filed as Exhibit 10.11 to the Company's Annual Report on Form 10-K for the year ended December 31, 2000, which is incorporated herein by reference).
- 10.13 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).
- 10.14 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).
- 10.15 The Company's Second Amended and Restated 1991 Stock Option Plan (filed as Exhibit 10.16 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2000), which is incorporated herein by reference.
- 10.16 Amendment to the Company's Second Amended and Restated 1991 Stock Option Plan (filed as Exhibit 10.15 to the Company's Annual Report on Form 10-K for the year ended December 31, 2000, which is incorporated herein by reference).
- 10.17 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 herein by reference).
- 10.18 Amendment to the Company's 1997 Stock Option Plan, a copy of which is filed herewith (filed as Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2000, which is incorporated herein by reference).
- 10.19 The Company's Amended and Restated 1998 Stock Option Plan (filed as Exhibit 10.18 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2000), which is incorporated herein by reference.
- 10.20 Amendments to the Company's Amended and Restated 1998 Stock Option Plan, a copy of which is filed herewith (filed as Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2000, which is incorporated herein by reference).
- 10.21 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 herein by reference).
- 10.22 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 herein by reference).
- 10.23 The Company's Employee Stock Purchase Plan, as amended (filed as Exhibit 10.22 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2000, which is incorporated herein by reference).
- 10.24 The Company's Executive Officer Incentive Plan (filed as Annex A to the Company's Definitive Proxy Statement filed on March 21, 2000, which is incorporated herein by reference).

- 10.25 The Company's 401(k) Associate Savings Plan, as amended and restated (filed as Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 2000, which is incorporated herein by reference).
- 10.26 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).
- 10.27 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 herein by reference).
- 10.28 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 herein by reference).
- 10.29 Foundation Health Corporation 1990 Stock Option Plan (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-8 (File No. 333-24621), which is incorporated herein by reference).
- 10.30 FHC Directors Retirement Plan (filed as an exhibit to FHC's Annual Report on Form 10-K for the year ended June 30, 1994, which is incorporated herein by reference).
- 10.31 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, which is incorporated herein by reference).
- 10.32 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, which is incorporated herein by reference).
- 10.33 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, which is incorporated herein by reference).
- 10.34 Five-Year Credit Agreement dated as of June 28, 2001 among the Company, the lenders party thereto and Bank of America, N.A., as Administrative Agent, Issuing Bank and Swingline Lender (filed as Exhibit 10.34 to the Company's Registration Statement on Form S-4 filed with the SEC on August 10, 2001, which is incorporated herein by reference).
- 10.35 364-Day Credit Agreement dated as of June 28, 2001 among the Company, the lenders party thereto and Bank of America, N.A., as Administrative Agent (filed as Exhibit 10.35 to the Company's Registration Statement on Form S-4 filed with the SEC on August 10, 2001, which is incorporated herein by reference).
- 10.36 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 herein by reference).
- 10.37 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 herein by reference).
- 10.38 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 herein by reference).

- 10.39 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 herein by reference).
- 10.40 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 herein by reference).
- 10.41 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 herein by reference).
- 10.42 Fifth Amendment to Credit Agreement, dated as of September 20, 2000, among the Company, Bank of America National Trust and Savings Association and the Banks, as defined therein (filed as Exhibit 10.45 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2000, which is incorporated herein by reference).
- 10.43 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 herein by reference).
- 10.44 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 herein by reference).
- 10.45 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 herein by reference).
- 10.46 Office Lease dated September 20, 2000 by and among Health Net of California, Inc., DCA Homes, Inc. and Lennar Rolling Ridge, Inc. (filed as Exhibit 10.46 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2000, which is incorporated herein by reference).
- 10.47 Purchase Agreement dated as of April 9, 2001, by and among the Company, JP Morgan, a division of Chase Securities Inc., Banc of America Securities LLC, Fleet Securities, Inc., Mizuho International plc, Salomon Smith Barney Inc. and Scotia Capital (USA) Inc. (filed as Exhibit 10.44 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2001, which is incorporated herein by reference).
- 10.48 Stock Purchase Agreement dated January 19, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.49 Amendment to Stock Purchase Agreement dated February 2, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.50 Second Amendment to Stock Purchase Agreement dated February 8, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.3 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).

- 10.51 Third Amendment to Stock Purchase Agreement dated February 16, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.4 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.52 Fourth Amendment to Stock Purchase Agreement dated February 28, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.5 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.53 Fifth Amendment to Stock Purchase Agreement dated May 1, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.6 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.54 Sixth Amendment to Stock Purchase Agreement dated June 4, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.7 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 10.55 Seventh Amendment to Stock Purchase Agreement dated June 29, 2001 by and between Health Net, Inc. and Florida Health Plan Holdings II, LLC (filed as Exhibit 10.8 to the Company's Current Report on Form 8-K dated August 1, 2001 and incorporated herein by reference).
- 11.1 Statement relative to computation of per share earnings of the Company (included in Note 3 to the Condensed Consolidated Financial Statements contained in this Quarterly Report on Form 10-Q).

**(b) REPORTS ON FORM 8-K**

We filed the following Current Report on Form 8-K during the quarter ended September 30, 2001:

A Current Report dated August 1, 2001 containing information related to the sale by us of Foundation Health, a Florida Health Plan, Inc. to Florida Health Plan Holdings II, LLC.

We did not file any other Current Reports on Form 8-K during the quarter ended September 30, 2001.

**SIGNATURES**

Pursuant to the requirements of the Securities Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

HEALTH NET, INC.  
(REGISTRANT)

Date: November 14, 2001

By:                   /s/ JAY M. GELLERT                    
                  Jay M. Gellert  
                  *President and Chief Executive Officer*

Date: November 14, 2001

By:                   /s/ STEVEN P. ERWIN                    
                  Steven P. Erwin  
                  *Executive Vice President and  
                  Chief Financial Officer*