1994 Annual Report

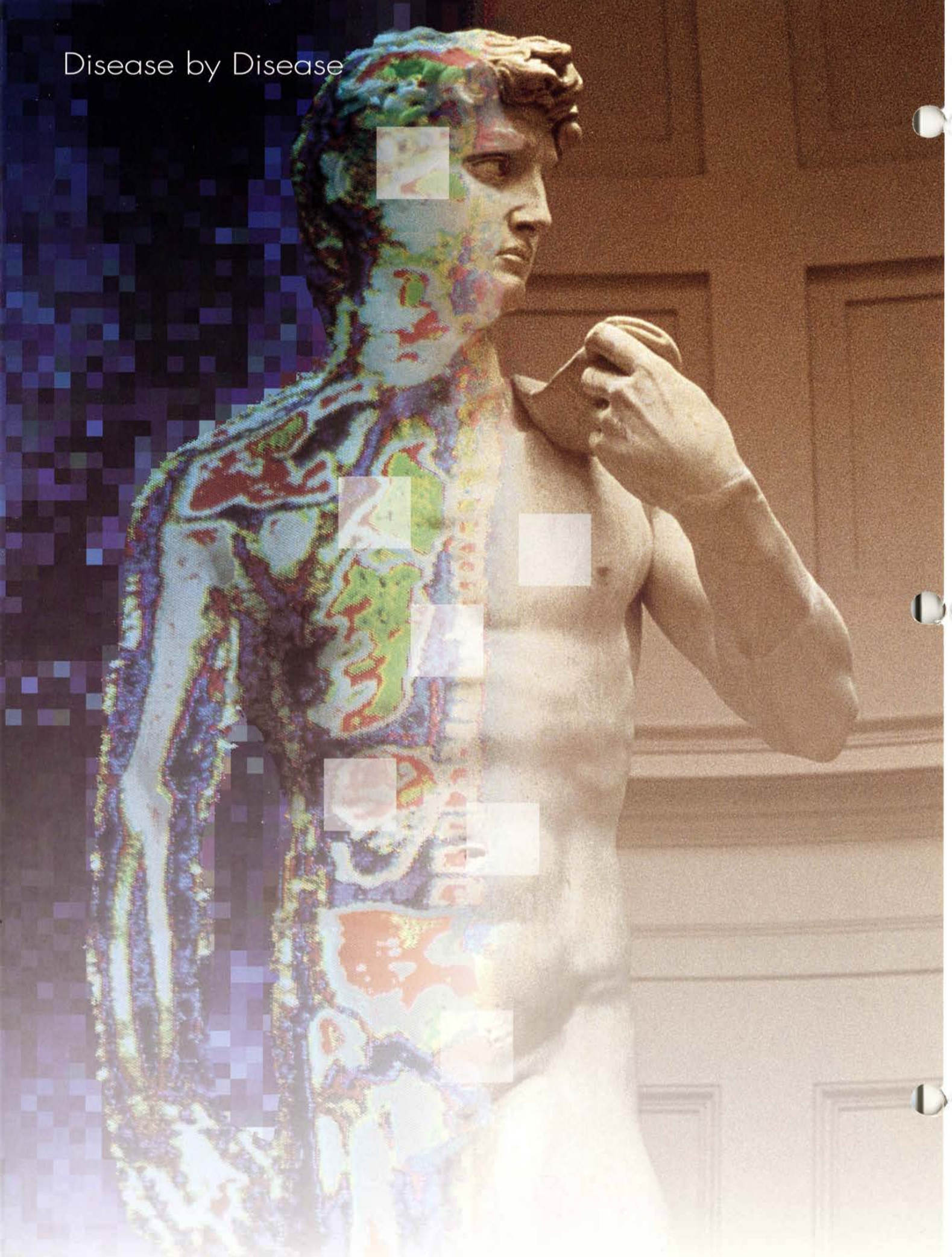
Value Health, Inc.

Bringing Science

to the Art of

Managed Care . . .

Disease by Disease



1994 Year in Review

February
ValueRx's 40,000 square foot state-of-the-art mail service facility in Davenport, Iowa became fully operational.

Shareholders Rights Plan adopted by Board of Directors to give the company adequate time to consider and evaluate any unsolicited takeover offers.

April
Value Behavioral Health awarded a subcontract from Group Health Incorporated (GHI) to provide mental health and chemical dependency benefits to more than 600,000 City of New York employees and their dependents.

Acquisition of Burke-Taylor Associates, an employee assistance program company in Raleigh/Durham, NC, to further strengthen and enlarge our network of providers.

May
Value Health entered a strategic partnership with Pfizer Inc to build major new disease management capabilities.

Value Health Sciences created breakthrough cancer treatment guidelines; first of a series to focus on the use of bone marrow transplantation in breast cancer treatment.

Reported record first quarter revenues of $197 million, a 44% increase from first quarter 1993; net earnings of $.28 per share.†

June
Acquisition of Community Care Network, Inc. (CCN), the nation's largest specialty workers' compensation managed care provider with more than 13 million covered lives.

Brief History Highlights

Value Health, Inc. is a leading provider of specialty managed care benefit programs and health care information services. Value Health companies hold leading market shares in all six of our product lines.

Our specialty managed care benefit programs are designed to enhance the quality and control costs in selected health care sectors that are of particular concern due to their size, rapid cost escalation and potential for overutilization. These areas include prescription drugs, mental health and substance abuse, and workers' compensation.

Our health care information services are based upon the use of clinical and data analysis to guide health care decision making. These products include clinically based precertification and claims review, provider profiling, claims cost analyses, evaluation and management of health benefit providers, disease management, and health policy and management consulting.

Value Health provides services to more than 64 million people, and our customers include 58 of the nation's 250 largest corporations.

1987

Year closed with $40 million in revenues

Company founded; received equity funding from Warburg, Pincus Capital Company

American Psych-Management (now Value Behavioral Health), Medicost (now ValueRx), and Health Information Designs acquired

1988

Year closed with $59 million in revenues

Value Health Sciences founded, building upon clinical research developed at the RAND Corporation

1989

Year closed with $82 million in revenues

Medical Review System (MRS) introduced by Value Health Sciences

First quarter of operating profits achieved

1990

July
Reported record second quarter revenues of $218 million, a 48% increase from second quarter 1993; net earnings of $.31 per share.†

August
Insurance Services Group, incorporating the CCN and Preferred Works workers' compensation and group health businesses, created; David Noone, former President and CEO of Preferred Works, named as President and CEO. James E. Buncher, CCN Chairman, President and CEO, is appointed to the Senior Management Committee of Value Health.

Acquisitions of RxNet, Inc. of California, Prescription Drug Service, Inc., and its affiliate Prescription Drug Service West, Inc., pharmacy benefit management companies. Increases covered lives for ValueRx to more than 8 million.

October
Preferred Works certified as an approved managed care plan for workers' compensation by the State of Minnesota's Department of Labor and Industry, becoming the first third-party administrator to be approved by the state.

November
Reported record third quarter revenues of $252 million, a 42% increase from third quarter 1993; net earnings of $.35 per share.*

Value Health announced termination of discussions regarding possible sale of ValueRx.

December
ValueRx and CCN team up to provide a trend-setting program for the State of Arizona with a workers' compensation pharmaceutical benefit program covering approximately 80,000 state workers.

Announced sale of National Foot Care Program back to its founder, Dr. Claude Oster.

1991

Year closed with $124 million in revenues, $3.2 million in pretax profits

Remaining minority interests in subsidiaries purchased by parent company

Year closed with $196 million in revenues, $13 million in pretax profits

Cost Containment Corporation acquired; combined with ValueRx

Value Health initial public offering raises $38 million, opens trading on NASDAQ

1992

Year closed with $366 million in revenues, $27 million in pretax profits

Practice Review System (PRS) introduced by Value Health Sciences

Lewin ICF (now Lewin-VHI) acquired

Stokeld Health Services Corporation acquired; integrated with ValueRx

Value Health begins trading on the NYSE

Recognized by *Fortune* as 93rd among America's fastest growing companies

Two secondary offerings raise $161 million; 3 for 2 stock split in September

1993

Year closed with $689 million* in revenues, $56 million* in pretax profits

Preferred Health Care acquired; integrated with American PsychManagement to form Value Behavioral Health (VBH)

Raleigh Group, the Center for Human Resources, and Associated Prescription Services acquired and integrated with existing Value Health businesses

Recognized by *Fortune* as 80th among America's fastest growing companies

Value Health and E.M. Warburg, Pincus & Co., Inc. provide funding to Value Health Management

1994

Year closed with $976 million* in revenues, $89 million* in pretax profits

ValueRx Mail Service Iowa facility becomes operational

Board adopts Shareholders Rights Plan

Burke-Taylor Associates acquired; integrated with VBH

Value Health and Pfizer create joint venture partnership to develop specialty disease management programs; Disease Management Sciences created

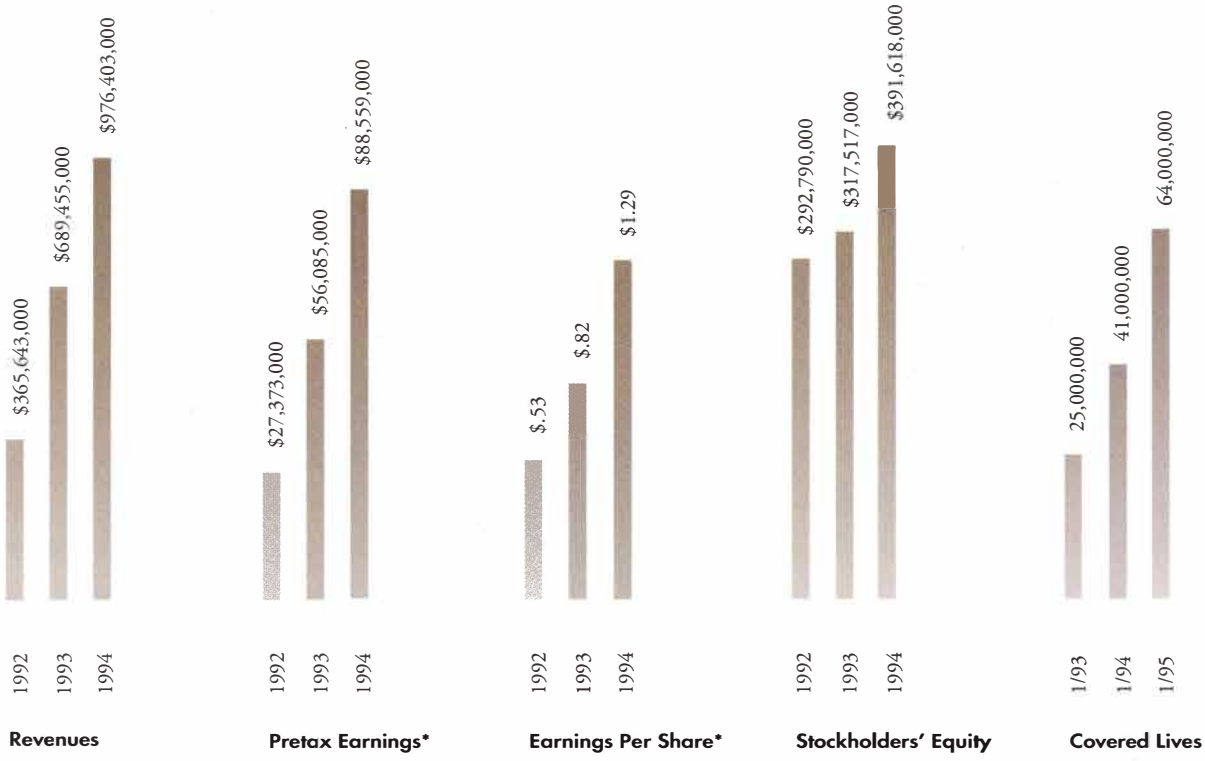
Value Health crosses $1 billion mark in annualized revenues in third quarter

Community Care Network acquired; integrated with Preferred Works to form Insurance Services Group

RxNet of CA, Prescription Drug Service, Prescription Drug Service West acquired; integrated with ValueRx

*before merger-related charges
†not restated for poolings

Financial Highlights



(Dollars in thousands, except per share data)	1994	1993	1992
Revenues:			
Prescription Drugs	**$654,405**	$439,842	$225,461
Mental Health	**198,599**	161,643	114,223
Insurance Services	**67,268**	35,895	1,409
Information Services	**40,721**	36,878	12,711
Other	**9,710**	7,413	6,128
Investment Income	**5,700**	7,784	5,711
Total Revenues	**$976,403**	$689,455	$365,643
Earnings from Continuing Operations before Merger-Related Expense and Taxes	**$ 88,559**	$ 56,085	$ 27,373
Pretax Margin	**9.1%**	8.1%	7.5%
Earnings from Continuing Operations Per Share Excluding Merger-Related Expense	**$ 1.29**	$ 0.82	$ 0.53
Stockholders' Equity Per Share	**$ 9.68**	$ 8.07	$ 7.58
Market Price of Common Stock:			
Range	**$ 30.13 - $52.00**	$ 22.00 - $41.00	$ 18.33 - $40.25
Close	**$ 37.25**	$ 31.50	$ 39.63

*From continuing operations, excluding merger-related expense

The Value Health
1994 Annual Report
is dedicated in memory of

Michael H. Walsh
July 8, 1942 - May 6, 1994

Chairman and
Chief Executive Officer
Tenneco

Value Health Board Member
April 1991-May 1994

To the Employees, Directors and Owners of Value Health:

I started writing this letter while on an airplane, feeling that if there was ever a year that needed to be viewed from 30,000 feet, it was 1994.

It was a year of such great change that it takes some distance from its peaks and valleys to properly judge the forward progress that was made. Remember back, if you can, to what the world was like in health care when the year began. The external context was somewhat foreboding. There was the real prospect of disruptive national health reform coming from Washington. Managed care was caught up in the legislative cross fire, and investor concerns about that were reflected in sluggish stock market performance. In our own world, we were facing a new kind of competitive challenge in the prescription drug management market as a result of Merck's acquisition of Medco, with many analysts predicting that pricing and margins would collapse as a result.

But stepping back from what seemed over the year to be constant crosscurrents, we can see now that the tide was swinging strongly in favor of private market approaches to health care reform, to managed care, and to companies like Value Health. It will prove, I think, to have been a watershed year nationally, and a year of confirmation of Value Health's basic strategies.

Health Care Reform

I will not dwell at any length on the national health care reform scene, though our Lewin-VHI subsidiary consistently made the front pages as the most credible source of cost estimates on the various reform plans. The whole national debate proved that the country prefers careful, incremental, market-based change, not untested and revolutionary governmental schemes. And, as if to punctuate the collapse of the Grand Designs, the data has now emerged to show that in 1994 employer health care costs actually went down for the first time in recorded history. While it is not without problems, managed care is working.

Sorting through the year's events to identify the key outcomes for Value Health, I would suggest that we focus on just

Bringing Science to the Art of Managed Care . . . Disease by Disease

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three key messages. They are: (1) our very positive financial and other results; (2) our emerging competitive advantage as an independent prescription benefit manager (PBM); and (3) the new field of disease management as a confirmation of our past strategies and as a direction for the future.

1994 Results and Achievements

Let's start with the year's results. It was, by any measure, an excellent year for Value Health. Quarter after quarter, our financial progress met or exceeded expectations, with the year ending with a 42% increase in revenues and a 59% increase in earnings per share before merger-related expense. We closed out 1994 having broken through the $1 billion mark in annualized revenues and with operating margins up a full point, to 9.1%. We registered strong internal sales growth with annualized revenues from new accounts starting in 1994 up 82% over the prior year.

Going beyond purely financial results, we racked up a number of other achievements:

- we successfully integrated American PsychManagement and Preferred Health Care, the latter acquired in December of 1993, to form the nation's largest managed mental health company, Value Behavioral Health (VBH). Substantial cost-saving synergies were achieved, as well as improvements in service performance as we preserved the best practices of both predecessor companies;
- at ValueRx, we completed and brought on-line one of the industry's most advanced mail service prescription facilities, capable of processing 25,000 scripts per day, and extended our formulary programs with drug manufacturers to 97% of our covered lives;

> "It was, by any measure, an excellent year for Value Health. Quarter after quarter, our financial progress met or exceeded expectations, with the year ending with a 42% increase in revenues and a 59% increase in earnings per share before merger-related expense. . . . All in all, it was a great year and we'd be delighted with 10 more just like it."

- we entered into a precedent-setting disease management contract with Pfizer Inc, creating an important new profit center for our Value Health Sciences subsidiary; and
- we expanded our position in the workers' compensation managed care business by acquiring the leading preferred provider organization company in that business, Community Care Network (CCN) of San Diego.

I stress those steady and positive results because, in the course of a year of stock market ups and downs, investors might well have lost sight of our very strong fundamentals. These results were the product of the effort of all of our 4400 employees nationwide, and I want to take this opportunity to thank each one for his or her continuing effort. This was a team result. Special thanks and best wishes go to Steve Linehan, Claude Oster and Matt Thomas, who left our senior management group at the end of the year to pursue other opportunities outside Value Health.

Were there disappointments? Of course. Sales were slow at VBH as staff were distracted with integration tasks. Our new rate under the Ford contract at ValueRx proved to involve a loss,

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$40 million in revenues

1988
$59 million in revenues

1989
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1990
$124 million in revenues

but the good news on that front was that we were able to absorb the unplanned loss through over-plan results elsewhere and still meet investor expectations. Moreover, in January 1995 we won a rebid for Ford at a significant rate increase which will restore that important contract to profitability. All in all, it was a great year and we'd be delighted with 10 more just like it.

The Future of Pharmacy Benefits Management

That gets us to the second subject – the future of the PBM business in general and of our PBM subsidiary, ValueRx, in particular. The PBM world was convulsed during the summer of 1993 with the announcement that Merck, the world's largest pharmaceutical manufacturer, would vertically integrate into drug distribution by buying one of the largest PBMs, Medco Containment Services. Frankly, neither we nor most other PBMs or manufacturers had seen that bold move coming. Uncertainty about the future shape of the industry prevailed, exacerbated by drastically lower PBM pricing offered by Medco to the Big Three auto companies during their bidding process in the fall of 1993. ValueRx was able to retain and even expand its business with Ford in that process, but as I noted earlier at a lowered rate that later proved to produce an earnings loss.

We responded to the Merck move by seeking to develop contract-based alliances with other drug companies, and that strategy unfolded positively as we entered into an exciting new arrangement with Pfizer in May. But then the situation seemed to deteriorate when two other drug manufacturers, SmithKline Beecham and Lilly, announced purchases of two more of our PBM competitors. Clearly, given the large amounts being paid, we had an obligation to our shareholders to investigate options with regard to ValueRx. We did just that, with vigor, in the second and third quarters of last year.

"We responded . . . by seeking to develop contract-based alliances with other drug companies, and that strategy unfolded positively as we entered into an exciting new arrangement with Pfizer in May."

As I look back on that activity now and reflect on the many conversations we had with drug company executives, it seems clear we were all playing out yet another version of the drama that was taking place on the national stage – the conflict between revolution and incrementalism, or that between bandwagon psychology and sober assessment. Three drug companies had opted for the revolutionary step of vertical integration – of buying the very managed care instrumentalities that were driving down their margins. But as it turned out, most of the drug industry ended up by disagreeing with that strategy, feeling that it was preferable not to compete with their customer PBMs and instead to maintain open channels of distribution. Moreover, as time went on, the vertical integration strategy came under closer scrutiny from federal antitrust regulators, further discouraging drug manufacturers from buying PBMs. These manufacturers did indeed want to talk to us, but as it turned out not about buying our PBM (or anyone else's). Their interest was instead in diversifying into the new field of disease management (more on that later). By the third quarter, it was clear that the urge to acquire PBMs was not shared by the remaining drug manufacturers.

In the meantime, we began to see a stabilization of pricing in the PBM business as the new drug company owners concluded that they could not or would not operate their distribution subsidiaries at a loss in an effort to shift market share. So we determined for all of these reasons that we would not sell ValueRx, feeling that this valuable and profitable business was one we wanted to keep.

" . . . we began to see a stabilization of pricing in the PBM business as the new drug company owners concluded that they could not or would not operate their distribution subsidiaries at a loss in an effort to shift market share. So we determined for all of these reasons that we would not sell ValueRx, feeling that this valuable and profitable business was one we wanted to keep."

When we announced that decision in November, some speculative investors concluded that our PBM prospects were somehow diminished and they sold our stock, driving the price down for a time. Our view, however, is precisely the opposite. We now find ourselves as one of the largest independent PBMs, able to market our clinical independence as an important distinction given manufacturer ownership of our three largest competitors. Moreover, these competitors will no doubt lose some of their entrepreneurial character as they are integrated, and they will be hampered in making acquisitions of other PBMs given Federal Trade Commission concerns. So far, our judgment seems confirmed as our business continues to grow and our 1995 margins are holding up at the 1993 levels that prevailed before the PBM acquisition activity began.

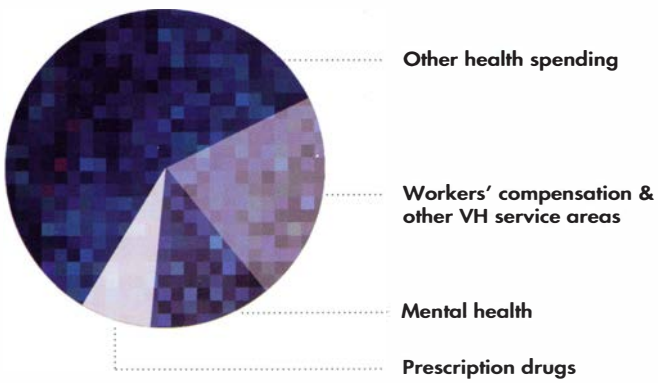
Disease Management Initiatives

This gets me now to the third subject, that of disease management, where in fact we are hoping to collaborate closely with the pharmaceutical industry. We believe that this new field is so important to managed care and to Value Health that we have devoted the entire essay portion of this annual report to it. So let me only introduce the subject here.

Value Health and drug manufacturers face something of the same strategic challenge – how do we carefully diversify beyond our current borders? At Value Health, we have products that address 20% to 30% of the $1 trillion in U.S. health care spending; drug companies, which are the largest health care organizations in the world, address only 7% to 10% of spending. Yet we both have needs and ambitions to leverage our current capabilities into more of the health care spending pie.

$1 Trillion in U.S. Health Care Spending

Value Health's products cover 20% to 30% of the health care dollar



Disease management is how we can do that. Simply put, it means focusing managed care techniques on high-cost diseases in order to improve patient outcomes and lower costs. For drug companies, it is a way to leverage their disease knowledge and capital in a focused way beyond "hard goods" into health care services. For Value Health, it is the natural extension of what we have already done in mental health – customizing managed care tools to focus on a particular disease state – and it fully uses the clinical and strategic skills of our Value Health Sciences and Lewin-VHI teams. For consumers of health care, it represents what we would all like to have – the ability to choose a health plan based on its performance in preventing and curing disease.

If this intrigues you, please read on in this report. Disease management will be an important part of Value Health's future.

Let me close on a personal note by saying that we are dedicating this report to the memory of Mike Walsh, our former Board member and my friend for almost 30 years. Mike's premature death deprived America of one of its great business and community leaders, but he left behind a wonderful family and a large number of organizations and people who are better for having known him – including all of us at Value Health.

We thank you for your continued support.

Robert E. Patricelli
Chairman of the Board and Chief Executive Officer

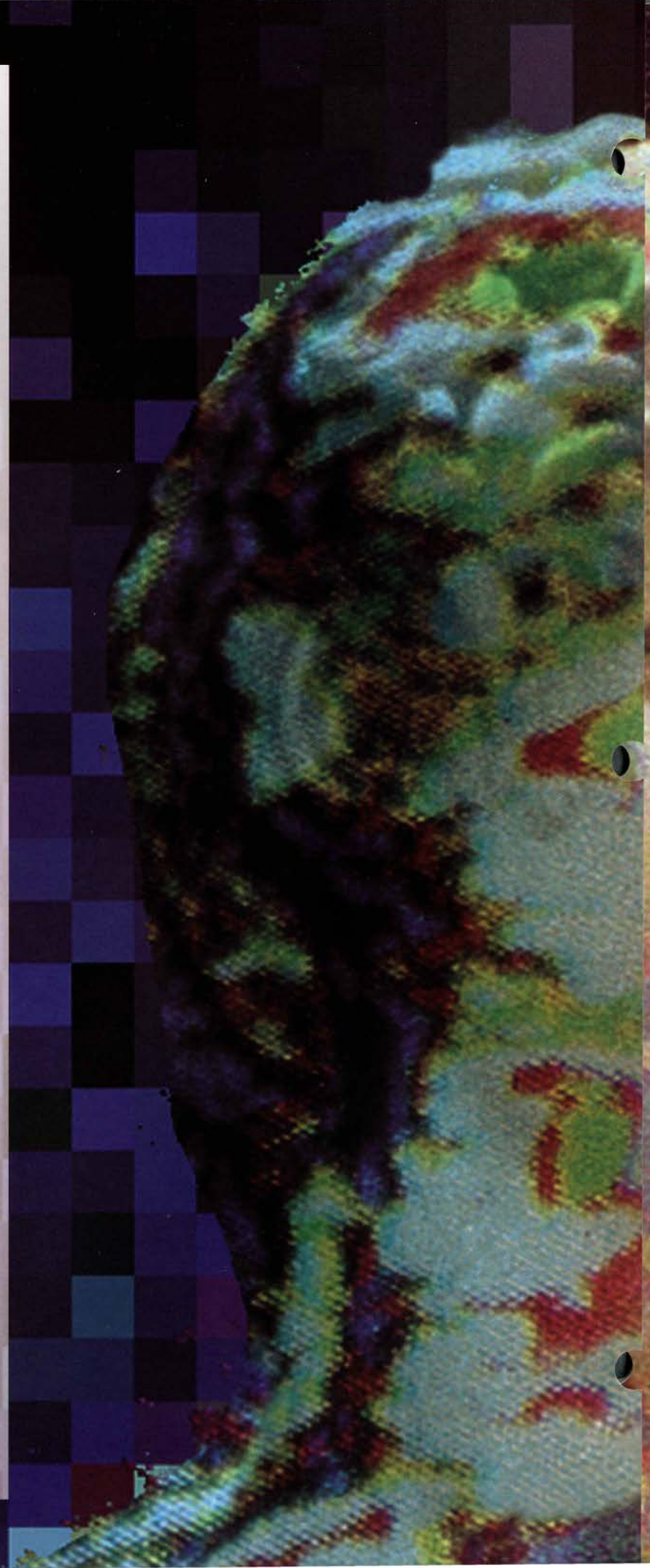
"Value Health and drug manufacturers face something of the same strategic challenge – how do we carefully diversify beyond our current borders? At Value Health, we have products that address 20% to 30% of the $1 trillion in U.S. health care spending; drug companies, which are the largest health care organizations in the world, address only 7% to 10% of spending. Yet we both have needs and ambitions to leverage our current capabilities into more of the health care spending pie."

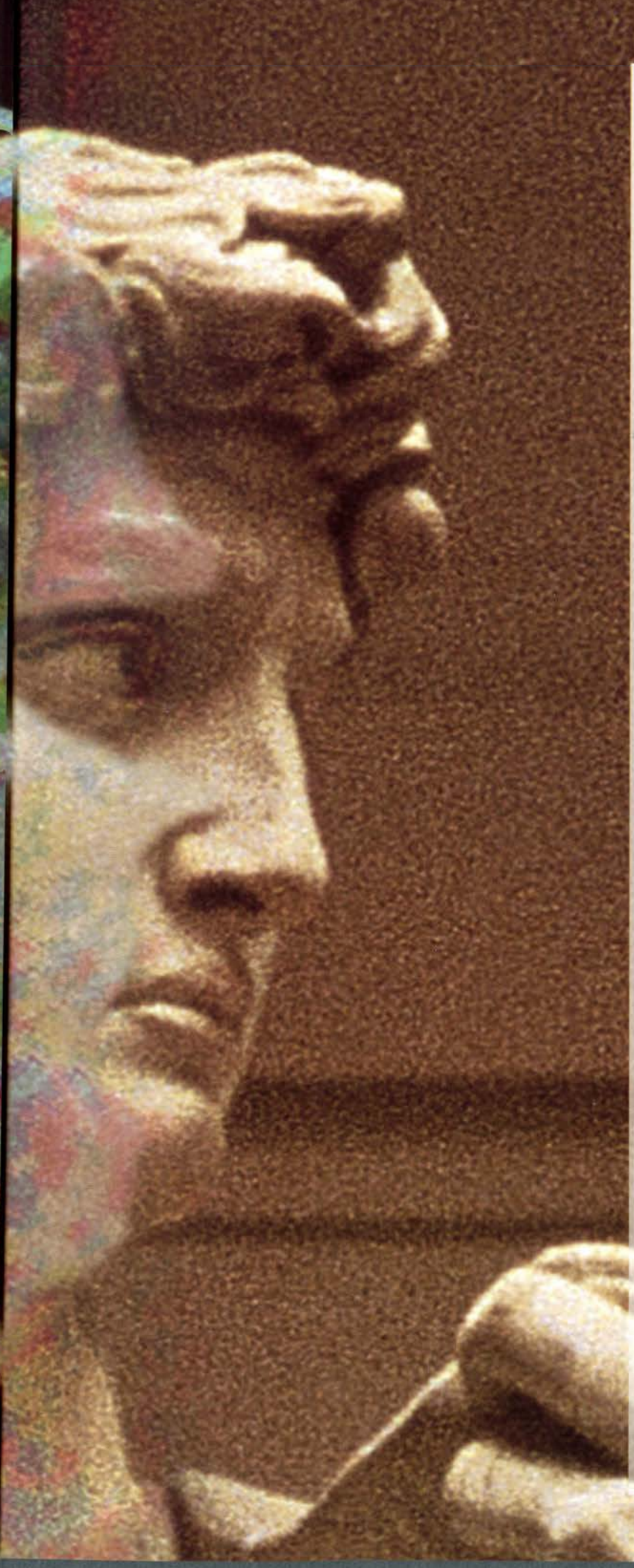
Specialty Benefit Programs

Employers are finding that certain areas of their health care benefits, in particular prescription drugs, mental health and substance abuse, and workers' compensation programs, are growing at rates in excess of general medical care inflation.

"Generalist" managed care techniques as employed in the medical-surgical world are not as effective in improving quality and reducing costs in these areas as are specialized techniques tailored to each segment.

Large self-insured employers, managed care organizations, and insurers are increasingly carving out the management of one or more of these rapidly escalating segments from the rest of their benefits programs, and giving them to specialty managed care companies like Value Health to administer. (For example, there are almost as many people in carve-out managed mental health programs – over 42 million – as there are enrolled in HMOs nationwide.) In customizing select provider networks, utilization review, case management techniques and clinical protocols, Value Health enhances quality and reduces costs of care in the areas of pharmacy, mental health, and workers' compensation programs.





Health Care Information Services

Over 14% of the U.S. economy is devoted to health care services and products. But, compared to other sectors of the economy, there is an acknowledged lack of meaningful information available to those responsible for making informed decisions about how health care resources are spent.

Value Health's health care information services are based upon the use of sophisticated clinical tools, data analyses, and expert consulting to guide health care decision makers in the public and private sectors. Programs are offered through an unrivaled 450-person team of clinicians, analysts, and managers in Value Health Sciences, Lewin-VHI, and Value Health Management.

A variety of consulting services, data analyses, clinical software programs, and disease management services are available to our clients, including:

- strategic and organizational consulting to assist providers in key decisions;
- clinical protocols to identify inappropriate care before and after it's given;
- profiling techniques to improve management of provider networks, utilization, and patient outcomes;
- utilization analyses to detail how money is spent and recommend improvements; and,
- assistance to payers in improving the performance of their managed care vendors.

ValueRx:
Pharmacy Benefits Management

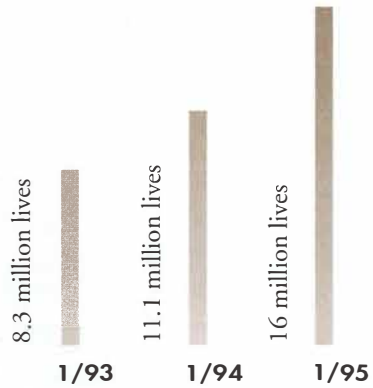
Employers spend approximately 7% to 8% of their benefit dollars on prescription drugs, and those costs are rising 15% annually, according to recent industry surveys.

This cost escalation results from increased and sometimes inappropriate drug utilization, new product developments, "trading up" on drug selections, and price increases.

ValueRx is the nation's leading independent pharmacy benefit manager, providing managed prescription drug programs to employers and intermediaries who carve out this benefit from their medical plans to better manage costs and enhance quality.

ValueRx services its clients through a nationwide network of over 37,000 retail pharmacies which are linked through our on-line computer system. Programs typically save customers 25% to 45% compared to unmanaged drug claim costs.

ValueRx's programs now cover 16 million lives.



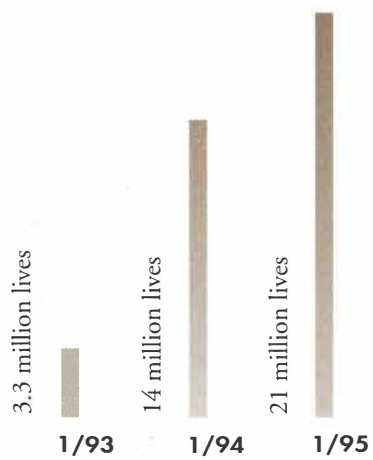
Value Behavioral Health:
Mental Health, Substance Abuse, and Employee Assistance Programs

Employers spend 8% to 10% of their benefit dollars on mental health and substance abuse programs. In addition to the increases in direct benefit costs, indirect expenses – such as those associated with absenteeism, decreased productivity, and higher workers' compensation claims – account for tens of billions of dollars more.

Value Behavioral Health (VBH) is the nation's largest provider of managed mental health, substance abuse, and employee assistance programs. VBH provides programs to large self-insured employers who carve out these benefits from their medical plans as well as by subcontract to HMOs and insurance companies. VBH, through its wholly owned subsidiary Health Management Strategies International, provides mental health utilization review services to nearly 5 million military dependents through CHAMPUS (The Civilian Health and Medical Program of the Uniformed Services).

VBH's comprehensive behavioral health programs utilize a network of over 36,000 practitioners and inpatient facilities nationwide. VBH services offer customers savings of 20% to 40% as compared to unmanaged programs.

VBH's programs now cover over 21 million lives.

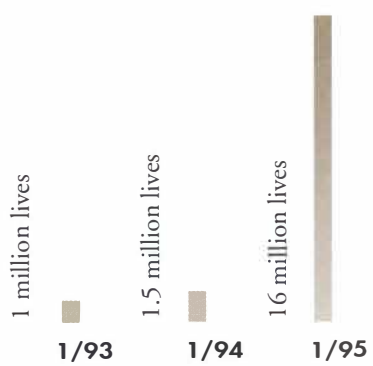


Value Health Insurance Services Group:
Managed Workers' Compensation, Group Health and Related Services

Workers' compensation costs to employers are now in excess of $70 billion a year. More than 40% of that rising cost is composed of medical expenses.

Value Health's Insurance Services Group (ISG) includes our managed workers' compensation and group health services. Our integrated resources offer network-based cost management and treatment strategies for medical and indemnity coverages and work-related injuries. Programs include comprehensive utilization management, claims administration, disability management, and health care data analysis. We have the largest specialty network of nearly 85,000 providers offering workers' compensation medical, behavioral, and prescription drug services to more than 14 million beneficiaries. Through our Preferred Works and Community Care Network companies, ISG demonstrates savings of 10% to 50% compared to unmanaged programs.

ISG programs now cover over 16 million employees.



ValueRx also offers customers:

Mail Service: A stand-alone or fully integrated complement to the retail pharmacy program, allowing members to receive maintenance prescription drugs conveniently by mail. ValueRx's primary mail service facility in Iowa, a state-of the-art, fully automated complex including an intelligent dispensing system, advanced material handling techniques, and integrated drug utilization review, is capable of dispensing 25,000 prescriptions per day;

National Formulary: Independent guidance for doctors and patients on quality, cost-effective prescription drug choices that can earn manufacturer rebates; developed by ValueRx with input from the National Pharmacy and Therapeutics Committee, selected subspecialists, and clinical pharmacists;

Clinical Services: Comprehensive programs including computerized drug utilization review (DURbase™) to identify individuals potentially at high risk for drug-induced illnesses; physician profiling to identify physicians with inappropriate prescribing patterns who then receive focused educational programs; patient profiling and education programs; and disease management.

Customers include:

ARAMARK
American Airlines
Blue Cross of Washington & Alaska
CareAmerica
Compaq Computer Corporation
Detroit Edison
FedEx
Ford Motor Company/UAW
Health Power HMO, Inc.
John Hancock
John Deere
Kaiser Aluminum
Navistar
Paramount
S.E. Michigan Council of Governments (SEMCOG)
State of Michigan
State of New York

As part of our comprehensive program, VBH incorporates:

Client-Centered Account Management: Teams of VBH personnel providing customer-specific services, including 24-hour, toll-free service, staffed by masters-level clinicians, to help members access practitioners suited to their particular needs and locations;

Case Management: Specialized mental health treatment plans developed by teams of patients' therapists, VBH registered psychiatric nurses, social workers, and physicians;

Clinical Groups (CGs): Specially selected local groups of therapists and facilities providing comprehensive services and agreeing to clinical and outcomes standards in return for preferred status as providers;

Employee Assistance Programs: Work-site-based employee assistance activities and specialists integrated into the managed mental health program to assure access and continuity of care;

Member Services: Regional customer service centers affording instant access to eligibility and claims information for quick and accurate response to member inquiries.

Customers include:

American Express
Bell Atlantic
Blue Cross Blue Shield of the National Capital Area
Blue Cross Blue Shield of CT
The Boeing Company
CHAMPUS
Chrysler Corporation
GHI
General Motors Corp.
GTE
Health Net
Kellogg
Nat'l Railroad Employees' Health & Welfare Fund
Quaker Oats Co.
Raytheon Corp.
Sears, Roebuck & Co.
Shell Oil Co.
Southland Corporation
State of New York
United Parcel Service
Xerox Corporation

Insurance Services Group capabilities include:

Specialty Networks: Occupational injury and health care networks specifically designed to control costs and produce improved medical outcomes;

Disability and Medical Case Management: Programs focused on early return-to-work planning and utilization review of high-cost cases;

Claims Adjustment and Payment Review Systems: Fee review systems and a claims adjustment process fully integrated with managed care strategies;

Workers' Compensation Pharmacy: Customized program with formulary designed for work-related injuries and conditions.

Customers include:

Aetna
Allstate
CIGNA
CNA Insurance Company
Employers Health Insurance Company
Fremont Compensation Insurance Company
Hughes Aircraft Company
Marriott
Mayo Clinic
Provident Life
Stanford University
State of Arizona
State Compensation Insurance Fund
Teamsters & Food Employers Security Trust Fund
Transamerica Insurance Group
United Food & Commercial Workers Union
Wal-Mart
Wausau

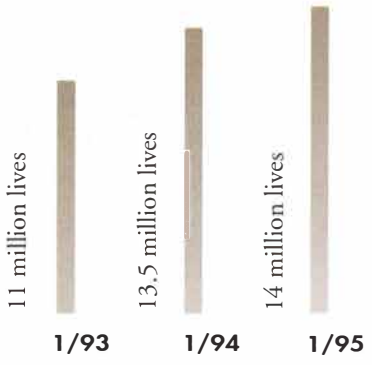
Value Health Sciences:
Disease Management Programs and Clinical Review Services

A significant challenge facing managed care organizations, payers, and health care providers is improving quality and outcomes of care while controlling costs.

Value Health Sciences (VHS) is a leading developer of sophisticated clinical software and provider review services which support medical decision making. VHS products and programs enable providers, third-party administrators, physician groups, HMOs, utilization review firms and employers to precertify medical, surgical, and diagnostic procedures, review claims to identify improper billing, identify best practice patterns and outcomes of care, profile providers, and provide comprehensive disease management. All services are designed to ensure medically appropriate high-quality clinical practice and cost-effectiveness. In addition, VHS maintains a drug data base on 16 million lives involving the addition of 150,000 drug and diagnosis claims per year. The data base is used in drug outcomes research for the FDA and pharmaceutical companies, and utilization review programs for 10 state Medicaid agencies.

VHS has one of the largest and most experienced applied health services research teams in the managed care industry, and includes leading authorities in clinical medicine, utilization management, and information systems.

Value Health Sciences' programs now cover over 14 million lives.



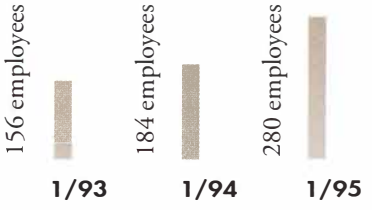
Lewin-VHI:
Health Policy, Research, and Management Consulting

Among the challenges facing both public and private sector organizations is how to improve the health care system and how to respond proactively and effectively to a changing marketplace.

Lewin-VHI is the leading health policy and management consulting firm to those inside and outside the government, offering expertise in corporate strategic planning and implementation, program and policy development, financial and cost-effectiveness analysis, evaluation design, outcomes research, and microsimulation modeling.

Our teams of nationally recognized professionals bring multidisciplinary skills, extensive field experience, and expert use of sophisticated, in-house data bases and economic tools. These combine to help organizations restructure or reevaluate their operations in response to the economic and regulatory forces driving health care system change.

Lewin-VHI now has 280 employees providing health policy, research, and management consulting.

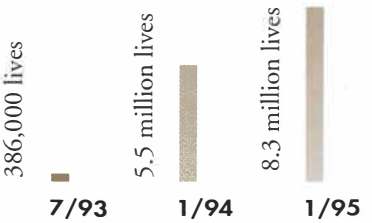


Value Health Management:
Information and Management Solutions

Purchasers face increased complexity and management challenges in getting greater value from their health care programs. Starting with a cornerstone of comprehensive data analysis, Value Health Management (VHM) helps purchasers evaluate the performance of their programs. Combining sophisticated analytic tools with a focus on evaluating production processes, VHM determines where performance can be improved.

VHM goes beyond identification of the problem to acting as out-sourced management staff to execute necessary changes. The extensive inventory of managed care best practices help purchasers and suppliers implement new programs and sustain performance improvements. In this role, VHM acts as a network manager for a diverse range of purchasers from large national employers to regional purchasing alliances to state Medicaid programs.

VHM provides information and management services to customers covering over 8 million lives.



VHS provides services in three major product areas:

Medical Review System (MRS): An interactive, clinically based expert system of practice guidelines that prospectively determines the appropriateness of selected high-cost medical, surgical, and diagnostic procedures. MRS can be used on a stand-alone basis, or integrated with other utilization management programs;

Practice Review System (PRS): A fully integrated, automated system that applies sophisticated clinical logic to analyze claims and other health data sources. PRS links data into clinically meaningful episodes of care and makes adjustments for severity and coexisting illnesses. PRS' prepayment modality analyzes and corrects or pends individual claims. Its postpayment modality produces profiles of providers, and networks for corporations. PRS also generates financial and utilization reports, and disease and best practice profiles;

Disease Management Services: Development of comprehensive programs that improve patient outcomes and control costs by organizing managed care initiatives around diseases. A functional clinical platform is integrated with expert decision support, incorporating national guidelines, expert judgment, and advanced case management techniques. Programs can be tailored to meet the specific needs of employers, managed care organizations, and provider groups.

Customers include:

Blue Cross Blue Shield Plans
Cedars-Sinai Medical Plan
Community Health Plan
Group Health Plans
Health Alliance Plan
HealthNet
Humana
Independent Health Plan
Intermountain Health Care Plans
William M. Mercer
MetraHealth
Pacificare Health Systems
Physicians Health Services
Principal Financial Group
Private Healthcare Systems
Provident Life & Accident
Prudential
3M Health Information Systems

Within Lewin-VHI, there are five practice areas:

Public Health and Finance Policy: Policy analysis, management consulting, program design, microsimulation, and program evaluation carried out for government agencies, foundations, purchasers, employers, community-based organizations, and for industry associations and professional societies;

Health Care Organizations: Consulting services including mergers and affiliations, medical staff development, strategic planning, and operations assessments provided to academic medical centers, hospitals and physician groups;

Economic Analysis: Economic research and analysis on health care, disability, and labor economics issues for government agencies (including health care programs sponsored by the Department of Defense), private clients, and interest groups;

Managed Care: Management consulting for public and private payers, HMOs, hospitals, providers, and investors, offering market analysis, strategic program design, capitation rate setting, network contracting, acquisition support, and implementation;

Medical Technology: Strategic marketing studies and evaluations of new medical technologies, and reimbursement for pharmaceutical and medical equipment companies, payers, regulators and associations.

Customers include:

AARP
American College of Cardiology
American Hospital Association
Beth Israel Hospital (Boston)
Bristol-Meyers Squibb
Catholic Health Association
Columbia Presbyterian Medical Center
Connecticut Department of Social Services
Department of Defense
Department of Health & Human Services
Medtronic
Nat'l Institute for Health Care Management
New Mexico Human Services Department
Pharmaceutical Partners for Better Healthcare
State of Washington Dept. of Health
Texas Department of Health
University Hospital Consortium
UCLA Medical Center
W. Virginia Public Employees Ins. Agency

VHM services include:

Integration of Health Information: Development of integrated health care reporting systems to produce consistent analysis of health plan performance;

"Out-Sourced" Supplier Management: Management of the linkages between fragmented and complex purchasing arrangements, including measuring performance against agreed-upon targets, implementation of new programs, establishment and negotiation of supplier contracts, coordination of enrollment and problem resolution services;

Ongoing Operational Oversight: Implementation of identified cost-saving opportunities using best practices and process improvement techniques.

Customers include:

Abbott Laboratories
Allied Signal
Amoco Corporation
Amphenol Corporation
BellSouth Corporation
Commonwealth of Mass. Medicaid
Connecticut Business & Industry Association
Harris Corporation
Long Island Association Health Alliance
Occidental Petroleum
Procter & Gamble
Promus Companies
Public Employees Retirement System of Ohio
State Teachers Retirement System of Ohio
United Technologies Corporation
The Walt Disney Corporation

Depression

1994 Direct Costs: $16.1 billion

Depression affects 15 million to 20 million Americans.

Indirect costs due to morbidity and mortality total $40.6 billion.

Asthma

1994 Direct Costs: $4.7 billion

9 million to 12 million Americans are afflicted.

5% of asthmatics account for 70% of the costs of the disease.

Indirect costs from morbidity and mortality contribute an additional $3.3 billion in costs.

Disease management programs for asthmatics could produce a system-wide savings of 25%.

Cardiovascular Disease

(heart disease, stroke, hypertensive disease)

1994 Direct Costs: $110 billion

56.5 million Americans have some form of cardiovascular disease.

Two out of every five Americans die of cardiovascular disease.

The indirect costs of cardiovascular disease total $18.2 billion.

Peptic Ulcer Disease

1994 Direct Costs: $3.7 billion

Nearly 6 million Americans are affected by peptic ulcer disease annually.

Indirect costs from morbidity and mortality total $1.2 billion annually.

Cancer

(excluding basal and squamous cell skin cancer and carcinoma in situ)

1994 Direct Costs: $35 billion

1,208,000 new cancer cases and 538,000 deaths were projected for 1994.

Indirect costs from cancer morbidity and mortality are estimated to total $69 billion annually.

Diabetes

1994 Direct Costs: $113 billion

Approximately 11.1 million people have diabetes (4.5% of the U.S. population).

The 4.5% of the U.S. population with diabetes accounts for 14.6% of health care expenditures.

Enrollment in Medicare's End Stage Renal Disease (ESRD) program has grown dramatically primarily due to older individuals and people with diabetes.

Benign Prostatic Hyperplasia (BPH)

1994 Direct Costs: $4 billion

14 million older men suffer from symptoms related to BPH.

An estimated one in every four men in the U.S. will be treated for relief of symptomatic BPH by age 80.

Prostate surgery (TURP) is the second most common surgical procedure performed in the Medicare population, second only to cataract surgery.

Value Health: Bringing Science to the Art of Managed Care . . . Disease by Disease

"Disease management" is a hot new topic in health care. At Value Health, we think it isn't just a fad, but an important, improved way of approaching health care – and managed care. So important, in fact, that we're devoting this part of the annual report to discussing this new concept. But just what is meant by "disease management"? How is it different from what's been done before? Why is it important? What are the tools needed to deliver disease management? And what makes Value Health's approach different? Let's answer the most obvious question first.

Defining Disease Management

There are a lot of definitions appearing around the concept of disease management. Often, they vary with the interests and perspectives of the user. At Value Health, we're trying to keep it simple. To us, *disease management means taking a comprehensive, systematic approach to improving patient outcomes and lowering costs in key disease categories*. Outcomes are the results achieved through a particular health care service. Desired outcomes include improved patient functionality, health status, satisfaction, and lowered costs of treatment.

We'll admit that probably doesn't sound revolutionary, but in fact it's quite different from how managed care is organized today. Managed care traditionally hasn't focused on diseases. It has instead measured its success in terms of input categories – often referred to as "component management." So, managed care experts pour over data "inputs" such as hospital admission rates, length of hospital stays, hospital days per thousand members, outpatient visits per thousand, per-member-per-month prescription drug costs, or Cesarean section rates. Moreover, the major premise of most HMOs is to avoid the use of specialists in favor of primary care generalists and gatekeepers. And yet, the sickest 5% of the population who in fact generate 60% of health care costs are typically beyond the care of primary care physicians alone. They need specialty care – and specialized disease management.

By and large, managed care hasn't yet concerned itself with, for example, how to improve cancer care in terms of specific patient outcomes – a disease management approach. This is, to us, the next frontier, or as one managed care CEO put it, "the holy grail" of health care as it relates to both cost and quality.

Why Is Disease Management Important?

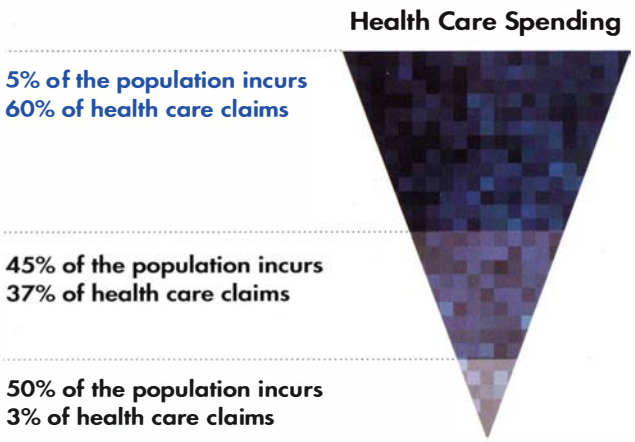
In terms of costs, disease management aims squarely at the major concentrations of health care expense. As mentioned earlier, in any year, 5% of the population accounts for 60% of health care claims costs. By contrast, 50% of people generate only 3% of claims costs. The *David* graphic at the left helps illustrate this important point still further. The big expenditures are inevitably with very sick people – these patients have chronic and acute diseases. So – disease management is important because it's where the greatest opportunity for improvement and savings resides.

In quality terms, outcomes-based disease management would give patients a whole new basis for choosing health plans and providers. Imagine being able to obtain severity-adjusted comparative data on real patient outcomes versus simply choosing your health plan based on cost and a physician list. Think what that would do to raise the level of quality competition in health care!

Simply stated, successfully managing the costliest disease states will have a profoundly positive effect on health care as we know it.

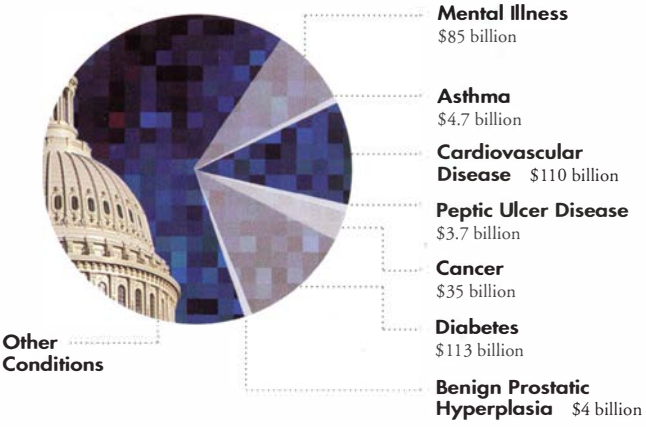
> "Targeting and monitoring at-risk patients for prevention and treatment is far more efficient than offering population-wide efforts." Mark Zitter, President, The Zitter Group, San Francisco

How to Expand? Go Where the Opportunity Is.



$1 Trillion in U.S. Health Care Spending

Direct Health Care Costs for Key Diseases in 1994



Value Health managers have been pioneers in managed care for over 20 years – long before the concept was even called "managed care." We believe the experience of our staff is unparalleled in our business, having attracted industry leaders from major managed care companies such as CIGNA, Kaiser Permanente, Aetna, MetraHealth (formerly Travelers and Metropolitan), United HealthCare, and Blue Cross Blue Shield plans. We've also drawn talented managers from leading health care product companies such as Merck, McKesson, and Baxter, benefits managers from Fleet, GE, and New York State, and researchers and analysts from RAND, UCLA, and federal and state agencies. From private practice physicians to successful senior managers, entrepreneurs to academicians, Value Health executives have been – and continue to be – at the forefront of managed care.

"Value Health's management team has the strength and breadth to successfully develop programs for new market sectors, especially in the area of disease management. They're one of the few companies positioned to do this – with the people, systems and programs to bring health care into the next century." Sara A. Fisher, Equity Analyst, Vice President, UBS Securities

Value Health: Bringing Science to the Art of Managed Care

Moving into disease management allows Value Health to evolve beyond selected carve-out areas such as mental health and prescription drugs, and into the entire medical-surgical field – affecting the greatest areas of cost and affording the most significant impact on outcomes.

For Value Health, disease management offers particularly fertile territory because it builds on the very techniques we've been pioneering for years. We were founded in 1987 with the objective – expressed in our tag line – of "bringing science to the art of managed care." By that phrase we meant that we wanted to focus on identifying and reducing medically inappropriate care, rather than aiming just at provider discounts or reduced hospital days. We determined that we had to focus on clinical issues, and that required organizing managed care around the same specialty categories that health care itself had developed – for example, mental health care. So, the business of "specialty managed care" was born. At the same time, we learned that we needed new information-based technologies – the ability to develop and apply clinical protocols, to measure and influence physician practice patterns, and to screen medical claims records to identify changing patient outcomes.

Our combined specialty managed care and information services technologies are described in the fold-out section preceding this essay. These programs have worked well for our customers, reducing costs by 10% to 50% as measured against unmanaged benefits. As important, outcomes analyses and member surveys indicate high levels of satisfaction and better health outcomes.

With this proven track record as our foundation, we find disease management to be a natural extension of our existing Value Health capabilities.

"Value Health has had a dual focus on quality and cost management from our beginning – that's what we meant by putting 'value' in our name. We're pleased to now find that the two broad areas in which we've been involved – specialty managed care tools and health care information services – are the key building blocks for disease management. Disease management is a natural evolution for us . . . and an important addition to our product line."

Robert E. Patricelli, Chairman and CEO, Value Health

"Quality information will play an ever-increasing and vital role in integrating health care delivery systems, making positive changes in physician practices, and in helping employees and their dependents make informed health care decisions. Value Health's clinically based information capabilities make them qualified to be a leading catalyst for these important changes."

Glen E. Cline, Senior Vice President, The Segal Company

What Are the Tools of Disease Management?

From our experience to date, we've learned that disease management requires the customizing of known managed care tools – like case management, network management, clinical protocols, practice guidelines, provider profiling, and patient education materials – and the need to build new tools, in such areas as the measurement of outcomes.

Our comprehensive concept of disease management encompasses analysis, planning, and integration of *all* factors required to diagnose, treat, and monitor a patient's disease over its full course. Disease management requires a continuum of care. Episodes of illness are reviewed, treated and managed as part of a continuum of the disease. Tools are designed to:

aid in more efficient and earlier diagnoses by physicians;

improve treatment through practice guidelines;

integrate treatment programs among all caregivers through case management;

provide patient education and compliance programs;

institute systems to make care more pleasant for patients and their families; and

demonstrate the value created through outcomes measurement.

Customized disease management programs will have unique sets of interventions in the diagnoses and treatment processes, tailored therapies for the different disease stages, and special tracking and reporting systems to assess and measure outcomes, and identify patterns. Programs are matched to physicians' work flows to assure acceptance and appropriate use. And proper incentives are developed that match the particular provider of care. We seek to assess the effectiveness of treatment programs

Value Health pioneered the tools and technologies that have a proven track record of positively changing provider practices and improving quality of care:

Medical Review System (MRS): assists utilization review teams in determining appropriateness of high-cost procedures – balancing risk to the patient against benefits. Direct savings: $500 per case reviewed.

Practice Review System (PRS): assists network managers and medical directors in maintaining network quality by profiling provider practice patterns. PRS enables us to measure the costs of providing care for a disease as well as identify the best practice patterns and the providers who use them. PRS incorporates over 1800 diagnostic categories with severity and comorbidity adjustments.

Outcomes Management Systems: customized and comprehensive retrospective and real-time systems developed to determine if disease management programs achieve their goals. There are five key components in assessing outcomes:

- **impacts on cost and utilization;**
- **patient and provider satisfaction;**
- **impacts on functional status, that is, the ability to perform the functions of daily life;**
- **process of care evaluations; and**
- **patient clinical outcomes, such as morbidity and mortality.**

"When you look into PRS and see what drives the clinical engine, it has no competitors. Quite simply – it's the most clinically advanced system in the industry."

Jim Cross, M.D., Senior Vice President and National Medical Director, MetraHealth

as they unfold, and continuously refine and improve them to ensure that the best care is provided. Our disease management programs strengthen the link between physicians and patients – an important change from component management that often causes managed care techniques be an unwelcome wedge in this relationship.

How Is Disease Management Delivered?

There are several ways to effectively deliver disease management programs to reduce cost inefficiencies while improving treatment and outcomes. All of these delivery systems can be offered either on a fee or a risk-sharing basis.

Delivering Disease Management as a Carve-Out

There are certain diseases that are managed mostly by physicians in a single subspecialty rather than being handled by a range of primary care and specialist doctors. In these areas, it's possible to "carve out" the management of the disease from a general provider network and to substitute a specialty program and network organized around disease management principles. So, employers, insurers and health plans can, in effect, subcontract the care for a particular group of patients to a specialty program.

This is what Value Health does now, in the disease area of mental health, for example.

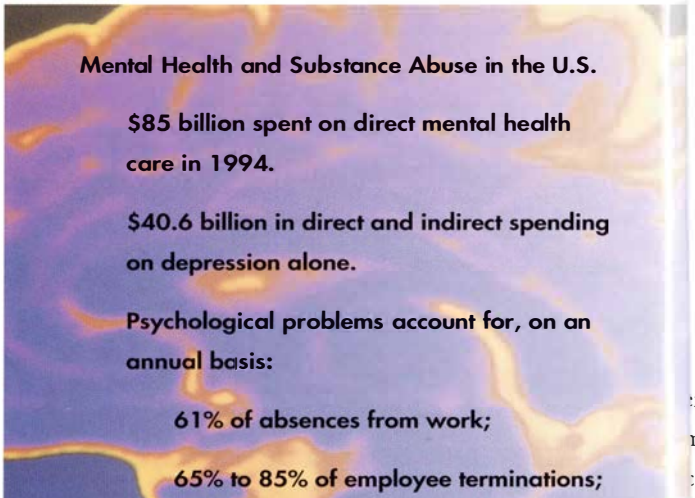
In 1993, Value Behavioral Health (VBH) was created. We combined two of the nation's leading mental health management companies, the former American PsychManagement (a Value Health company since 1987) and the former Preferred Health Care, both founded in 1983, to create the nation's largest behavioral health company. VBH provides our mental health, substance abuse, and employee assistance programs and has been a laboratory for formulating our disease management technology. By carving out mental illness from mainstream benefits, Value Health has been able to develop specialized techniques to reduce overall mental health costs and provide more appropriate treatments for mental illness. And the results speak for themselves as the chart on the next page – with results from just one of our nearly 1000 customers – helps show.

"Despite all of the evolutionary changes in managed care, one fundamental principle remains constant: Physicians have responsibility for their patients' quality of care. So, physicians' willingness to adopt new disease management approaches will directly relate to their confidence that the programs can improve care – not just save money."

Robert W. Dubois, M.D., Ph.D., Executive Vice President and Chief Medical Officer, Value Health Sciences

"I believe that Value Health is extraordinarily well positioned to develop disease management programs. I expect that the company will leverage their experience in managing specialty carve-out niches, their expertise in developing clinically driven information systems, and the strength of their management team, clinical staff, and extensive data bases to create industry-leading disease management programs."

Eleanor H. Kerns, CFA, Principal, Alex. Brown & Sons



Here are some examples of how general managed care techniques are changed and customized to a specific disease management program in the mental health field:

patient access: instead of relying on published provider directories, patients gain access through employer-based Employee Assistance Programs (EAPs) or 24-hour toll-free telephone "help" lines;

gatekeeping: assigning primary care gatekeepers ahead of time wouldn't work since most members don't have a current mental health need. Rather, members call a telephone help line to access care; trained clinicians triage the case to the most appropriate type of provider;

patient treatment plans: given the lack of continuity of care and the absence of clear objectives which often prevail in mental health treatment, VBH uses trained clinicians as case managers to work with treating therapists to coordinate care and to develop clear treatment plans;

case management: given the importance of avoiding unnecessary hospitalizations arising from emergency room visits, psychiatrists are contracted to be on call 24 hours a day to go to emergency rooms to assess patient severity. Typical telephone prior approval wouldn't work in such situations;

clinical protocols: VBH uses the mental health review system developed in collaboration with Value Health Sciences plus a widely distributed Clinical Procedures Manual to improve practice patterns among its providers;

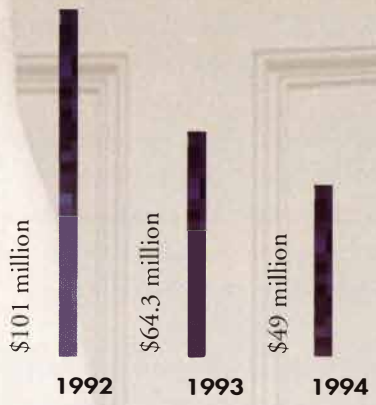
provider profiling: criteria specific to mental health and substance abuse treatment have been used to develop software which profiles provider practice patterns to identify those to whom referrals should be preferentially directed.

In the sense that mental health management can be considered a precursor to disease management, we've been at it for more than 10 years – since the inception of our predecessor companies. We organized our specialized managed care tools, interventions, and resulting data around the *diseases* of mental health and substance abuse. That's why we consider our specialty mental health management to be the best example today of a prototypical disease management program.

1994 program results for one VBH customer, a nationwide, multi-union employer covering more than 550,000 lives:

Service Type	Performance Standard	1994 Actual
Claims turnaround to employee		
<10 days	84%	87.42%
Claims accuracy		
Financial	99%	99.11%
Mechanical	96%	99.45%
Access to emergency provider care	95%	97.20%
Access to urgent provider care	95%	98.63%
Access to routine provider care	95%	99.13%
Clinical referral line, answer time	20 seconds	13 seconds
Clinical referral line, abandonment rate	2%	1.23%

Customer Plan Costs



In the two years VBH has managed the program for this customer, total direct savings of $52 million have been realized. And these savings were achieved with less than a 2% member appeals rate.

We decreased client costs by more than 50% while increasing the benefit level to 100% for in-network services and improving member access.

Clinical Groups: Partners with Providers in Managed Mental Health

" I participate in some capacity on over 50 mental health panels and I think VBH is clearly the best in the business – always ahead of the pack, doing things now that you can be sure others will try to follow in the future. Clinical Groups are an example.

As a part of VBH's Anchor Group concept for six or seven years providing inpatient and substance abuse treatments, I feel we've been a partner in the ongoing evolution to VBH's Clinical Group (CG) concept where now outpatient treatments are also included. VBH understands that the effective management of the disease takes into account all aspects on the care continuum.

To the patient, that means much better coordination of care throughout treatment. They're involved in their plan from the start – it's focused and goal driven. They get the right care at the right time by the right provider. And they're able to self-refer within the CG – eliminating things like precertification and paperwork often associated with managed care.

To employers, it means better functioning employees and dependents, and controlled costs because CG treatment plans look at all aspects – EAPs, community resources, 12-step programs, inpatient and alternative care facilities, psychotropic medications, primary care physicians . . . multiple factors.

To us as care providers, CGs bring a *welcomed* discipline to clinically based quality standards second to none – developed, monitored, and constantly improved by peer review. This translates into improved services, clinical skills, treatment planning, utilization of community resources – and results. There's an added value: As a CG participant, we're recognized as better care givers because of our unparalleled quality initiatives." Morris Gelbart, Ph.D., Clinical Director and Principal, PsychCare Alliance, Redondo Beach, CA

" A lot of mental health practitioners – and patients – have a "mythical" fear of managed care, thinking it's adversarial. With Clinical Groups, nothing could be further from the truth. Our group of 60 practitioners represents a wide range of disciplines and clinical expertise. As partners with VBH, our mutual dedication to effective management of the disease of mental illness for better outcomes gives us a singularity of purpose." Peter B. Hirsch, M.D., Ph.D., Medical Director and Principal, PsychCare Alliance, Redondo Beach, CA

And it's also just one of the reasons why we consider Value Health to be uniquely qualified – from both experience and strategic planning perspectives – to successfully develop and implement comprehensive disease management carve-outs.

In the area of a cancer carve-out, Value Health Sciences (VHS) recently completed, for one of the nation's leading cancer treatment centers, the first in a series of guidelines focusing on the use of bone marrow transplantation in breast cancer treatment. VHS also looked at the site of cancer chemotherapy and use of antiemetics, each to be the subject of future guidelines in our cancer disease management series.

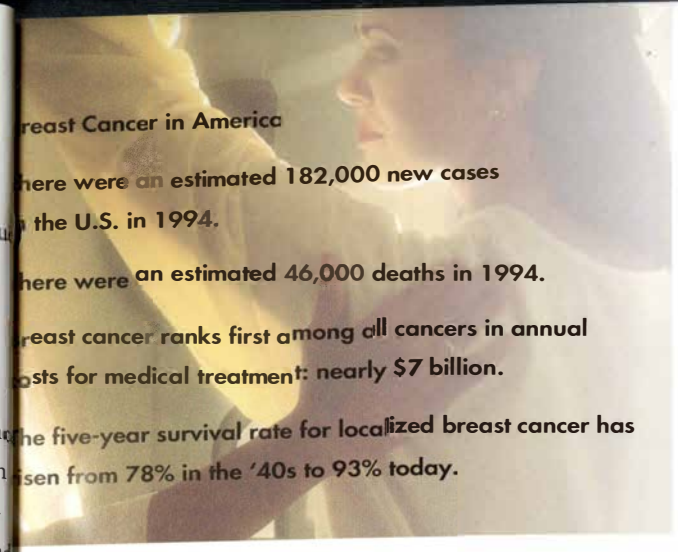
The resulting guidelines are based on the methodology first developed by the RAND Corporation that uses the collective judgments of internationally known academic and clinical experts to produce consensus-based protocols. This methodology was integrated with sophisticated statistical techniques to develop guidelines for the use of bone marrow transplantation covering more than 1200 patient categories.

Delivering Disease Management as a Carve-In

A "carve-in" is a program which provides tools to a managed care or provider organization to be used with its existing physicians, rather than substituting a different specialty network. This will be the case for diseases where treatments are provided by a range of primary care physicians and/or specialists rather than by a single subspecialty. Diabetes is an example of a disease likely for carve-in treatment because pervasive complications such as adult blindness, cardiovascular disease, and amputations involve virtually the complete spectrum of internal medicine.

The most significant cost savings can occur through the prevention of emergency hospitalizations for diabetes with acute blood-related complications, such as diabetic ketoacidosis (DKA) and hyperosmolar coma. Our diabetes disease management program will target reducing and preventing hospitalizations through:

- more aggressive metabolic targets for better control;
- blood pressure control;
- lipid (cholesterol) management;
- patient self-management and compliance with approved medical regimen; and
- physician and patient screening practices for complications.



The American Diabetes Association (ADA) has indicated that tightly controlling the disease of diabetes would roughly double the $1500 to $2000 diabetics spend on medication and testing annually. They also state that tight controls could reduce hospitalizations from complications between 45% and 60%, or between $17 billion and $23 billion annually.

Value Health case examples reveal potential savings of 70% in hospitalization costs alone which is actually more than that predicted by the ADA. And, analyses of customer data on patients with diabetes show that overall savings can average in excess of 20% following the implementation of proposed Value Health diabetes disease management programs.

The tools of a carve-in program include specialized case management, provider and patient education programs, clinical protocols and pathways, specialized utilization review and outcomes measurement programs.

Value Health has substantial experience in developing carve-in tools. VHS and Lewin-VHI – our clinical, analytic and health services research arms – are the engines that enable us to do disease management as no other company can. VHS creates clinical software tools like MRS and PRS, discussed on page 13, which it sells to HMOs, insurers, and group practices, among others. And Lewin-VHI has worked over the years with a wide range of physician specialty societies and provider groups on disease management systems.

Delivering Disease Management as a Provider

Another means of delivering disease management programs is by being the direct medical provider – rather than the network operator – presumably acting as a preferred provider to an employer or health plan. We're already seeing this development in the market as specialty provider-based disease management organizations have sprung up in such areas as medical oncology, hemophilia, and diabetes. Specialty provider management or ownership is a possible direction for Value Health as we deepen our engagement in disease management.

Delivering Disease Management as a Pharmacy Benefit Manager

The addition of customized programs as part of the prescription drug benefit offered by PBMs such as ValueRx is another delivery vehicle for disease management.

Asthma is a likely candidate for this scenario. The proper use of asthma medicine can help patients avoid expensive emergency treatments and hospital stays. ValueRx offers targeted programs that our customers use to educate their asthmatics on proper use of medication, and, importantly, the steps to take before the onset of a major attack to avoid hospitalization. Through our data analysis capabilities, we can identify patients who seem to be experiencing unnecessary emergency room visits, and begin the process of counseling and educating them to avoid costly services.

Select research of diabetes disease management programs shows large cost savings can result from reductions in chronic complications, including up to a:

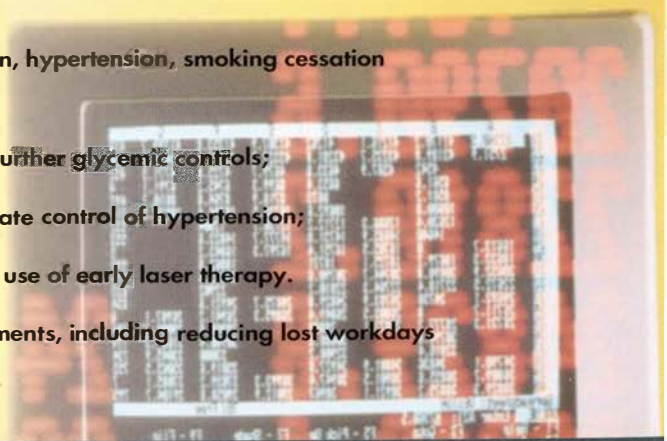
50% reduction in lower extremity amputations by implementing education, hypertension, smoking cessation and glycemic controls;

70% reduction in episodes of ketoacidosis through better education and further glycemic controls;

50% reduction in End Stage Renal Disease (ESRD) cases through appropriate control of hypertension;

60% reduction in diabetes-caused blindness by improving education and use of early laser therapy.

And still further savings can be accrued in occupational productivity improvements, including reducing lost workdays by up to 40%.



ValueRx provides extensive patient and provider education now as it relates to drugs and prescribing patterns, covering over 8.5 million people with drug utilization review designed to avoid adverse reactions.

Our experience supports findings that up to 40% of prescription drug use is inappropriate. That problem is particularly acute among the elderly, where 25% of people aged 65 or older are prescribed a potentially inappropriate medication, according to *The Journal of the American Medical Association.* Value Health's detailed follow-up assessments have shown our program results in changes in drug therapy producing plan cost savings and improved health outcomes for patients in 65% of all our cases. And we're continuously developing more effective programs and interventions, focusing on about 20 of the most promising disease areas.

Value Health and the Pharmaceutical Industry: Partnering for Success

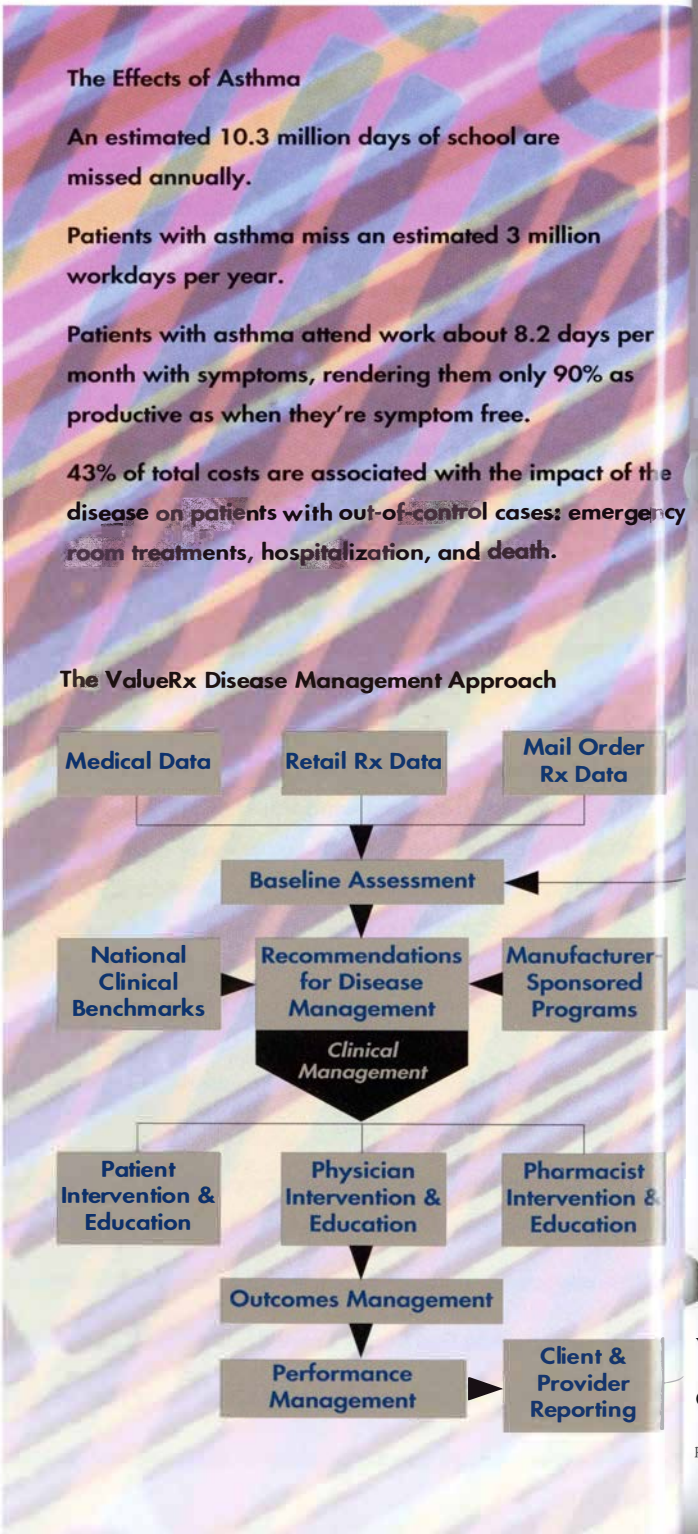
To capitalize on the opportunities present in disease management, Value Health is pursuing a variety of strategies. One is to form strategic alliances with leading pharmaceutical manufacturers.

"Pharma companies," as they're called, share our interest in disease management. It's viewed by them as an opportunity for strategic diversification into health care services, often in categories where they have a drug or medical/surgical device interest. Disease management leverages both the pharma companies' extensive knowledge of the science of the disease and its field forces for use in educational programs with physicians. As important, the companies have a culture of research and development, as well as a tradition of interest in outcomes forced by the need to measure and prove efficacy to the U.S. Food and Drug Administration.

Value Health has extensive experience in this area as well. We maintain a data base of over 16 million active patient lives, involving over 150 million drug and diagnosis claims inputs per year. Our data base is used in outcomes, efficacy, epidemiological, and scientific analyses performed for the FDA, making Value Health one of their leading non-academic advisers. The data is also used for research by the nation's leading pharmaceutical manufacturers.

"Value Health goes deeper than PBMs can into the medical end of disease management, with its various companies – like Value Health Sciences – developing practice guidelines and providing extensive utilization review."

Mark Zitter, President, The Zitter Group, San Francisco



Specialized Disease Management from Value Health Comprehensive programs with four unifying themes:

The focus needs to be on the entire population of patients who have the disease as well as those not yet diagnosed but who currently have symptoms or are at high risk.

The entire population of caregivers – physicians, nurses, pharmacists, clinicians, hospitals and other care facilities – must be included.

It's vital to address the complete nature of the illness – acute phases, remission, recurrences, maintenance, and cure.

Programs must identify and address the key junctures or levers in the provision of care where best practices can significantly affect patient outcomes.

At Value Health, we focus on how to justify and quantify – in advance – the benefits of such a program. Then we develop the clinical management systems, or series of tools, that enable the provision of the best care for the disease. Such systems include diagnostic aids, severity of illness stratification, practice guidelines, provider and patient education, and case management. Last, we use a comprehensive – and proprietary – set of outcome assessment tools, including cost and utilization data, patient and provider satisfaction surveys, functional status, intermediate outcomes throughout the cycle of care, and morbidity and mortality measures.

The result: Value Health can effectively develop disease management programs that help individual caregivers understand the care that they can provide, demonstrate to managed care entities the value of the disease management program in improving health and controlling costs, and improve patient outcomes . . . disease by disease.

"We believe that the development of disease management programs allows us to capitalize on all of our prior experience in specialty managed care and information management in health care. It's a wonderful confluence of where we've been and where the managed care and pharmaceutical worlds are going."

Robert E. Patricelli, Chairman and CEO, Value Health

"Pfizer research has given us unparalleled knowledge of diseases and world-class medicines to treat them. Value Health is a leader in translating that knowledge into therapeutic regimens that achieve the best patient outcomes and demonstrate the cost-effectiveness of high-quality therapies to managed care customers. This is a highly complementary fit." Edward C. Bessey, Vice Chairman, Pfizer Inc and President, U.S. Pharmaceuticals Group

Value Health and Pfizer

Our first alliance, forged in 1994, is a two-part agreement with Pfizer Inc, a world-renowned pharmaceutical company.

Under the first agreement, Pfizer entered into a multi-year contract with Value Health to develop value-added programs designed to improve physician and patient use of Pfizer pharmaceutical and medical device products, as well as a series of disease management programs that aren't necessarily linked to drugs or devices. These programs include many of the kinds of technologies we've addressed throughout this report – clinical protocols for drug and medical therapy, physician and education materials, and outcomes analyses.

The second agreement is a 50-50 joint venture partnership with Pfizer to develop network-based disease management carve-out programs. This new company, called Disease Management Sciences, has an initial committed capitalization of $100 million, funded equally by the two partners.

We intend to build on the pattern of our arrangement with Pfizer and develop more strategic alliances with major drug companies as we seek to develop and implement disease management.

Bringing Science to the Art of Managed Care . . . Disease by Disease

In managed care, no one programmatic approach is a panacea – but disease management will be an important part of the arsenal. And at Value Health, disease management represents an important third leg of our managed care stool, along with specialty benefits and health care information services.

Disease management is a new way of thinking about managed care. A way focused on outcomes – and that's good news for patients and consumers.

Value Health continues our evolutionary approach to better managing health care quality and costs by seeking to bring science to the art of managed care . . . disease by disease.

Value Health: Bringing Science to the Art of Managed Care . . . Disease by Disease

Summary

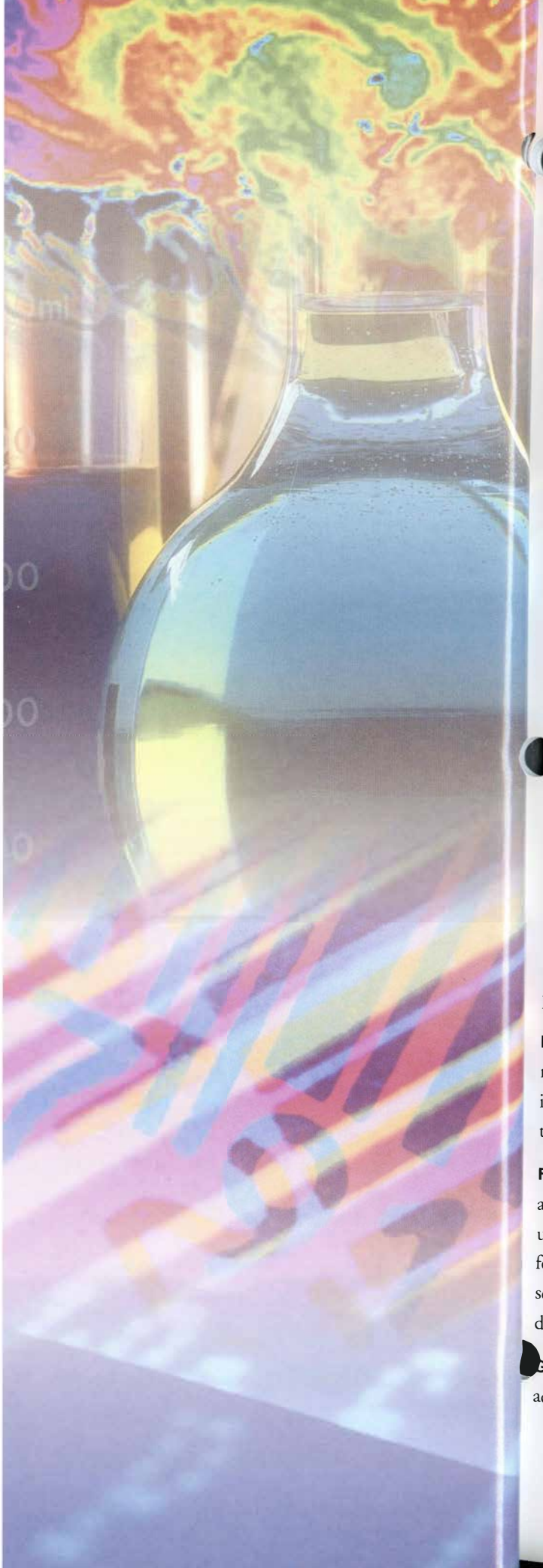
We've spent a good deal of time explaining our definition of and plans for disease management. We realize that there are terms and concepts with which you may not be familiar. So, we've provided a glossary of some of the most commonly used terms related to this concept. We hope it's helpful. And we hope we've successfully answered the questions we set forth at the start of this report. To summarize:

What is disease management? A comprehensive, systematic approach to improving patient outcomes and lowering costs in key disease categories by customizing managed care tools in a variety of program packages that can be sold for fees or on a risk-sharing basis.

Why is it important? Because the major diseases are where the money is in health care; it's where the major opportunities are to improve quality and reduce costs.

How is it different from the past? Managed care has traditionally organized around components or input categories of treatment; it hasn't focused on outcomes measurement. In addition to organizing the components around diseases, improved outcomes will be the focus of Value Health disease management programs.

What is the Value Health difference? Our experience in disease management in the mental health, data and program analysis, and clinical protocol fields. No other company has our combination of capabilities, battery of tools, and staff of industry experts to develop and manage disease-oriented programs.



Glossary of Terms

Capitation - a method of payment for providers or health plans. A primary care physician or a health plan is paid a fixed rate (or capitated fee) per month for certain defined care needs of a covered patient. Shifting the risk and melding finance and delivery are intended to stimulate preventive care and promote appropriate use of the delivery system.

Carve-in - applying specialized tools within a managed care or provider organization to be used with existing physicians.

Carve-out - a specialty network-based program designed to manage care of a disease that can be segregated from general benefit or treatment programs.

Clinical management protocols - guidelines developed from literature and consensus judgment aimed at determining the appropriateness of proposed procedures to support medical decision making.

Comorbidity - existence of more than one disease or the coexistence of disease symptoms.

Disease management - a comprehensive, systematic approach to improving patient outcomes and lowering costs in key disease categories.

Drug Utilization Review (DUR) - series of programs and computer-based analysis tools designed to provide a quantitative evaluation to promote clinically appropriate and cost-effective prescribing, dispensing and use of prescription medications.

DURbase™ - ValueRx's proprietary computerized drug claims review system that identifies people at risk for drug-induced illnesses; DURbase™ is the nation's largest retrospective outpatient-focused DUR program.

Formulary - a listing of preferred prescription medications and prescribing guidelines which is regularly reviewed and updated. An "open or voluntary" formulary allows coverage for both formulary and non-formulary medications. A "closed, select or mandatory" formulary limits coverage to just those drugs in the formulary.

Gatekeeper - point of contact through which members receive additional care or referral.

Managed fee-for-service - the cost of covered services is paid by the insurer after services have been received. Various managed care tools such as precertification, second surgical opinion, and utilization review are used.

Multispecialty medical practice - a group practice that provides a broad range of medical services through an affiliated practice of physicians that ranges from primary care physicians to highly focused specialists (e.g., cardiologists).

Outcomes - results achieved through a particular health care service; desired outcomes include improved functionality, health status, satisfaction, and lowered costs of treatment.

Outcomes management - systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying in a formal program of continuous quality improvement.

Pharmaceutical (or Prescription) Benefit Managers (PBM) - organizations that manage pharmaceutical benefits for the payer (self-funded employers, insurance companies, PPOs, HMOs). They provide many services designed to lower pharmaceutical costs for their clients, including: claims processing, developing pharmacy networks, negotiating pharmacy fees, formulary and generic substitution programs, and outcomes analysis. They also monitor physician and patient prescribing and provide physician education on appropriate drug use.

Primary Care Physicians (PCPs) - a group of physicians who care for the fundamental health care needs of a patient population. The following are generally considered primary care disciplines: internal medicine; family/general practice; and pediatrics. Obstetricians and gynecologists also can be considered primary care physicians.

Provider profiling - reviewing and comparing practice patterns among physicians or health plans based on criteria having to do with cost, utilization, quality, and patient satisfaction.

Risk-sharing agreements - compensation arrangements between payers and health plans, or health plans and providers, whereby the financial risks and benefits of higher or lower costs or utilization than was budgeted is shared by the parties. Capitation or insurance arrangements do this; pure self-insurance does not.

Financial Section Index

Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Value Health, Inc. ("the Company") is a leading provider of specialty managed health care benefit programs and health care information services.

On August 29, 1994, the Company completed its merger with Prescription Drug Service, Inc., based in Hauppauge, New York, and its affiliated company Prescription Drug Service West, Inc. (collectively, "PrescDrug"), based in Chandler, Arizona. The Company issued 937,178 shares of its common stock in exchange for all of the outstanding common stock of PrescDrug. The PrescDrug companies are suppliers of mail service and retail prescription drug benefits to national, regional and local union, corporate and HMO benefit plans.

On August 31, 1994, the Company acquired by merger all of the outstanding common stock of RxNet, Inc. ("RxNet") by issuing 256,136 shares of its common stock for all of the outstanding common stock of RxNet. RxNet is located in Fresno, California and offers prescription drug card programs to insurers, self-insured employer groups, third party administrators, and multiple employers trusts and associations.

Both of these transactions have been accounted for as poolings of interests and financial statements for all periods prior to these combinations have been restated to reflect the combined operations.

1994 revenues of $976.4 million increased $286.9 million or 41.6% over 1993, and 1993 revenues were $689.5 million or 88.6% ahead of 1992. The Company had earnings from continuing operations before income taxes (excluding merger-related expense) of $88.6 million for 1994, compared to $56.1 million in 1993, and $27.4 million in 1992.

Results of Operations – Continuing Operations

The following table sets forth certain consolidated financial data as percentages of total revenues for the three fiscal years ended December 31, and the percentage changes in the dollar amounts of revenues and expenses for 1994 as compared to 1993 and for 1993 as compared to 1992.

	Percentage of Revenues for the year ended December 31,			Percentage Increase (Decrease)	
	1994	1993	1992	**1994 over 1993**	1993 over 1992
Revenues:					
Prescription drugs	**67.0%**	63.8%	61.7%	**48.8%**	95.1%
Mental health	**20.3**	23.4	31.2	**22.9**	41.5
Insurance services	**6.9**	5.2	0.4	**87.4**	2,447.6
Information services	**4.2**	5.4	3.4	**10.4**	190.1
Other	**1.0**	1.1	1.7	**31.0**	21.0
Investment income	**0.6**	1.1	1.6	**(26.8)**	36.3
Total revenues	**100.0**	100.0	100.0	**41.6**	88.6
Expenses:					
Costs of services	**78.2**	78.4	77.8	**41.2**	90.0
Selling, general and administrative	**10.6**	11.3	12.3	**33.1**	73.7
Depreciation and amortization	**2.0**	2.0	2.2	**41.4**	71.1
Interest expense	**0.1**	0.1	0.2	**(12.4)**	1.3
Merger-related expense	**0.6**	5.6	—	**(84.4)**	—
Total expenses	**91.5**	97.4	92.5	**33.1**	98.6
Earnings from continuing operations before income taxes	**8.5**	2.6	7.5	**367.1**	(35.4)
Provision for income taxes	**3.4**	1.6	2.2	**208.6**	33.3
Earnings from continuing operations	**5.1%**	1.0%	5.3%	**609.1%**	(63.9%)

Years Ended December 31, 1994, 1993 and 1992 – Continuing Operations

Total revenues increased by $286.9 million in 1994 over 1993 and $323.8 million in 1993 over 1992. Existing customers produced $64.6 million and $39.5 million, respectively, of 1994 and 1993 revenue growth. Revenues from new customers grew by $177.1 million in 1994 over 1993 and $197.8 million in 1993 over 1992. Acquisitions accounted for $45.0 million and $84.5 million, respectively of 1994 and 1993 revenue growth.

Prescription drug revenues for 1994 of $654.4 million increased by $214.6 million or 48.8% over 1993, and 1993 revenues increased by $214.4 million or 95.1% over 1992. Of these increases, $73.0 million and $34.2 million, respectively, were associated with existing customers and resulted primarily from the addition of covered lives by current ValueFee customers and, in 1994, the expansion of the Ford contract. Approximately $136.8 million and $144.2 million, respectively, were associated with the addition of new customer accounts, primarily in the Company's ValueFee business.

Mental health and substance abuse 1994 revenues of $198.6 million increased by $37.0 million or 22.9% over 1993, and 1993 revenues of $161.6 million were $47.4 million or 41.5% higher than in 1992. Of these increases, $31.3 million and $43.7 million, respectively, resulted from new business. Revenue from existing customers in 1994 declined by $4.9 million over 1993 primarily due to changes in product selection by customers, from risk-based to administrative services only contracts. Revenue from existing customers in 1993 increased by $3.2 million over 1992.

Insurance services 1994 revenues of $67.3 million increased by $31.4 million or 87.4% over 1993 and 1993 revenues of $35.9 million increased by $34.5 million over 1992. Of the 1994 increase, $6.1 million was due to the addition of new customers and $29.3 million was due to the acquisition of Community Care Network, Inc. ("CCN") in June, 1994. Revenues from existing customers declined by $4.0 million in 1994 over 1993 primarily due to customer losses and enrollment reductions. Of the 1993 increase, $32.3 million resulted from the acquisitions of Adjustco, Inc. and Diversified Medical Resources, Inc. in December, 1992.

Information services 1994 revenues of $40.7 million increased by $3.8 million or 10.4% over 1993 and 1993 revenues of $36.9 million increased by $24.2 million or 190.1% over 1992. New customers produced $2.9 million and $7.1 million, respectively, of 1994 and 1993 revenue growth. Of the remaining 1994 increase, $.4 million was due to acquisitions and $.5 million was due to existing customers. The remainder of the 1993 increase was primarily due to the acquisition of Lewin-VHI, Inc. in December, 1992.

Other revenues in 1994 of $9.7 million increased by $2.3 million or 31.0% over 1993 in which revenues were $7.4 million or 21.0% higher than 1992. The increases in both years were due to additional covered lives in podiatric benefit programs. In addition, the 1994 increase is due to the sale by the Company of an option on its 5.4% interest in Health Spring, Inc. ("HSI") (see note 2).

Investment income in 1994 of $5.7 million was $2.1 million or 26.8% lower than 1993 revenue which was $2.1 million or 36.3% higher than 1992 revenue. The decrease in 1994 was due to lower investment balances resulting from acquisitions completed and the shift to tax-advantaged investments during the third quarter of 1993, which carry lower interest rates. The increase in 1993 was due to higher investment balances resulting from the Company's 1992 stock offerings and from operating cash flow.

The Company's costs of services consist of direct expenses of providing specialty managed care and information services, including costs of prescription drugs, mental health and substance abuse provider charges, foot care provider charges, salaries and wages of medical management and health policy consultants, customer service and claims processing personnel, and certain data processing costs. Costs of services for 1994 increased $222.9 million or 41.2% over 1993, and 1993 costs were $256.2 million or 90.0% greater than in 1992. Most of these increases were due to an increased number of plan participants and provider and drug price increases. As a percentage of revenues, costs of services decreased to 78.2% for 1994, from 78.4% in 1993 and 77.8% in 1992. In both 1994 and 1993 the mix of business shifted from mental health to prescription drugs, causing the cost of services percentage to increase. The 1994 decrease in this percentage was caused by the acquisition of CCN, which carries a lower cost of services ratio. During 1993 and 1994, the Company experienced significant price competition in the prescription drug business. In response, the Company undertook more aggressive pricing policies and also entered into a multi-year arrangement with Pfizer in 1994 to help offset price competition (see note 2). The Company expects to continue pursuing additional such arrangements in 1995.

Selling, general and administrative expenses for 1994 increased $25.9 million or 33.1% over 1993, and 1993 expenses were $33.1 million or 73.7% greater than in 1992. These increases were attributable to staffing and related costs associated with new contracts, added investment in claims processing capability, and continued growth in overhead costs to support growth within the Company's product lines. As a percentage of revenues, selling, general and administrative expenses decreased to 10.6% for 1994, compared to 11.3% in 1993 and 12.3% in 1992. These decreases were primarily due to greater operating efficiencies from a larger revenue base. During the second half of 1994, selling, general and administrative expenses were 11.3% of revenues. This increase was due to the effect of CCN which carries a higher ratio. On an annual basis, the Company expects these expenses as a percentage of revenues may slightly increase in 1995 due to a full year with CCN results.

Depreciation and amortization expense, which consists of the depreciation of property and equipment and the amortization of intangible assets arising from acquisitions and purchased and internally developed software, was $19.7 million for 1994 as compared to $13.9 million in 1993 and $8.1 million in 1992. The higher level of depreciation and amortization in each year was attributable to increased investment in fixed assets to support growth in the Company's business, goodwill amortization resulting from acquisitions and increased amortization of capitalized computer software. The Company expects future depreciation and amortization will increase over 1994 levels as a result of $36.9 million in capital additions in 1994 and $30.8 million in goodwill recorded in 1994.

In 1994, the Company incurred merger-related expense of $6.0 million in connection with its mergers with PrescDrug and RxNet. In 1993, the Company incurred $38.4 million in merger-related expense associated with its merger with Preferred Health Care Ltd. (see notes 2 and 3).

Earnings from continuing operations (excluding merger-related expense) before income taxes in 1994 of $88.6 million increased by $32.5 million or 57.9% over 1993 and by $28.7 million or 104.9% over 1992. Earnings improved in each year as a result of revenue growth from new and existing accounts, acquisitions, and in 1994 from the Company's arrangement with Pfizer (see note 2).

In each year, the provision for income taxes includes, among other things, the utilization of net operating loss carryforwards, the tax benefit associated with certain stock option transactions and an estimate for state income taxes. In 1994 and 1992 the provision for income taxes was also partially the result of goodwill reductions arising from the utilization of certain acquired net operating loss carryforwards. The tax rate was 40%, 60% and 29% for the years ended December 31, 1994, 1993 and 1992, respectively. The increase in the effective rate from 1992 to 1993 is due to a reduction in the benefit of the valuation allowance for deferred taxes and the result of certain nondeductible merger-related expenses recognized in 1993. The decrease in the effective rate from 1993 to 1994 is primarily the result of the higher level of nondeductible merger-related expenses recognized in 1993. At December 31, 1994, the Company recorded a deferred tax asset of $8.6 million to reflect the future tax benefits of loss carryforwards and temporary differences (see note 9). In 1994, the valuation allowance was increased by $0.7 million to $5.0 million primarily due to additional net operating losses from business combinations that were added to the deferred tax asset account.

Years Ended December 31, 1994, 1993 and 1992 – Discontinued Operations

During 1993, the Company recorded a loss from discontinued operations of $511,000. This related to an increase in the provision for state taxes on the gain from discontinued operations which occurred in 1991. During 1992, the Company recorded interest of $256,000, net of taxes, as provided for in the terms of loans receivable related to the discontinued operations of Hospital Advisory Services (see note 13).

Liquidity and Capital Resources

The Company has funded its operations and capital expenditures primarily from the proceeds of stock issuances and internally generated cash. During 1992, the Company completed two public offerings for an aggregate 5,889,480 additional shares of common stock. The net proceeds of these offerings were approximately $160.8 million.

As of December 31, 1994, the Company had working capital of $162.3 million and unrestricted cash and marketable securities of $136.1 million.

For 1994, net cash provided by operating activities was $22.8 million. During 1994, the Company incurred cash expenditures in connection with acquisitions and investments of $40.3 million and capital expenditures for property and equipment were approximately $36.9 million.

The Company's joint venture arrangement with Pfizer (see note 2) may require capital contributions of up to $50 million through 1995. In addition, the Company may in the future acquire certain businesses or products complementary to its strategy. In connection with such acquisitions, the Company may use its existing liquid resources. The Company believes that existing available cash and marketable securities, together with cash from operations, will be sufficient to meet its liquidity and funding requirements for normal operations, at least through 1995.

The Company did not pay dividends in 1994 and does not expect to pay dividends in 1995.

Inflation

Health care costs are rising and are expected to continue to rise at rates higher than the Consumer Price Index. The Company believes that its provider discount and risk sharing arrangements, together with its cost control measures such as utilization review and its pricing practices, help to protect against any adverse effect of inflation on its operations.

Recently Enacted Pronouncements

All recently enacted pronouncements either have been adopted by, or do not apply to, the Company.

Summary of Financial Data

(In thousands, except per share data)	Year Ended December 31, 1994	1993	1992	1991	1990
Total Revenues	**$976,403**	$689,455	$365,643	$195,592	$123,680
Earnings:					
Earnings From Continuing Operations Before Cumulative Effect of Change in Accounting Principle	**$ 49,621**	$ 6,998	$ 19,360	$ 10,292	$ 2,498
Earnings Per Share From Continuing Operations Before Cumulative Effect of Change in Accounting Principle	**$ 1.19**	$ 0.17	$ 0.53	$ 0.34	$ 0.10
Total Assets	**$537,115**	$482,423	$365,752	$144,767	$ 64,186
Long Term Liabilities	**$ 6,046**	$ 7,596	$ 6,118	$ 2,960	$ 4,520
Series B Preferred Stock	**—**	—	—	—	$ 5,000
Weighted Average Number Of Common Shares Outstanding	**41,585**	40,284	36,047	29,937	25,345
Cash Dividends Declared Per Common Share	**None**	None	None	None	None

Financial data for 1990 and 1991 have not been restated for the 1994 pooling transactions (see notes 2 and 3) as complete financial information for the acquired companies was not available.

Consolidated Statements of Operations

(In thousands, except per share amounts)	For the years ended December 31, 1994	1993	1992
Revenues			
Prescription drugs	**$654,405**	$439,842	$225,461
Mental health	**198,599**	161,643	114,223
Insurance services	**67,268**	35,895	1,409
Information services	**40,721**	36,878	12,711
Other	**9,710**	7,413	6,128
Investment income	**5,700**	7,784	5,711
Total revenues	**976,403**	689,455	365,643
Expenses			
Costs of services	**763,631**	540,728	284,560
Selling, general and administrative	**104,034**	78,140	44,991
Depreciation and amortization	**15,943**	11,274	6,872
Amortization of goodwill	**3,708**	2,625	1,252
Interest expense	**528**	603	595
Merger-related expense	**5,986**	38,409	—
Total expenses	**893,830**	671,779	338,270
Earnings from continuing operations before income taxes	**82,573**	17,676	27,373
Provision for income taxes	**32,952**	10,678	8,013
Earnings from continuing operations	**49,621**	6,998	19,360
Discontinued operations, net of taxes	**—**	(511)	256
Net earnings	**$ 49,621**	$ 6,487	$ 19,616
Earnings per share:			
Earnings from continuing operations	**$ 1.19**	$ 0.17	$ 0.53
Discontinued operations	**—**	(0.01)	0.01
Net earnings per share	**$ 1.19**	$ 0.16	$ 0.54

The accompanying notes are an integral part of the consolidated financial statements.

Consolidated Balance Sheets

(In thousands)	December 31, 1994	1993
Assets		
Current assets:		
Cash and cash equivalents	**$ 81,586**	$ 61,693
Restricted cash	**992**	1,348
Short-term investments	**30,688**	55,048
Accounts receivable (net of allowance for doubtful accounts of $7,877 and $2,298 in 1994 and 1993, respectively)	**162,802**	103,103
Deposits in escrow	**378**	5,305
Prepaid expenses and other current assets	**18,401**	17,335
Deferred taxes	**6,860**	10,642
Total current assets	**301,707**	254,474
Fixed assets:		
Land	**1,086**	955
Buildings and improvements	**9,228**	3,164
Furniture and fixtures	**15,338**	12,013
Equipment and software	**85,328**	64,546
Leasehold improvements	**7,328**	5,559
Construction in progress	**—**	2,715
	118,308	88,952
Less accumulated depreciation and amortization	**35,801**	25,063
	82,507	63,889
Long-term investments	**23,842**	63,902
Goodwill, net	**106,268**	79,897
Other assets	**22,791**	20,261
	152,901	164,060
Total assets	**$537,115**	$482,423

The accompanying notes are an integral part of the consolidated financial statements.

Consolidated Balance Sheets

(In thousands, except par value)	December 31, 1994	1993
Liabilities and Stockholders' Equity		
Current liabilities:		
Payable to providers	**$ 76,863**	$ 66,943
Accounts payable and accrued expenses	**38,283**	37,734
Merger-related expense	**8,303**	28,416
Income taxes payable	**3,729**	9,969
Accrued compensation	**7,520**	6,961
Current portion of capital lease obligations	**2,147**	2,416
Deferred revenue	**2,606**	4,871
Total current liabilities	**139,451**	157,310
Capital lease obligations, less current portion	**3,442**	5,083
Other liabilities	**2,604**	2,513
	6,046	7,596
Total liabilities	**145,497**	164,906
Commitments and contingencies		
Stockholders' equity:		
Preferred stock-$.01 par value, authorized 1,000 shares, none issued	—	—
Common stock-without par value, authorized 100,000 shares, issued and outstanding 40,459 and 39,332 shares for 1994 and 1993, respectively	**302,390**	277,618
Retained earnings	**89,520**	39,899
Unrealized loss on securities available-for-sale, net of tax	**(292)**	—
Total stockholders' equity	**391,618**	317,517
Total liabilities and stockholders' equity	**$537,115**	$482,423

The accompanying notes are an integral part of the consolidated financial statements.

Consolidated Statements of Changes in Stockholders' Equity

(In thousands)

For the years ended December 31,	Common Stock Shares	Common Stock Amount	Retained Earnings	Total
Balance at December 31, 1991	31,455	$ 93,953	$13,796	$107,749
Issuance of common stock	5,889	160,763	—	160,763
Exercise of common stock options and warrants	1,231	5,339	—	5,339
Tax benefits related to common stock option exercises and restricted stock activity	—	6,948	—	6,948
Amortization of deferred compensation	—	325	—	325
Issuance of restricted stock	12	—	—	—
Sale of stock to officers	16	236	—	236
Loans related to officers' stock	—	(236)	—	(236)
Net earnings	—	—	19,616	19,616
Note receivable from officer	—	—	—	(7,950)
Balance at December 31, 1992	38,603	267,328	33,412	292,790
Exercise of common stock options	714	6,135	—	6,135
Tax benefits related to common stock option exercises and restricted stock activity	—	3,551	—	3,551
Amortization of deferred compensation	—	604	—	604
Issuance of restricted stock	15	—	—	—
Net earnings	—	—	6,487	6,487
Repayment of note receivable from officer	—	—	—	7,950
Balance at December 31, 1993	39,332	277,618	39,899	317,517
Exercise of common stock options	1,127	14,121	—	14,121
Tax benefits related to common stock option exercises and restricted stock activity	—	10,490	—	10,490
Amortization of deferred compensation	—	161	—	161
Unrealized loss on securities available-for-sale, net of tax	—	—	—	(292)
Net earnings	—	—	49,621	49,621
Balance at December 31, 1994	40,459	$302,390	$89,520	$391,618

The accompanying notes are an integral part of the consolidated financial statements.

Consolidated Statements of Cash Flows

(In thousands)	For the years ended December 31, 1994	1993	1992
Cash flows from operating activities			
Net earnings	**$ 49,621**	$ 6,487	$ 19,616
Adjustments to reconcile net earnings to net cash provided by (used in) operating activities:			
Depreciation and amortization	**15,943**	11,274	6,872
Deferred compensation expense	**161**	604	325
Provision for doubtful accounts	**6,341**	1,267	1,058
Deferred taxes	**5,153**	(6,026)	(1,787)
Tax effect on goodwill of acquired loss carryforward utilization	**416**	—	641
Tax effect of certain stock option and restricted stock transactions	**10,490**	3,551	6,948
Amortization of goodwill	**3,708**	2,625	1,252
Amortization of deferred revenue	**(4,871)**	(3,723)	(2,716)
Amortization of investment premiums	**826**	2,255	662
Other non-cash items	**—**	261	219
Change in assets and liabilities:			
(Increase) decrease in assets:			
Restricted cash	**356**	(21)	384
Accounts receivable	**(57,766)**	(40,500)	(13,018)
Other current and non-current assets	**(3,817)**	(14,431)	(4,609)
Deposits in escrow	**4,927**	(3,467)	(46)
Increase (decrease) in liabilities:			
Accounts payable and accrued expenses	**(3,147)**	10,756	7,804
Merger-related expense	**(10,374)**	28,416	—
Payable to providers	**9,920**	31,344	14,598
Income taxes payable	**(6,240)**	8,718	(5,666)
Deferred revenue	**2,606**	4,613	3,390
Other liabilities	**(1,459)**	(79)	41
Total adjustments	**(26,827)**	37,437	16,352
Net cash provided by operating activities	**22,794**	43,924	35,968
Cash flows from investing activities			
Capital expenditures	**(36,948)**	(35,765)	(15,296)
Acquisitions and investments, net of cash acquired	**(40,334)**	(25,954)	(39,077)
Advances under loan agreement	**(1,039)**	(5,778)	(1,647)
Repayments of advances under loan agreement	**—**	4,182	—
Purchases of investment securities	**(86,857)**	(152,736)	(218,218)
Proceeds from maturities and sales of investment securities	**151,044**	176,846	95,426
Net cash used in investing activities	**(14,134)**	(39,205)	(178,812)
Cash flows from financing activities			
Net proceeds from issuance of common stock	**—**	—	160,763
Proceeds from exercise of common stock options and warrants and issuance of restricted stock	**14,121**	6,135	5,339
Payments of long-term debt and capital lease obligations	**(2,888)**	(1,917)	(1,266)
Loan to officer	**—**	—	(7,950)
Repayment of loan to officer	**—**	7,950	—
Net cash provided by financing activities	**11,233**	12,168	156,886
Net increase in cash and cash equivalents	**19,893**	16,887	14,042
Cash and cash equivalents at beginning of year	**61,693**	44,806	30,764
Cash and cash equivalents at end of year	**$ 81,586**	$ 61,693	$ 44,806

The accompanying notes are an integral part of the consolidated financial statements.

Notes To Consolidated Financial Statements

1 Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and all its subsidiaries. All significant inter-company balances and transactions have been eliminated.

Cash and Cash Equivalents

For purposes of reporting cash flows, investments with original maturities of three months or less are considered to be cash equivalents.

Restricted Cash

Restricted cash consists of amounts on deposit in compliance with state regulatory requirements and building and equipment lease agreements.

Deposits in Escrow

Pursuant to contracts with certain program sponsors, deposits in escrow are established in which the funds can be used, under certain conditions, to pay claims as specified in the agreements.

Inventories

Inventories consist of prescription drugs and are stated at the lower of cost or market. Cost is determined using the first-in, first-out method. Inventories of $9,011,000 and $6,859,000 are included in prepaid expenses and other current assets at December 31, 1994 and 1993, respectively.

Investments

Effective January 1, 1994, the Company adopted Statement of Financial Accounting Standards No. 115 ("SFAS 115"). Under SFAS 115, the Company has classified its investments in debt securities as "available-for-sale" securities and carries such securities at market value. Accordingly, the net unrealized gain or loss, net of tax, is included as a separate component of stockholders' equity. Prior to 1994, all investments were classified as held-to-maturity. Under this classification, short-term investments were carried at the lower of cost or market and long-term investments at amortized cost. At December 31, 1993, long-term investments were those investment securities which the Company had the intent and the ability to hold to maturity. Premiums are amortized on a straight-line basis until maturity. In determining the gain or loss on sales of investments, cost is based on specific identification of the asset sold.

Fixed Assets

Fixed assets are recorded at cost. The Company uses straight-line and accelerated methods of depreciation over the estimated useful lives of the assets, which range from three to twenty-five years. Assets acquired under capital lease agreements are recorded at the lesser of the present value of the minimum lease payments or the fair value of the property. These assets are amortized on a straight-line basis over periods consistent with the Company's depreciation policy for similar purchased assets or over the lease term, whichever is less.

Expenditures for maintenance and repairs are charged to income as incurred and renewals and improvements are capitalized. Upon sale or retirement of fixed assets, the cost and related accumulated depreciation are removed from the accounts and any resulting gain or loss is credited or charged to income.

Included in equipment at December 31, 1994 and 1993 are capitalized computer software costs, related to purchased software and software developed internally for sale as part of its product lines, of $23,791,000 and $21,301,000, respectively. The Company capitalizes costs of software to be sold once technological feasibility has been established. Accumulated amortization on computer software was $6,221,000 and $5,021,000 at December 31, 1994 and 1993, respectively, and is included in accumulated depreciation and amortization. The Company uses the straight-line amortization method over estimated useful lives which range from three to five years.

Goodwill

Goodwill related to acquisitions represents the excess of cost over fair value of net tangible and separately identifiable intangible assets acquired, and is amortized on a straight-line basis over 15 to 40 years. Accumulated amortization was $9,712,000 and $5,733,000 at December 31, 1994 and 1993, respectively. The Company reviews its amortization policy and carrying value of goodwill on an ongoing basis. This review includes an analysis of whether carrying values and amortization periods are appropriate based upon product life cycle, Company performance compared to expectations and industry practice.

Payables to Providers

Payables to providers are recorded as services are rendered. The costs of claims for services rendered but not yet reported are estimated based on historical data, current enrollment statistics, patient census data and other information. Such estimates and the resulting accrued liabilities are periodically reviewed and updated. Any adjustments resulting therefrom are reflected in earnings currently.

Deferred Rent

The Company has received rent abatements for limited periods in connection with leases for certain office space. Costs associated with these leases, recorded on a straight-line basis over the full lease term, resulted in a deferred rent liability of $1,324,000 and $799,000 at December 31, 1994 and 1993, respectively.

Revenue Recognition

Revenue is recognized at the time related services are performed. Revenue from sales of prescription drugs is recognized at the time of shipment. Deferred revenue represents amounts advanced to the Company on contracts for which performance is expected to be completed in future periods.

Revenues recognized from billings to a major customer represented 9.3%, 8.0% and 13.2% of consolidated total revenues for the years ended December 31, 1994, 1993 and 1992, respectively.

Licensure Costs

Costs directly incurred to obtain licenses to do business in new market areas are capitalized and amortized on a straight-line basis over three years.

Income Taxes

The Company files a consolidated federal income tax return which includes all of its subsidiaries. The Company's income tax liability has been determined under the provisions of Statement of Financial Accounting Standards No. 109, *Accounting for Income Taxes* ("SFAS 109"), requiring an asset and liability approach for financial accounting and reporting for income taxes. The liability is based on the current and deferred tax consequences of all events recognized in the consolidated financial statements as of the date of the consolidated balance sheet. Deferred taxes are provided for temporary differences which will result in taxable or deductible amounts in future years, primarily attributable to a different basis in certain assets for financial and tax reporting purposes, including recognition of deferred tax assets net of a related valuation allowance.

Common Stock Split

On August 6, 1992, the Board of Directors authorized a stock split of 3-for-2 effected as a stock dividend on outstanding shares of common stock. All shares and per share amounts have been retroactively restated in the consolidated financial statements to give effect to the split.

Net Earnings Per Share

Net earnings per share are based on the weighted average number of common shares and common share equivalents (if dilutive) resulting from options outstanding during the periods, after giving retroactive effect to the common stock split. The weighted average number of common shares and common share equivalents outstanding is approximately 41,585,000, 40,284,000 and 36,047,000 for the years ended December 31, 1994, 1993 and 1992, respectively. There is not a significant difference between primary and fully diluted earnings per share.

Reclassifications

Certain amounts from the 1992 consolidated financial statements are reclassified to conform with the 1993 and 1994 presentation.

2 Mergers and Acquisitions, Joint Venture, Investments and Advances

On August 29, 1994, the Company completed its merger with PrescDrug. The Company issued 937,178 shares of its common stock in exchange for all of the outstanding common stock of PrescDrug at an exchange ratio of 1:1.

On August 31, 1994, the Company acquired by merger all of the outstanding common stock of RxNet by issuing 256,136 shares of its common stock for all of the outstanding common stock of RxNet at an exchange ratio of 1:1.

Both of these transactions have been accounted for as poolings of interests and financial statements for all periods prior to these combinations have been restated to reflect the combined operations.

Included in the consolidated results of operations for the year ended December 31, 1994 are the following unaudited results of the previously separate companies for the period January 1, 1994 to June 30, 1994:

(In thousands)	Company	PrescDrug	RxNet	Consolidated
Total revenues	$414,857	$25,163	$14,601	$454,621
Net earnings	$ 23,749	$ (87)	$ (678)	$ 22,984

The following are reconciliations of revenues and net earnings previously reported by the Company for the years ended December 31, 1993 and 1992, with the combined amounts currently presented in the financial statements for those years:

(In thousands)	Year ended December 31, 1993			
	Company	PrescDrug	RxNet	Consolidated
Total revenues	$614,151	$48,186	$27,118	$689,455
Net earnings	$ 8,103	$ 377	$(1,993)	$ 6,487

(In thousands)	Year ended December 31, 1992			
	Company	PrescDrug	RxNet	Consolidated
Total revenues	$317,840	$46,918	$885	$365,643
Net earnings	$ 20,546	$ (958)	$ 28	$ 19,616

Notes To Consolidated Financial Statements

On December 14, 1993, the Company completed its merger with Preferred Health Care Ltd. ("Preferred"). The Company's American Psych-Management, Inc. ("APM") subsidiary and Preferred's mental health and substance abuse division have each become wholly-owned subsidiaries of the Company's Value Behavioral Health, Inc. subsidiary, headquartered in Falls Church, Virginia. Workers' compensation and related services are provided by Preferred Works, Inc. (formerly named Adjustco, Inc., a subsidiary of Preferred), headquartered in Wilton, Connecticut. The transaction was accounted for as a pooling-of-interests in which each share of Preferred common stock was exchanged for .88 shares of the Company's common stock. The Company issued 10,958,841 shares of its common stock to effect the merger. Financial statements for all periods prior to the combination have been restated to reflect the combined operations.

All other acquisitions by the Company, since its inception, were accounted for as purchases. The purchase prices assigned to the net assets acquired were based on the fair value of such assets and liabilities at the respective acquisition dates.

On November 19, 1991, the Company completed its acquisition of Cost Containment Corporation of America ("CCC"), a prescription drug management company. At closing, the minimum purchase price (as defined in the agreement and plan of merger) of $5.4 million was paid by the issuance of 406,962 shares of common stock of which 101,741 shares are being held in escrow subject to the satisfaction of certain conditions. Up to 1,452,054 additional shares could be earned over a four-year period. The excess cost over net liabilities acquired of $14.3 million was recorded as goodwill and is being amortized over 25 years. Any additional shares issued will result in an increase in goodwill.

On October 30, 1992, the Company completed its acquisition of Stokeld Health Services Corporation ("Stokeld"), a Davenport, Iowa based mail order pharmacy provider, which has been renamed ValueRx of Iowa, Inc. In the transaction, the Company acquired all of the outstanding common stock of Stokeld for $9.9 million and advanced $6.3 million to Stokeld to retire certain of its liabilities. Goodwill of $14.1 million was recorded and is being amortized over 40 years.

On December 1, 1992, Value Health completed its acquisition of Lewin-ICF, Inc. ("Lewin"), a national health policy and management consulting firm based in the Washington, DC area, from ICF International, Inc. Lewin provides health policy consulting, contract research and management consulting services. In connection with the acquisition, the Company acquired all of the outstanding common stock of Lewin for $11.0 million in cash. In addition, the Company paid certain senior managers of Lewin $1.0 million in cash at closing, and will pay up to $3.0 million depending upon the financial performance of Lewin during 1993, 1994, and 1995, in exchange for their rights in certain intellectual property. The Company also paid approximately $0.6 million to certain managers in connection with the termination of certain benefits. Goodwill of $8.8 million was recorded and is being amortized over 15 years. Lewin has been renamed Lewin-VHI, Inc.

On December 31, 1992, the Company purchased all of the outstanding stock of Adjustco, Inc., a Delaware corporation which has been renamed Preferred Works, Inc. ("PWI"). PWI provides claims administration, adjusting, processing, and related services to insurance companies and self-insured businesses throughout the United States. The purchase price was $7.0 million in cash. Goodwill of $7.9 million was recorded and is being amortized over 35 years.

On December 31, 1992, the Company also acquired all of the outstanding stock of Diversified Medical Resources Corporation, which has been renamed Value Medical Resources Corporation ("VMRC"). VMRC provides independent medical examinations and other services to insurance companies and law firms for workers' compensation, personal injury and product liability injury claims. VMRC is headquartered in Minneapolis, Minnesota. The purchase price was $2.9 million in cash and contingent consideration of $2.0 million payable in 1994 and $1.0 million payable in 1995, based upon achieving certain revenue and profit goals. No 1994 payment was made as the revenue and profit goals were not met. Such contingent consideration will be recorded as additional goodwill if paid. Goodwill of $2.7 million was recorded and is being amortized over 35 years.

On January 13, 1993, the Company completed its acquisition of Wellington Life Insurance Company, an insurer based in Arizona with insurance and reinsurance licenses in 32 states, for $6.3 million in cash. The purchase price was equal to the fair value of the net assets acquired.

On July 20, 1993, the Company acquired all of the outstanding shares of Square Lake Corporation ("SLC") for $3.6 million in cash and contingent consideration of up to $8.4 million if certain revenue goals are met. Goodwill of $4.5 million was recorded and is being amortized over 35 years. SLC, based in Michigan, specializes in managed care programs for HMOs and PPOs in the areas of mental health and substance abuse treatment.

On July 29, 1993, the Company's Value Health Sciences, Inc. ("VHS") subsidiary purchased the assets and assumed certain liabilities of the Raleigh Group of Cleveland, Ohio for

$1.6 million in cash and contingent consideration of up to $1.0 million during 1994 and 1995 based upon achieving certain revenue levels. In September, 1994, $0.5 million of contingent consideration was paid. Additional contingent consideration will be recorded as goodwill if paid. Goodwill of $1.8 million has been recorded and is being amortized over 15 years. The Raleigh Group offers data analysis and consulting services to health care insurers and providers.

On August 1, 1993, APM completed its acquisition of the Center for Human Resources, Inc. ("CHR") for $1.1 million in cash. Of this amount, $0.2 million was placed in escrow and was paid in September, 1994 upon the achievement of certain seller warranties and representations. In addition, APM may pay contingent consideration of up to $0.8 million, depending upon the achievement of certain revenue levels between June, 1993 and February, 1995. Goodwill of $1.1 million was recorded and is being amortized over 25 years. CHR is an employee assistance company based in Fairfax, Virginia.

On October 1, 1993, the Company's ValueRx Pharmacy Program, Inc. ("VRx") subsidiary purchased the assets of the Associated Prescription Services division of United HealthCare, Inc. ("APS") for $7.7 million in cash. Of this amount, $1.1 million was held in escrow and was released in March, 1994 upon the fulfillment of contractual warranties, representations and consents. VRx may pay additional contingent consideration of up to $0.4 million on or before June 30, 1995 if certain revenue objectives are met. This contingent consideration will be recorded as additional goodwill if paid. Goodwill of $7.5 million was recorded and is being amortized over 25 years. APS provides prescription drug management services and is based in Baltimore, Maryland.

VRx completed its acquisition of the remaining 92% of Complete Pharmacy Network ("CPN") on November 3, 1993, for $7.5 million in cash. Prior to that date, the Company held an 8% interest in CPN which was included in other assets and carried at cost. Upon completion of the acquisition, goodwill of $9.9 million was recorded and is being amortized over 25 years. CPN is a retail pharmacy preferred provider organization based in Medina, Ohio.

On June 21, 1994, the Company completed its acquisition of CCN. The purchase price was $40.0 million in cash and contingent consideration of up to an additional $80.0 million. The contingent consideration is payable in cash and is based upon CCN's earnings during a twelve month calculation period, which period will end not later than December 31, 1996. Goodwill of $23.4 million was recorded and is being amortized over 35 years. Any contingent payments will be recorded as additional goodwill.

The following unaudited pro forma consolidated results of operations assume that the CCN acquisition occurred on January 1, 1993.

(Unaudited) In thousands, except per share amounts	Year Ended December 31, 1994	1993
Total revenues	$1,001,166	$738,931
Earnings before income taxes	$ 83,859	$ 24,715
Net earnings	$ 50,122	$ 10,678
Earnings per share	$ 1.21	$ 0.27

The pro forma results of operations do not purport to be indicative of the results which would actually have been obtained had the acquisition occurred on the dates indicated or which may be obtained in the future.

On May 1, 1994, the Company and Pfizer Inc ("Pfizer") entered into a joint venture partnership to develop specialty disease management programs. The partnership is owned equally by VHI Venturer, Inc., a wholly-owned subsidiary of the Company and Pfizer Health Sciences, Inc., a wholly-owned subsidiary of Pfizer. Each partner has committed to contribute up to $50 million of capital, subject to approval of specific business plans. Further, the Company entered into a multi-year contract with Pfizer to develop value-added programs designed to improve physician and patient use of Pfizer prescription and medical device products. In addition, several Pfizer drug products will receive assured positions on Value Health's prescription drug formularies in return for rebate arrangements.

On December 9, 1993, the Company purchased for $3.0 million a 5.4% interest in HSI, a developer and manager of physician group practices based in Reston, Virginia. The investment in HSI is included in other assets at December 31, 1994 and 1993. On December 28, 1994, the Company sold a non-refundable option on its 5.4% interest to Warburg Pincus Capital Company, L.P. ("Warburg") for $4.0 million. The option is exercisable through March 15, 1995.

On July 29, 1993, the Company, in connection with an investment by Warburg to finance the development of Value Health Management, Inc. ("VHM"), entered into a loan agreement with VHM ("the Agreement"). Under the Agreement, the Company may provide VHM up to $3.0 million in loans. In addition, the Company obtained options to purchase from VHM stockholders, all of the outstanding common and preferred stock of VHM. The exercise price for the common stock will be calculated based upon VHM's performance during specified time periods through April 1, 1996. The preferred stock option is exercisable on or prior

Notes To Consolidated Financial Statements

to January 1, 1996. As of December 31, 1994, loans to VHM, including relocation amounts, were $2,975,000 and are included in other assets. The loans, which mature on December 2, 1996, bear interest at one percent above the prime rate, and are carried at cost. In January, 1995, VHM repaid $975,000 of loans.

3 Merger-Related Expense

During the third quarter of 1994, the Company recorded a charge of $6.0 million in connection with its mergers with PrescDrug and RxNet. Of this amount, approximately $2.8 million was incurred for transaction costs and $3.2 million was related to costs associated with the combining of operations and the related restructuring activities, such as reduction of head count and elimination of duplicate facilities and excess capacity.

During the fourth quarter of 1993, the Company recorded a charge of $38.4 million in connection with its merger with Preferred. Of this amount, approximately $9.3 million was incurred for transaction costs and $29.1 million was related to costs associated with the combining of operations and the related restructuring activities, such as the reduction of head count and elimination of duplicate facilities and excess capacity.

The following table is a reconciliation of the merger-related expense for the years ended December 31, 1994 and 1993.

(In thousands)	Transaction Costs	Asset Writeoffs	Reduction of Head Count and Capacity	Total
Balance at December 31, 1992	$ —	$ —	$ —	$ —
Expenses recorded	9,268	9,689	19,452	38,409
Payments and writeoffs	(8,318)	—	(1,675)	(9,993)
Balance at December 31, 1993	950	9,689	17,777	28,416
Expenses recorded	2,800	1,193	1,993	5,986
Payments and writeoffs	(3,444)	(9,689)	(12,966)	(26,099)
Balance at December 31, 1994	$ 306	$1,193	$6,804	$8,303

4 Lease Obligations

Capital Leases

Future minimum lease payments under noncancelable capital leases having terms in excess of one year are as follows:

Years ended December 31:	
1995	$2,575,000
1996	1,791,000
1997	1,444,000
1998	633,000
1999	12,000
Total future minimum lease payments	6,455,000
Less amount representing interest	(866,000)
Present value of minimum lease payments	5,589,000
Less current portion	(2,147,000)
Capital lease obligations, less current portion	$3,442,000

Included in fixed assets are the following assets under capital leases:

	1994	1993
Furniture and fixtures	**$2,188,000**	$2,817,000
Equipment	**6,255,000**	6,766,000
	8,443,000	9,583,000
Less accumulated amortization	**4,034,000**	3,542,000
	$4,409,000	$6,041,000

Operating Leases

The Company has cancelable and noncancelable operating lease agreements for equipment and office space which include renewal options. Total rental expense was $16,153,000, $15,535,000 and $6,727,000, in 1994, 1993 and 1992, respectively. The Company's minimum future lease payments under noncancelable operating leases are as follows:

Years ended December 31:	
1995	$ 16,873,000
1996	14,771,000
1997	12,825,000
1998	8,924,000
1999	7,594,000
Thereafter	44,249,000
	$105,236,000

5 Capital Stock

The Company has one class of common stock outstanding. At December 31, 1994, there were 40,459,000 shares of common stock outstanding. In February, 1991, the Company amended its charter to authorize 1,000,000 shares of undesignated preferred stock, $.01 par value per share. No undesignated preferred shares are issued or outstanding.

In June, 1993, the Company amended its Certificate of Incorporation to increase the number of authorized shares of the Company's common stock without par value from 49,000,000 shares to 100,000,000 shares.

In connection with a Shareholder Rights Plan adopted in February, 1994, the Company granted to holders of record of the Company's common stock on March 7, 1994, a preferred stock purchase right for each share of common stock held. The rights entitle stockholders, in certain circumstances, to purchase 1/1000th of a share of the Company's Series A Junior Participating Preferred Stock at an exercise price of $120.

6 Stock Option Plans

In 1987, the Company adopted the 1987 Stock Plan (the "1987 Plan") which provided that incentive stock options could be granted to officers and key employees and certain non-qualified options could be granted to purchase up to an aggregate of 1,358,577 shares of common stock. Options are exercisable in installments as determined by the Board of Directors of the Company. Incentive stock options that are granted have terms not exceeding 10 years and exercise prices not less than the fair market value at the date of grant.

In February, 1991, the Company adopted the 1991 Stock Plan (the "1991 Plan"). The 1991 Plan provides that options to purchase up to 1,912,500 shares of Company common stock may be granted to officers and key employees. Under the 1991 Plan, the Company may grant incentive stock options, non-qualified stock options, restricted stock, stock appreciation rights and performance units. Options are exercisable in installments as determined by the Company. Incentive stock options must have a term not exceeding 10 years and an exercise price not less than the fair market value of the Company common stock on the date of grant.

On June 14, 1990, the Company amended and restated the Stock Incentive Plan (the "Preferred Plan"). The Preferred Plan provides that up to 1,751,000 shares of common stock may be subject to stock options or awards of restricted stock, and the number of shares subject to the Preferred Plan shall be increased annually by an amount equal to 3% of the shares outstanding at the end of the preceding year, unless the Board of Directors authorizes a lesser amount. During 1993, an additional 313,619 shares of common stock were authorized for issuance under the Preferred Plan. Options and awards are exercisable in installments as determined by the Company. In addition, the Company has granted options to certain consultants that are not included in the Preferred Plan.

On May 4, 1994, the Company amended and restated the 1991 Plan to provide that the shares issuable under the 1991 Plan be increased each year by a number of shares equal to two percent of the Company's common stock outstanding at the end of the immediately preceding year plus such number of shares as were available for grant in any preceding year and were not otherwise granted. During 1994, an additional 762,780 shares of common stock were authorized for issuance under the 1991 Plan.

On the date of the merger with Preferred, the Company replaced all options outstanding under the Preferred Plan with options to purchase shares of the Company's common stock based on the exchange ratio of .88 to 1.

Common stock option transactions under the 1987 Plan, the 1991 Plan, and the Preferred Plan, as adjusted for the stock split, follow:

	Common Shares Available For Grant	Options Outstanding	
		Common Shares	Average Option Price
Balance, December 31, 1991	2,864,866	2,002,950	$ .01-22.59
Change in shares reserved	300,502	—	—
Options:			
Granted	(1,821,100)	1,821,100	10.51-36.13
Exercised	—	(442,954)	.01-21.83
Forfeited	214,406	(214,406)	6.07-31.00
Balance, December 31, 1992	1,558,674	3,166,690	.01-36.13
Change in shares reserved	730,803	—	—
Options:			
Granted	(1,602,740)	1,602,740	15.63-39.00
Exercised	—	(673,951)	.01-32.00
Forfeited	170,159	(170,159)	5.94-36.13
Balance, December 31, 1993	856,896	3,925,320	.01-39.00
Change in shares reserved	857,760	—	—
Options:			
Granted	(1,028,900)	1,028,900	30.50-48.00
Exercised	—	(1,071,702)	.01-39.00
Forfeited	51,157	(51,157)	5.94-42.25
Balance, December 31, 1994	736,913	3,831,361	$ .01-48.00

Options exercisable to purchase shares of common stock under the above plans at December 31, 1994, 1993 and 1992 were 1,664,349, 1,388,693 and 1,390,745 respectively.

On May 8, 1987, an option was issued to an executive officer to purchase 13,235 shares of the Company's Series A Preferred. The Series A Preferred option was convertible into 451,644 shares of common stock, at an exercise price of $3.66 per common share, adjusted for common stock splits, and was exercisable in whole or in part at any time prior to May 8, 1994. On December 21, 1992, the executive officer exercised this option to purchase 451,644 shares of common stock. In addition, the executive officer exercised fully vested options granted under the 1991 Plan to purchase 37,950 shares of common stock at $21.83 per share. The Company loaned the executive officer $7,950,000 at 4% in connection with these transactions. The loan, which was repaid in April, 1993, is included as a reduction in stockholders' equity at December 31, 1992.

Notes To Consolidated Financial Statements

On June 29, 1990, the Company issued certain other non-qualified options to purchase 480,000 shares of its common stock at $.0073 per share. These options were issued outside the 1987 Plan under separate agreements. During 1994, 1993 and 1992, approximately 9,926, 2,500, and 16,000 of these options were exercised, respectively. Of these options, 8,303 were exercisable at December 31, 1994.

In February, 1991, the Company adopted the 1991 Non-Employee Director Stock Option Plan (the "Directors' Plan"). The Directors' Plan provides that options to purchase up to 112,500 shares of the Company's common stock may be granted to certain non-employee directors of the Company. The exercise price per share of options granted under the Directors' Plan will be equal to the fair market value of the Company's common stock at the date of grant. Options granted under the Directors' Plan expire five years from the date of grant. One-half of the shares covered by the options become exercisable upon the date of grant and the remaining one-half of such shares become exercisable on the first anniversary of the date of grant. On May 4, 1994, the Company amended and restated the Directors' Plan to provide for: (i) the increase in the number of shares of common stock subject to the Directors' Plan from 112,500 to 250,000; (ii) the automatic annual grant of vested options to acquire up to 2,500 shares of the Company's common stock to continuing eligible directors beginning upon the second anniversary of initial election to the Board; (iii) the automatic grant of vested options to acquire an additional 500 shares to such continuing directors who serve as Chairmen of the Company's Audit Committee or Compensation Committee; and (iv) the extension of the period of time such options are exercisable from five years to ten years. At December 31, 1994, options to purchase 67,500 shares of common stock at prices ranging from $8.00 to $33.25 per share had been granted. Approximately 67,240 of these options were exercisable at December 31, 1994.

In November, 1991, Preferred's Board of Directors approved the 1991 Directors' Stock Option Plan (the "1991 Directors' Plan"). Under the 1991 Directors' Plan, certain non-employee directors of the Company were each granted options to purchase 4,400 shares of the Company's stock. The options under the 1991 Directors' Plan were immediately vested and exercisable at the fair market value of the Company's common stock at the date of grant. During 1993 and 1992, the 1991 Directors' Plan granted options for 13,200 and 17,600 shares, respectively. No shares were granted in 1994.

On May 4, 1992, 142,406 options with original grant prices between $22.58 and $17.33 were repriced to $15.48, the market value at that date. On June 30, 1992, 286,488 options with grant prices between $15.48 and $14.85 were repriced to $11.36, the market value at that date.

7 Other Employee Benefits

In February, 1991, the Company established the 1991 Employee Stock Purchase Plan (the "Purchase Plan"), providing for the purchase, by employees of the Company, of up to 750,000 shares of common stock. The Purchase Plan commenced May 1, 1991. All employees of the Company on May 1, 1991, and all persons who become employees thereafter are eligible to participate in the Purchase Plan. Employees who own five percent or more of the Company's stock and directors who are not employees of the Company may not participate in the Purchase Plan. During 1994, 1993 and 1992, participating employees purchased 53,945, 33,830, and 34,344 shares, respectively, of common stock under the Purchase Plan at average prices of $30.54, $27.26 and $15.81 per share, respectively.

The Company adopted a 401(k) Retirement Savings Plan (the "Savings Plan") for all employees, which became effective on May 1, 1991. The Company made matching contributions to the Savings Plan, subject to certain limitations, equal to 100% of each participant's pre-tax contribution of an amount up to 2% of such participant's total compensation and 50% of the next 2% of such participant's compensation in 1993 and 1994. The Company match in 1992 was 50% of each participant's pre-tax contribution on an amount up to 4% of such participant's total compensation. All employees of the Company on May 1, 1991, and all persons who become employees thereafter and complete at least one year of employment with the Company, are eligible to participate in the Savings Plan. The Company's matching contribution expense was $929,000, $724,000 and $240,000 in 1994, 1993 and 1992, respectively.

The Company also maintains the Preferred Health Care Savings and Investment Plan, a qualified defined contribution plan with Section 401(k) features (the "Preferred Savings Plan"). The Preferred Savings Plan covers employees who are at least 21 years of age and have at least approximately three months of service. Participants may elect to have a portion of their pre-tax salary paid by the Company to the trustees under the Preferred Savings Plan. The Preferred Savings Plan also provides that the Company may make contributions, up to certain limits, of a percentage of the salary contributions made by the participants. During 1994, 1993 and 1992, the Company contributed $284,000, $370,000 and $304,000 respectively, to the Preferred Savings Plan.

The Company also maintains the Community Care Network, Inc. 401(k) Savings Plan, a qualified defined contribution plan (the "CCN Plan"). All employees of CCN on August 1, 1989 and all persons who become employees thereafter and complete at least six months of employment with CCN are eligible to participate in the CCN Plan. CCN made matching contributions to the CCN Plan, subject to certain limitations of 100% of each participant's pre-tax contribution of an amount up to 5% of compensation. Included in 1994 consolidated results of the Company are matching contributions of $356,000 under the CCN Plan.

8 Supplemental Disclosures of Cash Flow Information

	1994	1993	1992
Cash paid during the year for:			
Interest	**$ 449,000**	$ 640,000	$ 554,000
Income taxes	**$13,472,000**	$5,852,000	$10,793,000
Noncash transactions:			
Capital leases entered into for equipment	**$ 731,000**	$5,008,000	$ 3,428,000

Income Taxes

The provision for income taxes for the years ended December 31, 1994, 1993 and 1992 consisted of the following:

	1994	1993	1992
Currently payable:			
Federal	**$25,841,000**	$14,452,000	$9,049,000
State	**4,000,000**	2,111,000	1,121,000
Deferred taxes:			
Federal provision (benefit)	**2,026,000**	(7,343,000)	(1,061,000)
Valuation allowance	**669,000**	1,458,000	(1,737,000)
Goodwill reduction for acquired net operating loss carryforward utilization	**416,000**	—	641,000
	$32,952,000	$10,678,000	$8,013,000

Taxes payable for 1994, 1993 and 1992 were reduced by $10,490,000, $3,551,000 and $6,948,000, respectively, for the tax benefit of disqualified dispositions of common stock and the exercise of non-qualified common stock options.

The tax benefits of carryforwards and temporary differences related to the deferred tax asset at December 31, 1994 and 1993 are as follows:

	1994	1993
Carryforwards:		
Net operating loss carryforwards related to purchase business combinations	**$ 2,359,000**	$ 4,549,000
Temporary differences:		
Merger-related expense	**2,975,000**	7,986,000
Estimated claims liabilities	**3,083,000**	2,491,000
Depreciation and amortization	**(1,500,000)**	(2,151,000)
Reserves and other	**6,649,000**	2,717,000
	11,207,000	11,043,000
Gross deferred tax benefit	**13,566,000**	15,592,000
Valuation allowance	**(4,976,000)**	(4,307,000)
Net deferred tax benefit	**8,590,000**	11,285,000
Less current portion	**6,860,000**	10,642,000
Long term portion	**$ 1,730,000**	$ 643,000

The valuation allowance was increased in 1994 by $669,000 in connection with additional net operating losses from business combinations that were added to the deferred tax asset. The valuation allowance of $4,976,000 has been maintained primarily due to the uncertainty regarding the timing of net operating loss utilization related to certain business combinations. At December 31, 1994, the valuation allowance included approximately $900,000 for net operating loss carryforwards related to purchase business combinations. Should deferred tax assets subsequently be recognized for such carryforwards, the reduction of the valuation allowance will be offset by a corresponding reduction of goodwill.

In connection with the acquisition of PWI, the Company elected to treat the acquisition as an asset purchase rather than a stock purchase for income tax reporting purposes. As a result of that election, PWI was able to utilize approximately $5,160,000 of net operating losses to offset the resulting tax gain. In addition, the election had the effect of increasing the tax basis of goodwill, which is now deductible for tax purposes under the provisions of the Omnibus Budget Reconciliation Act of 1993. The Company has reduced its deferred tax accounts as they relate to the allocation of purchase price to account for the utilization of the net operating losses.

The Company's effective tax rate on earnings from continuing operations before income taxes and cumulative effect of change in accounting principle differs from the federal statutory regular tax rate as follows:

Notes To Consolidated Financial Statements

	1994	1993	1992
Federal tax expense at statutory rate	**35.0%**	35.0%	34.0%
State income tax expense, net	**3.2**	4.1	2.7
Tax exempt income	**(1.2)**	(3.2)	(0.9)
Deferred taxes:			
Federal provision (benefit)	**(1.1)**	—	(2.3)
Valuation allowance	—	—	(6.1)
Recognized net operating loss carryforwards	—	—	(0.5)
Recognition of acquired net operating loss carryforwards	**0.5**	—	2.2
Non deductible merger-related expense	**0.8**	16.6	—
Excess of federal alternative minimum tax (AMT) over regular tax	—	—	0.3
Utilization of alternative minimum tax credit carryforwards	—	(0.6)	—
Other	**2.7**	8.5	(0.1)
	39.9%	60.4%	29.3%

The Company had the following income tax carryforwards available at December 31, 1994:

	Tax Reporting	
	Amount	Years of Expiration
U.S. federal regular net operating loss carryforwards acquired in purchase business combinations available for offset against future taxable income	$6,740,000	2002-7
U.S. federal AMT net operating loss carryforwards acquired in purchase business combinations	$6,471,000	2002-7

10 Related Parties

On July 2, 1990, a subsidiary of the Company loaned an aggregate principal of $160,000 at 10% to an executive officer. Of that amount, $60,000 was repaid in 1993 and $100,000 was repaid in 1994. The amounts receivable from the executive officer at December 31, 1994 and 1993, including accrued interest, were $0 and $125,000, respectively. The amounts receivable are carried at cost which approximates fair value.

The Company entered into a five year employment contract with an executive officer as a result of the acquisition of certain subsidiaries. The employment contract terminated in 1993. An acquisition liability was established at the inception of the employment contract and was amortized through 1992. Acquisition liability amortization was $0, $0, and $80,000 in 1994, 1993 and 1992, respectively.

In January, 1991, a previously acquired company was sold back to an executive officer. The purchase price was $1, and the Company made a working capital contribution of $20,000. The executive officer guaranteed payment of a pre-existing note from the former subsidiary to the Company of $111,000 by the pledge of 71,467 shares of the Company's common stock. The note bears interest at 5.5% and is due November 30, 2006.

Pursuant to a 1988 agreement, the Company acquired for $230,000 a 27% equity interest in a house purchased by the President of one of its subsidiaries. The Company is entitled to a proportional share of the proceeds when the house is sold. The interest is carried at cost which approximates fair value, and is included in other assets.

On August 31, 1991, the Company sold all of the outstanding capital stock of an inactive subsidiary to an executive officer for $238,000. In connection with the sale, the Company loaned the executive officer $238,000 and made an additional $254,057 loan to the inactive subsidiary. Both loans bore interest at the rate of 9%. The $254,057 loan was repaid in February, 1994. The $238,000 is due June 30, 1995.

In February, 1994 the Company loaned $308,108 to a company owned by an executive officer. The loan is collateralized by the pledge of the executive officer's common stock in the Company and is due November 30, 2006. The loan bears interest at 5.5%.

On September 1, 1992, the Company loaned $250,000 to an executive officer. The note included interest at floating rates which were expected to approximate 8% on average and was due on August 31, 2001. The loan was collateralized by the executive officer's residence and was repaid in June, 1994. The amount receivable from the executive officer at December 31, 1993, including accrued interest, was $270,000.

On July 1, 1993, the Company purchased a 60% interest in a company owned by an executive officer for $400,000. The Company's interest was sold back to the executive officer on July 1, 1994.

Under Preferred's incentive compensation and officer loan plan, its Board of Directors was authorized to grant loans to officers to purchase its common stock directly from Preferred. The maximum term to maturity of each loan is forty-eight months. Loans to finance the purchase of stock are made pursuant to notes bearing interest at the applicable federal rate as defined in the Internal Revenue Code. Interest rates on loans outstanding during 1992 ranged from 6.69% to 7.04%. During 1994, 1993, and 1992, interest income of $8,941, $15,858 and $12,945, respectively, was recorded.

In connection with the merger with Preferred, the Company terminated the employment of a former executive officer of Preferred. Accordingly, under an existing employment agreement, the Company will pay the former executive officer severance in the amount of $304,500, to be increased through 1997, by approximately 5% per year.

In 1994, the Company loaned $150,000 to an executive officer. The note includes interest at 8% and is due upon the earlier of the sale of his residence or his departure from the Company. The loan is not collateralized. The amount receivable from the executive officer at December 31, 1994 is $150,000.

The Company also maintains employment agreements with certain of its executive officers providing for severance payments of up to two years' current base salary in the event any of the agreements are terminated, under certain specified conditions.

11 Fair Value of Financial Instruments

Statement of Financial Accounting Standards No. 107, *Disclosures about Fair Value of Financial Instruments* ("SFAS 107"), requires disclosure of fair value information about financial instruments, whether or not recognized in the balance sheet, for which it is practicable to estimate the value. Financial instruments include cash and short-term investments, notes receivable, long-term investments, other investments and accounts receivable, accounts payable and accrued expenses. The methods and assumptions used to estimate the fair value of each class of financial instruments are as follows:

Cash and Short-Term Investments

The carrying amount for cash and short-term investments is a reasonable estimate of those assets' fair value.

Notes Receivable

Notes receivable consist of loans to officers and other entities (see notes 2 and 10). There are no established trading markets for these loans which management intends to hold to maturity. Generally, fair value is determined by discounting future cash flows using current rates at which similar loans would be made to borrowers with similar credit ratings and for the same remaining maturities. However, due to the nature of certain notes receivable, it is impracticable to determine fair value.

Long-Term Investments

Fair value for these securities is based on quoted market prices. At December 31, 1994, long-term investments are carried at fair value. At December 31, 1993, carrying value approximated fair value.

Other Investments

Due to the nature of certain other investments, it is impracticable to determine fair value. With respect to real estate, fair value is determined based upon local market data.

Accounts Receivable, Accounts Payable and Accrued Expenses

The carrying value of accounts receivable, accounts payable and accrued expenses approximates their fair values due to their short maturities.

12 Commitments and Contingencies

The Company is involved in litigation arising in the normal course of business. The Company believes that resolution of these matters will not result in any payment that, in the aggregate, would be material to the financial position or results of operations of the Company.

In 1994, the Company established a $22.4 million letter of credit on behalf of one of its customers. The letter had not been drawn upon as of December 31, 1994.

13 Discontinued Operations

The Company had administrative and financial advisory agreements with Four Winds, Inc. and its affiliates. On September 30, 1991, the Company and Four Winds, Inc. and its affiliates, in exchange for $20 million, agreed to terminate agreements under which the Company had been providing them with administrative services and to settle a $2.9 million receivable. In accordance with the agreement, on October 31, 1991 a definitive agreement was signed and the Company received cash in the amount of $18.7 million and a note in the principal amount of $1.3 million due October 30, 1995. The note bears interest at 10% annually, payable quarterly, and its payment is collateralized by U.S. Treasury securities.

This transaction resulted in the discontinuation of the Company's former Hospital Advisory Services operation. Accordingly, its

Notes To Consolidated Financial Statements

operating results and the interest income related to the above note have been classified as discontinued operations for 1992 in the consolidated financial statements. Interest income in 1994 and 1993 is included in investment income.

Details of the income (loss) from discontinued operations for the years ended December 31, 1994, 1993 and 1992 are as follows:

	1994	1993	1992
Interest income	$ —	$ —	$413,000
Income before income taxes	—	—	413,000
Provision for income taxes	—	510,677	156,940
Income (loss) after income taxes	$ —	$(510,677)	$256,060

14 Investments

Investments in debt securities as of December 31, 1994 and 1993 are summarized as follows:

Available-for-Sale December 31, 1994	Amortized Cost	Unrealized Gain	Unrealized Loss	Aggregate Fair Value
Obligations of States and Municipalities	$48,393,000	$ —	($423,000)	$47,970,000
Obligations of U.S. Government and Agencies	6,623,000	—	(63,000)	6,560,000
	$55,016,000	$ —	($486,000)	$54,530,000

Maturities:	Less Than One Year	One To Five Years	Total
Amortized Cost	$30,748,000	$24,268,000	$55,016,000
Aggregate Fair Value	$30,688,000	$23,842,000	$54,530,000

Proceeds from the sale of available-for-sale securities were $71,883,000 for the year ended December 31, 1994. Realized losses from these sales were $59,000.

Held-to-Maturity December 31, 1993	Amortized Cost	Unrealized Gain	Unrealized Loss	Aggregate Fair Value
Commercial Paper	$ 3,065,000	$ —	$ —	$ 3,065,000
Obligations of States and Municipalities	81,529,000	320,000	—	81,849,000
Obligations of U.S. Government and Agencies	34,356,000	11,000	—	34,367,000
	$118,950,000	$331,000	$ —	$119,281,000

Maturities:	Less Than One Year	One To Five Years	Total
Amortized Cost	$55,048,000	$63,902,000	$118,950,000
Aggregate Fair Value	$55,053,000	$64,228,000	$119,281,000

15 Subsequent Events

In February, 1995, the Company entered into a definitive agreement for the sale of its National Footcare Program, Inc. subsidiary back to its original owner and founder, Dr. Claude Oster, for book value.

On February 15, 1995, the Company completed its acquisition of Health Management Strategies International, Inc. ("HMS") of Alexandria, Virginia for $14 million in cash. HMS provides managed behavioral health services.

16 Selected Quarterly Financial Data (Unaudited)

(In thousands, except per share amounts) Quarter	Revenues	Costs of services	Earnings (loss) from continuing operations before taxes	Net earnings (loss)	Earnings (loss) per share
1994					
First	$216,350	$172,572	$ 18,038	$ 10,777	$ 0.26
Second	238,271	189,735	20,431	12,207	0.29
Third	252,310	194,549	18,153	11,025	0.26
Fourth	269,472	206,775	25,951	15,612	0.38
Year	$976,403	$763,631	$ 82,573	$ 49,621	$ 1.19
1993					
First	$155,255	$122,578	$ 11,287	$ 6,694	$ 0.17
Second	166,350	130,387	13,224	7,798	0.20
Third	178,163	138,940	15,022	9,037	0.22
Fourth	189,687	148,823	(21,857)	(17,042)	(0.43)
Year	$689,455	$540,728	$ 17,676	$ 6,487	$ 0.16

Report of Independent Accountants

To the Stockholders and Board of Directors of Value Health, Inc.:

We have audited the accompanying consolidated balance sheets of Value Health, Inc. and its subsidiaries as of December 31, 1994 and 1993, and the related consolidated statements of operations, changes in stockholders' equity and cash flows for each of the three years in the period ended December 31, 1994. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of Preferred Health Care Ltd. for the years ended December 31, 1993 and 1992 or of Rx Net, Inc. for the year ended December 31, 1992, which statements reflect revenues of approximately 16% for the years ended December 31, 1993 and 1992, and total assets of approximately 17% as of December 31, 1993, of the related consolidated totals. Those statements were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to amounts included for these subsidiaries, which are wholly-owned subsidiaries of Value Health, Inc., is based solely on the report of such other auditors.

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

In our opinion, based on our audits and the reports of other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Value Health, Inc. and its subsidiaries as of December 31, 1994 and 1993, and the results of their operations and cash flows for each of the three years in the period ended December 31, 1994, in conformity with generally accepted accounting principles.

As stated in note 1, the Company adopted the provisions of Statement of Financial Accounting Standards No. 115, Accounting for Certain Investments in Debt and Equity Securities, as of January 1, 1994.

Coopers & Lybrand L.L.P.

Hartford, Connecticut
February 22, 1995

Corporate Information

Market Price Range of Common Stock

The following table sets forth the range of high and low sales prices of the Company's Common Stock on the New York Stock Exchange.

1994	High	Low
Fourth Quarter	$48.25	$31.75
Third Quarter	$52.00	$37.50
Second Quarter	$45.50	$37.25
First Quarter	$43.50	$30.13
1993		
Fourth Quarter	$37.88	$26.25
Third Quarter	$40.25	$29.00
Second Quarter	$35.00	$23.00
First Quarter	$41.00	$22.00

Board of Directors

Robert E. Patricelli
Chairman of the Board and Chief Executive Officer Value Health, Inc.

William J. McBride
President and Chief Operating Officer Value Health, Inc.

Steven J. Shulman
Executive Vice President Value Health, Inc.

David J. McDonnell, D.S.W.
Former Chairman of the Board and Chief Executive Officer Preferred Health Care Ltd.

Walter J. McNerney
Herman Smith Professor of Health Policy J.L. Kellogg Graduate School of Management, Health Services Management Program, Northwestern University

Rodman W. Moorhead III
Senior Managing Director E.M. Warburg, Pincus & Co., Inc.

Constance B. Newman
Under Secretary and Chief Operating Officer Smithsonian Institution

John L. Vogelstein
Vice Chairman of the Board and President, E.M. Warburg, Pincus & Co., Inc.

Principal Officers and Senior Management Committee

Robert E. Patricelli
Chairman of the Board and Chief Executive Officer Value Health, Inc.

William J. McBride
President and Chief Operating Officer Value Health, Inc.

Steven J. Shulman
Executive Vice President Value Health, Inc.

Paul M. Finigan
Vice President, General Counsel and Secretary Value Health, Inc.

David M. Wurzer
Vice President, Treasurer and Chief Financial Officer Value Health, Inc.

Jacqueline Kosecoff
President and Chief Operating Officer Value Health Sciences, Inc.; Vice President Value Health, Inc.

Leslie D. Michelson
Chairman and
Chief Executive Officer
Value Health Sciences, Inc.

Barry M. Smith
Chairman, President and
Chief Executive Officer
ValueRx Pharmacy
Program, Inc.

Charlton C. Tooke
President and
Chief Executive Officer
Value Behavioral Health, Inc.

David G. Noone
President and
Chief Executive Officer
Value Health Insurance
Services Group

James E. Buncher
Chairman, President and
Chief Executive Officer
Community Care Network

Lawrence S. Lewin
Chairman and
Chief Executive Officer
Lewin-VHI, Inc.

Investor Information

Stock Exchange

Value Health common stock is traded on the New York Stock Exchange under the symbol "VH." Options on Value Health common stock are traded on the Chicago Board of Options Exchange under the symbol "VH." At December 31, 1994, there were approximately 40,459,000 shares outstanding and approximately 20,000 shareholders.

Transfer Agent

Mellon Securities Transfer Services of East Hartford, Connecticut, serves as the transfer agent for Value Health common stock.

Notice of 10-K Annual Report

The Form 10-K Annual Report of Value Health, Inc. filed with the Securities and Exchange Commission is available without charge after March 31 of each year to stockholders and prospective investors. Requests should be made to the Investor Relations Department at Value Health's corporate office.

Annual Meeting

The annual meeting of Value Health shareholders will be held on May 4, 1995 at 10 A.M. at the Avon Old Farms Hotel in Avon, Connecticut.

Investor Inquiries

Investor inquiries should be directed to the Investor Relations Department at Value Health's corporate office.

News releases and quarterly reports are available 24 hours a day via fax. Call "Company News On Call," 1-800-758-5804, Ext. 932938.

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Front cover design: Michelangelo's *David* is shown half in its original form and half as seen through an advanced imaging device, thereby combining art and science. We do this because medicine is both the art of caring for another human being and the science of diagnosis and treatment. Value Health seeks this combination in its products and services . . . the best in the art of caring and the best in the science of appropriate care.

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