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

Form 10-Q

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

For the quarterly period ended June 30, 2003

or

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

For the transition period from _____ to _____

Commission file number: 1-10864

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

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

41-1321939
*(I.R.S. Employer
Identification No.)*

**UnitedHealth Group Center
9900 Bren Road East
Minnetonka, Minnesota**
(Address of principal executive offices)

55343
(Zip Code)

(952) 936-1300

(Registrant's telephone number, including area code)

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

As of August 11, 2003, 596,223,753 shares of the registrant's Common Stock, \$.01 par value per share, were issued and outstanding.

UNITEDHEALTH GROUP
INDEX

	<u>Page Number</u>
Part I. Financial Information	
Item 1. Financial Statements (Unaudited)	
Condensed Consolidated Balance Sheets as of June 30, 2003 and December 31, 2002	3
Condensed Consolidated Statements of Operations for the three and six month periods ended June 30, 2003 and 2002	4
Condensed Consolidated Statements of Cash Flows for the six month periods ended June 30, 2003 and 2002	5
Notes to Condensed Consolidated Financial Statements	6
Independent Accountants' Report	14
Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations	
	15
Item 3. Quantitative and Qualitative Disclosures about Market Risk	
	24
Item 4. Controls and Procedures	
	25
Part II. Other Information	
Item 1. Legal Proceedings	25
Item 4. Submission of Matters to a Vote of Security Holders	26
Item 6. Exhibits and Reports on Form 8-K	27
Signatures	28

PART I. FINANCIAL INFORMATION

Item 1. Financial Statements (unaudited)

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED BALANCE SHEETS
(Unaudited)
(In millions, except per share data)

	<u>June 30, 2003</u>	<u>December 31, 2002</u>
ASSETS		
Current Assets		
Cash and Cash Equivalents	\$ 2,253	\$ 1,130
Short-Term Investments	231	701
Accounts Receivable, net	836	835
Assets Under Management	2,007	2,069
Deferred Income Taxes and Other	<u>457</u>	<u>439</u>
Total Current Assets	5,784	5,174
Long-Term Investments	4,470	4,498
Property, Equipment, Capitalized Software, and Other Assets, Net	1,036	1,007
Goodwill	3,403	3,363
Other Intangible Assets, net	<u>145</u>	<u>122</u>
TOTAL ASSETS	<u>\$14,838</u>	<u>\$14,164</u>
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current Liabilities		
Medical Costs Payable	\$ 4,031	\$ 3,741
Accounts Payable and Accrued Liabilities	1,753	1,459
Other Policy Liabilities	1,765	1,781
Commercial Paper and Current Maturities of Long-Term Debt	350	811
Unearned Premiums	<u>452</u>	<u>587</u>
Total Current Liabilities	8,351	8,379
Long-Term Debt, less current maturities	1,400	950
Deferred Income Taxes and Other Liabilities	<u>414</u>	<u>407</u>
Commitments and Contingencies (Note 11)		
Shareholders' Equity		
Common Stock, \$0.01 par value — 1,500 shares authorized; 590 and 599 shares issued and outstanding	6	6
Additional Paid-In Capital	14	170
Retained Earnings	4,468	4,104
Accumulated Other Comprehensive Income:		
Net Unrealized Gains on Investments, net of tax effects	<u>185</u>	<u>148</u>
Total Shareholders' Equity	<u>4,673</u>	<u>4,428</u>
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	<u>\$14,838</u>	<u>\$14,164</u>

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited)
(In millions, except per share data)

	<u>Three Months Ended</u> <u>June 30,</u>		<u>Six Months Ended</u> <u>June 30,</u>	
	<u>2003</u>	<u>2002</u>	<u>2003</u>	<u>2002</u>
REVENUES				
Premiums	\$6,248	\$5,316	\$12,396	\$10,562
Services	779	711	1,549	1,416
Investment and Other Income	<u>60</u>	<u>51</u>	<u>117</u>	<u>113</u>
Total Revenues	<u>7,087</u>	<u>6,078</u>	<u>14,062</u>	<u>12,091</u>
MEDICAL AND OPERATING COSTS				
Medical Costs	5,109	4,418	10,159	8,853
Operating Costs	1,195	1,075	2,394	2,115
Depreciation and Amortization	<u>74</u>	<u>62</u>	<u>147</u>	<u>118</u>
Total Medical and Operating Costs	<u>6,378</u>	<u>5,555</u>	<u>12,700</u>	<u>11,086</u>
EARNINGS FROM OPERATIONS	709	523	1,362	1,005
Interest Expense	<u>(24)</u>	<u>(20)</u>	<u>(47)</u>	<u>(44)</u>
EARNINGS BEFORE INCOME TAXES	685	503	1,315	961
Provision for Income Taxes	<u>(246)</u>	<u>(178)</u>	<u>(473)</u>	<u>(341)</u>
NET EARNINGS	<u>\$ 439</u>	<u>\$ 325</u>	<u>\$ 842</u>	<u>\$ 620</u>
BASIC NET EARNINGS PER COMMON SHARE	<u>\$ 0.74</u>	<u>\$ 0.53</u>	<u>\$ 1.42</u>	<u>\$ 1.01</u>
DILUTED NET EARNINGS PER COMMON SHARE	<u>\$ 0.71</u>	<u>\$ 0.51</u>	<u>\$ 1.36</u>	<u>\$ 0.97</u>
BASIC WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING				
	590	610	593	612
DILUTIVE EFFECT OF OUTSTANDING STOCK OPTIONS				
	<u>28</u>	<u>31</u>	<u>28</u>	<u>30</u>
WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING, ASSUMING DILUTION				
	<u>618</u>	<u>641</u>	<u>621</u>	<u>642</u>

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited)
(In millions)

	<u>Six Months Ended</u> <u>June 30,</u>	
	<u>2003</u>	<u>2002</u>
OPERATING ACTIVITIES		
Net Earnings	\$ 842	\$ 620
Noncash Items:		
Depreciation and Amortization	147	118
Deferred Income Taxes and Other	(5)	70
Net Change in Other Operating Items, net of effects from acquisitions, sales of subsidiaries and changes in AARP balances:		
Accounts Receivable and Other Current Assets	25	(30)
Medical Costs Payable	283	48
Accounts Payable and Accrued Liabilities	349	409
Unearned Premiums	<u>(151)</u>	<u>(205)</u>
Cash Flows From Operating Activities	<u>1,490</u>	<u>1,030</u>
INVESTING ACTIVITIES		
Cash Paid for Acquisitions, net of cash assumed and other effects	(56)	(45)
Purchases of Property, Equipment and Capitalized Software, net	(181)	(216)
Purchases of Investments	(1,045)	(1,353)
Maturities and Sales of Investments	<u>1,649</u>	<u>1,515</u>
Cash Flows From (Used For) Investing Activities	<u>367</u>	<u>(99)</u>
FINANCING ACTIVITIES		
Proceeds from Common Stock Issuances	145	114
Common Stock Repurchases	(859)	(826)
Repayments of Commercial Paper, net	(461)	(454)
Proceeds from Issuance of Long-Term Debt	450	400
Dividends Paid	<u>(9)</u>	<u>(9)</u>
Cash Flows Used For Financing Activities	<u>(734)</u>	<u>(775)</u>
INCREASE IN CASH AND CASH EQUIVALENTS	1,123	156
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	<u>1,130</u>	<u>1,540</u>
CASH AND CASH EQUIVALENTS, END OF PERIOD	<u>\$ 2,253</u>	<u>\$ 1,696</u>
Supplementary schedule of noncash investing activities:		
Common stock issued for acquisitions	\$ —	\$ 72

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

1. Basis of Presentation and Use of Estimates

Unless the context otherwise requires, the use of the terms the “Company,” “we,” “us,” and “our” in the following refers to UnitedHealth Group Incorporated and its subsidiaries.

The accompanying unaudited condensed consolidated financial statements reflect all adjustments, consisting solely of normal recurring adjustments, needed to present the financial results for these interim periods fairly. In accordance with the rules and regulations of the Securities and Exchange Commission, we have omitted certain footnote disclosures that would substantially duplicate the disclosures contained in our annual audited financial statements. Read together with the disclosures below, we believe the interim financial statements are presented fairly. However, these unaudited condensed consolidated financial statements should be read together with the consolidated financial statements and the notes included in our Annual Report on Form 10-K for the year ended December 31, 2002.

These consolidated financial statements include certain amounts that are based on our best estimates and judgments. These estimates require us to apply complex assumptions and judgements, often because we must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to medical costs, medical costs payable, revenues, contingent liabilities, and asset valuations, allowances and impairments. We adjust these estimates each period, as more current information becomes available, and any adjustment could have a significant impact on our consolidated operating results. The impact of any changes in estimates is included in the determination of earnings in the period in which the estimate is adjusted.

2. Stock-Based Compensation

We account for activity under our stock-based employee compensation plans under the recognition and measurement principles of Accounting Principles Board Opinion No. 25, “Accounting for Stock Issued to Employees.” Accordingly, we do not recognize compensation expense when we grant employee stock options because we grant stock options at exercise prices not less than the fair value of our common stock on the date of grant.

The following table shows the effect on net earnings and earnings per share had we applied the fair value expense recognition provisions of Statement of Financial Accounting Standards (FAS) No. 123, “Accounting for Stock-Based Compensation,” to stock-based employee compensation (in millions, except per share data).

	<u>Three Months</u> <u>Ended June 30,</u>		<u>Six Months</u> <u>Ended June 30,</u>	
	<u>2003</u>	<u>2002</u>	<u>2003</u>	<u>2002</u>
NET EARNINGS				
As Reported	\$ 439	\$ 325	\$ 842	\$ 620
Compensation Expense, net of tax effect	<u>(31)</u>	<u>(25)</u>	<u>(60)</u>	<u>(49)</u>
Pro Forma	<u>\$ 408</u>	<u>\$ 300</u>	<u>\$ 782</u>	<u>\$ 571</u>
BASIC NET EARNINGS PER COMMON SHARE				
As Reported	\$0.74	\$0.53	\$1.42	\$1.01
Pro Forma	\$0.69	\$0.49	\$1.32	\$0.93
DILUTED NET EARNINGS PER COMMON SHARE				
As Reported	\$0.71	\$0.51	\$1.36	\$0.97
Pro Forma	\$0.66	\$0.47	\$1.26	\$0.89

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

3. Cash, Cash Equivalents and Investments

As of June 30, 2003, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments were as follows (in millions):

	<u>Amortized Cost</u>	<u>Gross Unrealized Gains</u>	<u>Gross Unrealized Losses</u>	<u>Fair Value</u>
Cash and Cash Equivalents	\$2,253	\$ —	\$—	\$2,253
Debt Securities — Available for Sale	4,189	284	(3)	4,470
Equity Securities — Available for Sale.....	149	10	(1)	158
Debt Securities — Held to Maturity.....	<u>73</u>	<u>—</u>	<u>—</u>	<u>73</u>
Total Cash and Investments	<u>\$6,664</u>	<u>\$294</u>	<u>\$(4)</u>	<u>\$6,954</u>

During the three and six month periods ended June 30, we recorded realized gains and losses on the sale of investments as follows (in millions):

	<u>Three Months Ended June 30,</u>		<u>Six Months Ended June 30,</u>	
	<u>2003</u>	<u>2002</u>	<u>2003</u>	<u>2002</u>
Gross Realized Gains	\$14	\$ 28	\$ 22	\$ 38
Gross Realized Losses.....	<u>(9)</u>	<u>(36)</u>	<u>(16)</u>	<u>(46)</u>
Net Realized Gains (Losses)	<u>\$ 5</u>	<u>\$(8)</u>	<u>\$ 6</u>	<u>\$(8)</u>

4. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by operating segment, for the six months ended June 30, 2003, were as follows (in millions):

	<u>Health Care Services</u>	<u>Uniprise</u>	<u>Specialized Care Services</u>	<u>Ingenix</u>	<u>Consolidated Total</u>
Balance at December 31, 2002.....	\$1,693	\$698	\$363	\$609	\$3,363
Goodwill acquired	<u>5</u>	<u>—</u>	<u>26</u>	<u>9</u>	<u>40</u>
Balance at June 30, 2003	<u>\$1,698</u>	<u>\$698</u>	<u>\$389</u>	<u>\$618</u>	<u>\$3,403</u>

The weighted-average useful life, gross carrying value, accumulated amortization and net carrying value of other intangible assets as of June 30, 2003 and December 31, 2002 were as follows (in millions):

	<u>Weighted- Average Useful Life</u>	<u>June 30, 2003</u>			<u>December 31, 2002</u>		
		<u>Gross Carrying Value</u>	<u>Accumulated Amortization</u>	<u>Net Carrying Value</u>	<u>Gross Carrying Value</u>	<u>Accumulated Amortization</u>	<u>Net Carrying Value</u>
Customer Contracts and Membership Lists	14 years	\$ 72	\$ (3)	\$ 69	\$ 64	\$ (1)	\$ 63
Patents, Trademarks and Technology	11 years	80	(27)	53	58	(24)	34
Non-compete Agreements and Other	<u>7 years</u>	<u>32</u>	<u>(9)</u>	<u>23</u>	<u>31</u>	<u>(6)</u>	<u>25</u>
Total	<u>10 years</u>	<u>\$184</u>	<u>\$(39)</u>	<u>\$145</u>	<u>\$153</u>	<u>\$(31)</u>	<u>\$122</u>

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Amortization expense relating to other intangible assets was approximately \$4 and \$8 million for the three and six month periods ended June 30, 2003. Estimated amortization expense relating to other intangible assets for the years ending December 31 are as follows (in millions):

<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>
\$17	\$18	\$17	\$16	\$14

5. Medical Costs Payable

As further discussed in the Critical Accounting Policies and Estimates section of Management's Discussion and Analysis, a substantial portion of our medical costs payable is based on estimates, which include estimates for the costs of health care services eligible individuals have received under risk-based arrangements but for which claims have either not yet been received or processed, and liabilities for physician, hospital and other medical cost disputes. Each period, our operating results include the effects of revisions in estimates related to all prior periods, based on actual claims processed and other changes in facts and circumstances. Our medical costs payable estimates as of December 31, 2001, 2000 and 1999 each developed favorably in the subsequent fiscal year by approximately \$70 million, \$30 million and \$15 million, respectively. Our medical costs payable estimate as of December 31, 2002 also developed favorably by approximately \$110 million during the six month period ended June 30, 2003.

Medical costs for the three month period ended June 30, 2003 include approximately \$50 million of favorable medical cost development related to prior years and approximately \$50 million of favorable medical cost development related to the first quarter of 2003. Management believes the amount of medical costs payable is reasonable and adequate to cover the company's liability for unpaid claims as of June 30, 2003.

6. Commercial Paper and Debt

Commercial paper and debt consisted of the following (in millions):

	<u>June 30, 2003</u>		<u>December 31, 2002</u>	
	<u>Carrying Value</u>	<u>Fair Value</u>	<u>Carrying Value</u>	<u>Fair Value</u>
Commercial Paper	\$ —	\$ —	\$ 461	\$ 461
Floating-Rate Notes due November 2003	100	100	100	100
6.6% Senior Unsecured Notes due December 2003	250	255	250	260
Floating-Rate Notes due November 2004	150	150	150	150
7.5% Senior Unsecured Notes due November 2005	400	451	400	450
5.2% Senior Unsecured Notes due January 2007	400	437	400	423
4.9% Senior Unsecured Notes due April 2013	<u>450</u>	<u>474</u>	<u>—</u>	<u>—</u>
Total Commercial Paper and Debt	1,750	1,867	1,761	1,844
Less Current Maturities	<u>(350)</u>	<u>(355)</u>	<u>(811)</u>	<u>(821)</u>
Long-Term Debt, less current maturities	<u>\$1,400</u>	<u>\$1,512</u>	<u>\$ 950</u>	<u>\$1,023</u>

As of June 30, 2003, we had no outstanding commercial paper. The interest rates on the floating-rate notes are reset quarterly to the three-month LIBOR (London Interbank Offered Rate) plus 0.3% for the notes due November 2003 and to the three-month LIBOR plus 0.6% for the notes due November 2004. As of June 30, 2003, the applicable rates on the notes were 1.6% and 1.9%, respectively.

In March 2003, we issued \$450 million of 4.9% fixed-rate notes due April 2013. In January 2002, we issued \$400 million of 5.2% fixed-rate notes due January 2007. We used proceeds from these borrowings to repay

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

commercial paper and for general corporate purposes including working capital, capital expenditures, business acquisitions, and share repurchases. When we issued these notes, we entered into interest rate swap agreements that qualify as fair value hedges to convert a portion of our interest rate exposure from a fixed to a variable rate. The interest rate swap agreements have aggregate notional amounts of \$225 million, maturing April 2013 and \$200 million, maturing January 2007. The variable rates are benchmarked to the six-month LIBOR rate and are reset on a semiannual basis in arrears. At June 30, 2003, the rate used to accrue interest expense on these swaps ranged from 1.2% to 1.3%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Condensed Consolidated Statements of Operations.

We have credit arrangements for \$900 million that support our commercial paper program. These credit arrangements include a \$450 million revolving facility that expires in July 2005, and a \$450 million, 364-day facility that expires in July 2004. We also have the capacity to issue approximately \$200 million of extendible commercial notes (ECNs). As of June 30, 2003, we had no amounts outstanding under our credit facilities or ECNs.

Our debt agreements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

7. AARP

In January 1998, we initiated a 10-year contract to provide insurance products and services to members of AARP. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings are approximately \$3.8 billion annually.

The underwriting gains or losses related to the AARP business are recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the accompanying Condensed Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

The following AARP program-related assets and liabilities are included in our Condensed Consolidated Balance Sheets (in millions):

	Balance as of	
	June 30, 2003	December 31, 2002
Accounts Receivable	\$ 342	\$ 294
Assets Under Management	\$1,960	\$2,045
Medical Costs Payable	\$ 881	\$ 893
Other Policy Liabilities	\$1,261	\$1,299
Other Current Liabilities	\$ 160	\$ 147

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The effects of changes in balance sheet amounts associated with the AARP program accrue to AARP policyholders through the RSF balance. Accordingly, we do not include the effect of such changes in our Condensed Consolidated Statements of Cash Flows.

8. Stock Split and Stock Repurchase Program

On May 7, 2003, the Company's Board of Directors declared a two-for-one split of the Company's common stock in the form of a 100 percent common stock dividend. The stock dividend was issued on June 18, 2003, to shareholders of record on June 2, 2003. All share and per share amounts have been restated to reflect the stock split.

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to restrictions on volume, pricing and timing. During the six months ended June 30, 2003, we repurchased 18.5 million shares at an aggregate cost of \$808 million. In July 2003, the board of directors renewed the stock repurchase program and authorized the Company to repurchase up to 60 million shares of common stock under the program.

9. Comprehensive Income

The table below presents comprehensive income for the three and six month periods ended June 30 (in millions):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2003	2002	2003	2002
Net Earnings	\$439	\$325	\$842	\$620
Change in Net Unrealized Gains on Investments, net of tax effects	35	56	37	42
Comprehensive Income	\$474	\$381	\$879	\$662

10. Segment Financial Information

The following is a description of the types of products and services from which each of our business segments derives its revenues:

- *Health Care Services* consists of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare coordinates network-based health and well-being services on behalf of local employers and consumers. Ovations delivers health and well-being services for Americans age 50 and older. AmeriChoice facilitates and manages health care services for state Medicaid programs and their beneficiaries. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been combined in the Health Care Services segment column in the tables presented below because these businesses have similar economic characteristics and have similar products and services, types of customers, distribution methods and operational processes, and operate in a similar regulatory environment, typically within the same legal entity.
- *Uniprise* provides health and well-being access and services, business-to-business transaction processing services, consumer connectivity and technology support services to large employers and health plans.
- *Specialized Care Services* is a portfolio of health and well-being companies, each serving a specialized market need with a unique blend of benefits, networks, services and resources.

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

- *Ingenix* is an international leader in the field of health care data analysis and application, serving pharmaceutical companies, health insurers and other payers, health care providers, large employers and governments.

Transactions between business segments principally consist of customer service and transaction processing services Uniprise provides to Health Care Services, certain product offerings sold to Uniprise and Health Care Services customers by Specialized Care Services, and sales of medical benefits cost, quality and utilization data and predictive modeling to Health Care Services and Uniprise by Ingenix. These transactions are recorded at management's best estimate of fair value, as if the services were purchased from or sold to third parties. All intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each segment using estimates of pro-rata usage. Cash and investments are assigned such that each segment has minimum specified levels of regulatory capital or working capital for non-regulated businesses.

Effective January 1, 2003, within the Health Care Services Segment, the Company transferred Medicaid-related business oversight from UnitedHealthcare to AmeriChoice, as well as certain Medicare-related businesses from UnitedHealthcare to Ovations. In addition, the Company transferred managed health plan services from UnitedHealthcare to Uniprise. The 2002 segment financial information has been restated for comparability purposes to conform to the current composition of business segments. The restatement had no effect on previously reported 2002 consolidated financial information.

The following tables present segment financial information for the three and six month periods ended June 30, 2003 and 2002 (in millions):

<u>Three Months Ended June 30, 2003</u>	<u>Health Care Services</u>	<u>Uniprise</u>	<u>Specialized Care Services</u>	<u>Ingenix</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenues — External Customers	\$6,056	\$626	\$262	\$ 83	\$ —	\$7,027
Revenues — Intersegment	—	143	197	43	(383)	—
Investment and Other Income . . .	50	6	4	—	—	60
Total Revenues	<u>\$6,106</u>	<u>\$775</u>	<u>\$463</u>	<u>\$126</u>	<u>\$(383)</u>	<u>\$7,087</u>
Earnings from Operations	<u>\$ 450</u>	<u>\$153</u>	<u>\$ 93</u>	<u>\$ 13</u>	<u>\$ —</u>	<u>\$ 709</u>

<u>Three Months Ended June 30, 2002</u>	<u>Health Care Services</u>	<u>Uniprise</u>	<u>Specialized Care Services</u>	<u>Ingenix</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenues — External Customers	\$5,201	\$527	\$223	\$ 76	\$ —	\$6,027
Revenues — Intersegment	—	129	148	33	(310)	—
Investment and Other Income . . .	41	6	4	—	—	51
Total Revenues	<u>\$5,242</u>	<u>\$662</u>	<u>\$375</u>	<u>\$109</u>	<u>\$(310)</u>	<u>\$6,078</u>
Earnings from Operations	<u>\$ 314</u>	<u>\$129</u>	<u>\$ 68</u>	<u>\$ 12</u>	<u>\$ —</u>	<u>\$ 523</u>

<u>Six Months Ended June 30, 2003</u>	<u>Health Care Services</u>	<u>Uniprise</u>	<u>Specialized Care Services</u>	<u>Ingenix</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenues — External Customers	\$12,023	\$1,240	\$517	\$165	\$ —	\$13,945
Revenues — Intersegment	—	291	393	82	(766)	—
Investment and Other Income . .	97	13	7	—	—	117
Total Revenues	<u>\$12,120</u>	<u>\$1,544</u>	<u>\$917</u>	<u>\$247</u>	<u>\$(766)</u>	<u>\$14,062</u>
Earnings from Operations	<u>\$ 852</u>	<u>\$ 305</u>	<u>\$181</u>	<u>\$ 24</u>	<u>\$ —</u>	<u>\$ 1,362</u>

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

<u>Six Months Ended June 30, 2002</u>	<u>Health Care Services</u>	<u>Uniprise</u>	<u>Specialized Care Services</u>	<u>Ingenix</u>	<u>Eliminations</u>	<u>Consolidated</u>
Revenues — External Customers	\$10,333	\$1,049	\$442	\$154	\$ —	\$11,978
Revenues — Intersegment	—	260	292	64	(616)	—
Investment and Other Income . .	92	13	8	—	—	113
Total Revenues	<u>\$10,425</u>	<u>\$1,322</u>	<u>\$742</u>	<u>\$218</u>	<u>\$(616)</u>	<u>\$12,091</u>
Earnings from Operations	<u>\$ 590</u>	<u>\$ 257</u>	<u>\$134</u>	<u>\$ 24</u>	<u>\$ —</u>	<u>\$ 1,005</u>

11. Commitments and Contingencies

Legal Matters

Because of the nature of our businesses, we are routinely party to a variety of legal actions related to the design, management and offerings of our services. We record liabilities for our estimate of probable costs resulting from these matters. These matters include, but are not limited to: claims relating to health care benefits coverage; medical malpractice actions; contract disputes; and claims related to disclosure of certain business practices. Following the events of September 11, 2001, the cost of business insurance coverage increased significantly. As a result, we have increased the amount of risk that we self-insure, particularly with respect to routine matters incidental to our business.

Beginning in 1999, a series of class action lawsuits were filed against us and virtually all major entities in the health benefits business. The suits are purported class actions on behalf of certain customers and physicians for alleged breaches of federal statutes, including the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Racketeer Influenced Corrupt Organization Act (RICO). On May 1, 2003, the customer related claims were dismissed following a de minimis settlement.

In April 2000, the American Medical Association filed a lawsuit against the Company in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the court dismissed certain ERISA claims and the claims brought by the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. We are engaged in discovery in this matter.

Although the results of pending litigation are always uncertain, we do not believe the results of any such actions currently threatened or pending, including those described above, will, individually or in aggregate, have a material adverse effect on our consolidated financial position or results of operations.

Governmental Regulation

Our business is regulated at federal, state, local and international levels. The laws and rules governing our business are subject to frequent change, and agencies have broad latitude to administer those regulations. State legislatures and Congress continue to focus on health care issues as the subject of proposed legislation. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability related to coverage interpretations or other actions. Further, we must obtain and maintain regulatory approvals to market many of our products.

We are also subject to various ongoing governmental investigations, audits and reviews, and we record liabilities for our estimate of probable costs resulting from these matters. Although the results of pending matters are always uncertain, we do not believe the results of any of the current investigations, audits or

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

reviews, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

12. Recently Issued Accounting Standards

In January 2003, the FASB issued Interpretation (FIN) No. 46, “Consolidation of Variable Interest Entities — an Interpretation of ARB No. 51.” FIN No. 46 requires an enterprise to consolidate a variable interest entity (previously known generally as a special purpose entity) if that enterprise has a variable interest that will absorb a majority of the entity’s expected losses, receive a majority of the entity’s expected residual returns, or both. This interpretation applies immediately to variable interest entities created or obtained after January 31, 2003. For those variable interest entities created or obtained prior to that date, the interpretation must be applied in the third quarter of 2003. We do not expect that the adoption of FIN No. 46 will have any impact on our consolidated financial position or results of operations.

In April 2003, the FASB issued FAS No. 149, “Amendment of Statement 133 on Derivative Instruments and Hedging Activities”. FAS No. 149 amends and clarifies accounting for derivative instruments and hedging activities under FAS No. 133, “Accounting for Derivative Instruments and Hedging Activities”. We do not expect that the adoption of FAS No. 149, which is effective for contracts entered into or modified after June 30, 2003, will have any impact on our consolidated financial position or results of operations.

In May 2003, the FASB issued FAS No. 150, “Accounting for Certain Financial Instruments with Characteristics of Both Liabilities and Equity”. FAS No. 150 establishes standards for classifying and measuring as liabilities certain freestanding financial instruments that represent obligations of the issuer and have characteristics of both liabilities and equity. The adoption of FAS No. 150, which became effective on May 31, 2003, did not have a significant impact on our consolidated financial position or results of operations.

INDEPENDENT ACCOUNTANTS' REPORT

To the Board of Directors and Shareholders
UnitedHealth Group Incorporated
Minnetonka, Minnesota

We have reviewed the accompanying condensed consolidated balance sheet of UnitedHealth Group Incorporated and Subsidiaries (the Company) as of June 30, 2003, and the related condensed consolidated statements of operations and cash flows for the three-month and six-month periods ended June 30, 2003 and 2002. These interim condensed consolidated financial statements are the responsibility of the Company's management.

We conducted our review in accordance with standards established by the American Institute of Certified Public Accountants. A review of interim financial information consists principally of applying analytical procedures to financial data and of making inquiries of persons responsible for financial and accounting matters. It is substantially less in scope than an audit conducted in accordance with auditing standards generally accepted in the United States of America, the objective of which is the expression of an opinion regarding the financial statements taken as a whole. Accordingly, we do not express such an opinion.

Based on our reviews, we are not aware of any material modifications that should be made to such interim condensed consolidated financial statements for them to be in conformity with accounting principles generally accepted in the United States of America.

We have previously audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated balance sheet of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2002, and the related consolidated statements of operations, shareholders' equity, and cash flows for the year then ended (not presented herein); and in our report dated January 23, 2003, we expressed an unqualified opinion on those consolidated financial statements. In our opinion, the information set forth in the accompanying condensed consolidated balance sheet as of December 31, 2002 is fairly stated, in all material respects, in relation to the consolidated balance sheet from which it has been derived.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
July 17, 2003

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

The following discussion should be read together with the accompanying unaudited condensed consolidated financial statements and notes. In addition, the following discussion should be considered in light of a number of factors that affect the Company, the industry in which we operate, and business generally. These factors are described in Exhibit 99 to this Quarterly Report.

Summary highlights of our second quarter 2003 results include:

- Diluted net earnings per share of \$0.71 increased 39% from \$0.51 per share reported in the second quarter of 2002 and increased 9% from \$0.65 per share reported in the first quarter of 2003.
- Cash flows from operations were nearly \$1.5 billion for the six months ended June 30, 2003, compared to \$1.0 billion for the six months ended June 30, 2002, an increase of \$460 million, or 45%.
- Earnings from operations increased to \$709 million in the second quarter of 2003, up \$186 million, or 36%, over the prior year and up \$56 million, or 9%, sequentially over the first quarter of 2003.
- Consolidated revenues of \$7.1 billion increased \$1.0 billion, or 17%, over the second quarter of 2002 and \$112 million, or 2%, sequentially over the first quarter of 2003.
- The consolidated medical care ratio was 81.8%, a decline from 83.1% in the second quarter of 2002.
- The operating cost ratio was 16.9%, an improvement from 17.7% during the second quarter of 2002.
- Consolidated operating margin reached 10.0%, improving from 8.6% in the second quarter of 2002.
- Annualized return on equity reached 38.5% in the second quarter of 2003, up from 33.2% in the second quarter of 2002.

Summary Operating Information

<u>(In millions, except per share data)</u>	<u>Three Months Ended June 30,</u>			<u>Six Months Ended June 30,</u>		
	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>
Total Revenues	\$7,087	\$6,078	17%	\$14,062	\$12,091	16%
Earnings from Operations	\$ 709	\$ 523	36%	\$ 1,362	\$ 1,005	36%
Net Earnings	\$ 439	\$ 325	35%	\$ 842	\$ 620	36%
Diluted Net Earnings Per Common Share	\$ 0.71	\$ 0.51	39%	\$ 1.36	\$ 0.97	40%
Medical Care Ratio	81.8%	83.1%		82.0%	83.8%	
Medical Care Ratio, Excluding AARP	80.4%	81.2%		80.7%	82.1%	
Operating Cost Ratio	16.9%	17.7%		17.0%	17.5%	
Return on Equity (annualized)	38.5%	33.2%		37.3%	31.7%	
Operating Margin	10.0%	8.6%		9.7%	8.3%	

Results of Operations

Consolidated Financial Results

Revenues

Revenues are comprised of premium revenue from risk-based products; service revenues, which primarily include fees for management, administrative, and consulting services; and investment and other income.

Premium revenues are derived from risk-based arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding health care services and related administrative costs. Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. For both premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services, transaction processing, customer, consumer and care provider services, and access to contracted networks of physicians, hospitals and other health care professionals.

Consolidated revenues increased by \$1.0 billion, or 17%, year-over-year in the second quarter of 2003 to \$7.1 billion. Consolidated revenues increased by 11% as a result of premium rate increases and growth across business segments and 6% as a result of revenues from businesses acquired since the second quarter of 2002. Following is a discussion of second quarter consolidated revenue trends for each of our three revenue components.

Premium Revenues

Consolidated premium revenues for the three and six months ended June 30, 2003 totaled \$6.2 billion and \$12.4 billion, respectively, an increase of \$932 million, or 18%, and \$1.8 billion, or 17%, over the comparable 2002 periods.

UnitedHealthcare premium revenues for the three and six months ended June 30, 2003 were \$3.6 billion and \$7.2 billion, respectively, an increase of \$453 million, or 14%, and \$938 million, or 15%, over the comparable 2002 periods. This was due primarily to premium rate increases on renewing commercial risk-based business. Premium revenues from Medicaid programs for the three and six months ended June 30, 2003 increased by \$303 million and \$586 million, respectively, over the three and six month periods ended June 30, 2002. This increase was primarily the result of the acquisition of AmeriChoice on September 30, 2002. The remaining premium revenue growth for the three and six months ended June 30, 2003 resulted primarily from an increase in the number of individuals served by both Ovations' Medicare supplement products provided to AARP members and by its Evercare business. In addition, Specialized Care Services realized an increase in premium revenues due to strong growth in several of its specialty benefits businesses.

Service Revenues

Service revenues for the three and six months ended June 30, 2003 totaled \$779 million and \$1.5 billion, representing an increase of \$68 million, or 10%, and \$133 million, or 9%, over the comparable 2002 periods. The increase in service revenues was driven primarily by aggregate growth of 7% in individuals served by Uniprise and UnitedHealthcare under fee-based arrangements. For the three and six months ended June 30, 2003, Uniprise and UnitedHealthcare service revenues grew by an aggregate of \$66 million and \$120 million, respectively, over the comparable prior year periods.

Investment and Other Income

Investment and other income during the three and six months ended June 30, 2003 totaled \$60 million and \$117 million, respectively, representing increases of \$9 million and \$4 million, respectively, from the comparable periods in 2002. For the three and six months ended June 30, 2003, interest income decreased by \$4 million and \$10 million, respectively, driven by lower interest yields on investments partially offset by the impact of increased levels of cash and fixed income investments. Net capital gains on sales of investments

were \$5 million and \$6 million for the three and six months ended June 30, 2003, respectively, compared to a net capital loss of \$8 million for both the three and six months ended June 30, 2002.

Medical Costs

The combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts is reflected in the medical care ratio (medical costs as a percentage of premium revenues).

For the three month periods ended June 30, the consolidated medical care ratio decreased from 83.1% in 2002 to 81.8% in 2003. Excluding the AARP business,¹ on a year-over-year basis, the medical care ratio decreased 80 basis points from 81.2% in 2002 to 80.4% in 2003. The decrease in the medical care ratio was primarily driven by favorable development of prior period medical cost estimates, as further discussed below. Excluding the impact of favorable medical cost development, the medical care ratio in the second quarter of 2003 was largely consistent with the second quarter of 2002.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in estimates may relate to the prior fiscal year or to prior quarterly reporting periods within the same fiscal year. Changes in estimates for prior quarterly reporting periods within the same fiscal year have no impact on total medical costs reported for that fiscal year. Changes in medical costs payable estimates for prior fiscal years that are identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for the three months ended June 30, 2003 include approximately \$50 million of favorable medical cost development related to prior years and approximately \$50 million of favorable medical cost development related to the first quarter of 2003. Medical costs for the three months ended June 30, 2002 include approximately \$30 million of favorable medical cost development related to prior years and approximately \$10 million of favorable medical cost development related to the first quarter of 2002.

For the six months ended June 30, the consolidated medical care ratio decreased from 83.8% in 2002 to 82.0% in 2003. Excluding the AARP business, on a year-over-year basis, the medical care ratio decreased 140 basis points from 82.1% to 80.7%. Approximately 50 basis points of the decrease in the medical care ratio was driven by the favorable development of prior period medical cost estimates. Medical costs for the six months ended June 30, 2003 and 2002 include approximately \$110 million and \$50 million, respectively, of favorable medical cost development related to prior years. The balance of the medical care ratio decrease resulted primarily from changes in product, business, and customer mix.

For the three and six months ended June 30, 2003, on an absolute dollar basis, medical costs increased \$691 million, or 16%, and \$1.3 billion, or 15%, respectively, over the comparable 2002 periods. The increase was driven primarily by a rise in medical costs of approximately 11% driven by medical cost inflation and increased health care consumption and the additional medical costs related to businesses acquired since June 30, 2002. These increases were partially offset by the improved medical care ratios described above.

Operating Costs

The operating cost ratio (operating costs as a percentage of total revenues) for the three and six months ended June 30, 2003 was 16.9% and 17.0%, down from 17.7% and 17.5% in the comparable 2002 periods. These decreases were driven primarily by business mix changes, productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for the three and six months ended June 30, 2003 increased \$120 million, or 11%, and \$279 million, or 13%, over the comparable periods in 2002. This increase was driven

¹Management believes disclosure of the medical care ratio excluding the AARP business is meaningful since underwriting gains or losses related to the AARP business accrue to AARP policyholders through a rate stabilization fund (RSF). Although the Company is at risk for underwriting losses to the extent cumulative net losses exceed the balance in the RSF, the Company has not been required to fund any underwriting deficits to date and management believes the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract during the foreseeable future.

by a 7% increase in total individuals served by Health Care Services and Uniprise, increases in broker commissions and premium taxes, general operating cost inflation and the additional operating costs associated with acquired businesses.

Depreciation and Amortization

Depreciation and amortization for the three and six months ended June 30, 2003 was \$74 million and \$147 million, respectively, an increase of \$12 million and \$29 million over the comparable prior year periods. These increases are due to additional depreciation and amortization resulting from higher levels of property, equipment, computer hardware and capitalized software as a result of technology enhancements, business growth and businesses acquired since the first half of 2002.

Income Taxes

Our effective income tax rate was 36.0% in the second quarter of 2003 and 35.5% in the second quarter of 2002. The increase is mainly due to the September 30, 2002 acquisition of AmeriChoice, which operates primarily in markets that have comparatively higher state and local income tax rates.

Business Segments

The following summarizes the operating results of our business segments for three and six months ended June 30 (in millions):

Revenues

	<u>Three Months Ended June 30,</u>			<u>Six Months Ended June 30,</u>		
	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>
Health Care Services	\$6,106	\$5,242	16%	\$12,120	\$10,425	16%
Uniprise	775	662	17%	1,544	1,322	17%
Specialized Care Services.....	463	375	23%	917	742	24%
Ingenix	126	109	16%	247	218	13%
Corporate	<u>(383)</u>	<u>(310)</u>	<u>n/a</u>	<u>(766)</u>	<u>(616)</u>	<u>n/a</u>
Total Consolidated	<u>\$7,087</u>	<u>\$6,078</u>	<u>17%</u>	<u>\$14,062</u>	<u>\$12,091</u>	<u>16%</u>

Earnings from Operations

	<u>Three Months Ended June 30,</u>			<u>Six Months Ended June 30,</u>		
	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>	<u>2003</u>	<u>2002</u>	<u>Percent Change</u>
Health Care Services	\$450	\$314	43%	\$ 852	\$ 590	44%
Uniprise	153	129	19%	305	257	19%
Specialized Care Services.....	93	68	37%	181	134	35%
Ingenix	<u>13</u>	<u>12</u>	<u>8%</u>	<u>24</u>	<u>24</u>	<u>—%</u>
Total Consolidated	<u>\$709</u>	<u>\$523</u>	<u>36%</u>	<u>\$1,362</u>	<u>\$1,005</u>	<u>36%</u>

Health Care Services

The Health Care Services segment (comprised of the UnitedHealthcare, Ovations and AmeriChoice businesses) had revenues of \$6.1 billion and \$12.1 billion for the three and six months ended June 30, 2003, respectively, representing increases of \$864 million, or 16%, and \$1.7 billion, or 16%, over the comparable 2002 periods.

The increase in revenues primarily resulted from an increase in UnitedHealthcare premium revenues for the three and six months ended June 30, 2003, of \$453 million, or 14%, and \$938 million, or 15%, respectively, over the comparable 2002 periods. This increase was due primarily to premium rate increases on renewing commercial risk-based business. Premium revenues from Medicaid programs for the three and six months ended June 30, 2003 increased by \$303 million and \$586 million, respectively, over the three and six month periods ended June 30, 2002. This increase was primarily the result of the acquisition of AmeriChoice on September 30, 2002. The remaining revenue growth in 2003 resulted primarily from an increase in the number of individuals served by both Ovations' Medicare supplement products provided to AARP members and by its Evercare business.

For the three and six months ended June 30, 2003, Health Care Services earnings from operations were \$450 million and \$852 million, respectively, representing increases of \$136 million, or 43%, and \$262 million, or 44%, over the comparable periods in 2002. These increases primarily resulted from improved gross margins on UnitedHealthcare's risk-based products and revenue growth. Health Care Services' operating margin for the three and six months ended June 30, 2003 was 7.4% and 7.0%, respectively, an increase of 140 basis points and 130 basis points from the three and six months ended June 30, 2002, respectively. These increases were driven by a combination of an improved medical care ratio and a shift in product mix from risk-based products to higher-margin, fee-based products.

UnitedHealthcare's commercial medical care ratio improved to 80.7% for the second quarter of 2003 from 81.6% in the second quarter of 2002. The decrease in the medical care ratio was primarily driven by favorable development of prior period medical cost estimates, as previously discussed. Excluding the impact of favorable medical cost development, the medical care ratio in the second quarter of 2003 was largely consistent with the second quarter of 2002.

The number of individuals served by UnitedHealthcare increased by 205,000, or 3%, in the second quarter of 2003 over the second quarter of 2002. This included an increase of 220,000, or 9%, in the number of individuals served with fee-based products, driven by new customer relationships and customers converting from risk-based products to fee-based products. In addition, there was a decrease of 15,000 in the number of individuals served by risk-based products, driven by customers converting to self-funded, fee-based arrangements and UnitedHealthcare's targeted withdrawal of risk-based product offerings from unprofitable arrangements with customers using multiple health benefit carriers, partially offset by new customer relationships.

Ovation's year-over-year Medicare+Choice enrollment was relatively stable, with 225,000 individuals served as of June 30, 2003. Medicaid enrollment increased by 430,000, largely due to the acquisition of AmeriChoice on September 30, 2002, which served approximately 360,000 individuals as of the acquisition date.

The following table summarizes individuals served by Health Care Services, by major market segment and funding arrangement, as of June 30 (in thousands):

	<u>2003</u>	<u>2002</u>
Commercial		
Risk-based	4,985	5,000
Fee-based	<u>2,805</u>	<u>2,585</u>
	7,790	7,585
Medicare	225	225
Medicaid	<u>1,070</u>	<u>640</u>
Total Health Care Services	<u>9,085</u>	<u>8,450</u>

Uniprise

Uniprise revenues for the three and six months ended June 30, 2003 were \$775 million and \$1.5 billion, respectively, an increase of 17% over each of the comparable 2002 periods. These increases were driven primarily by a 7% year-over-year increase in Uniprise's customer base, annual service fee increases for self-

insured customers, and changes in customer funding mix in the third quarter of 2002. Uniprise served 9.2 million and 8.6 million individuals as of June 30, 2003 and 2002, respectively.

For the three and six months ended June 30, 2003, Uniprise earnings from operations were \$153 million and \$305 million, respectively, an increase of 19% over each of the prior year comparable periods. Operating margin for the three and six months ended June 30, 2003 improved to 19.7% and 19.8% from 19.5% and 19.4%, respectively, in the comparable 2002 periods. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives, primarily in the form of reduced labor and occupancy costs supporting its transaction processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

Specialized Care Services

For the three and six months ended June 30, 2003, Specialized Care Services revenues of \$463 million and \$917 million, respectively, increased by \$88 million, or 23%, and \$175 million, or 24%, over the comparable 2002 periods. These increases were principally driven by an increase in the number of individuals served by United Behavioral Health, its mental health benefits business, Dental Benefit Providers, its dental services business, and Spectera, its vision care benefits business, as well as rate increases related to these businesses.

Earnings from operations for the three and six months ended June 30, 2003 of \$93 million and \$181 million, respectively, increased \$25 million, or 37%, and \$47 million, or 35%, over the comparable 2002 periods. Specialized Care Services' operating margin increased to 20.1% in the second quarter of 2003, up from 18.1% in the comparable 2002 period. This increase was driven primarily by operational and productivity improvements at United Behavioral Health. With the continuing growth of the Specialized Care Services segment, we are currently consolidating production and service operations to a segment-wide service and production infrastructure to improve service quality and consistency and enhance productivity and efficiency.

Ingenix

For the three and six months ended June 30, 2003, Ingenix revenues of \$126 million and \$247 million, respectively, increased by \$17 million, or 16%, and \$29 million, or 13%, over the comparable 2002 periods. This was driven by new business growth in the health information business as well as businesses acquired since the second quarter of 2002.

Earnings from operations were \$13 million in the second quarter of 2003, up \$1 million, or 8%, from the comparable 2002 period. The operating margin was 10.3% in the second quarter of 2003, down from 11.0% in the second quarter of 2002. The reduction in operating margin was primarily due to cancellations and delays of certain clinical research trials by pharmaceutical clients. This reduction was partially offset by growth and expanding margins in the health information business. Ingenix generates higher revenues and operating margins in the second half of the year due to seasonally strong demand for higher margin software and information content products.

Financial Condition and Liquidity at June 30, 2003

Liquidity

We manage our cash, investments and capital structure so we are able to meet the short- and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment and financing within the confines of our financial strategy, such as our self-imposed limit of 30% on our debt-to-total-capital ratio (calculated as the sum of commercial paper and debt divided by the sum of commercial paper, debt and shareholders' equity).

A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest monies of regulated subsidiaries that exceed our near-term obligations in longer term, investment grade marketable debt

securities, to improve our overall investment return. Factors we consider in making these investment decisions include our board of directors' approved investment policy, regulatory limitations, return objectives, tax implications, risk tolerance and maturity dates. Our long-term investments are also available for sale to meet short-term liquidity and other needs. Monies in excess of the capital needs of our regulated entities are paid to their non-regulated parent companies, typically in the form of dividends, for general corporate use, when and as permitted by applicable regulations.

Our non-regulated businesses also generate significant cash from operations. Also, we issue long-term debt and commercial paper with staggered maturity dates and have available credit facilities. These additional sources of liquidity allow us to maintain further operating and financial flexibility. Because of this flexibility, we typically maintain low cash and investment balances in our non-regulated companies. Cash in these entities is generally used to reinvest in our businesses in the form of capital expenditures, to expand the depth and breadth of our services through business acquisitions, and to repurchase shares of our common stock, depending on market conditions.

Cash generated from operating activities, our primary source of liquidity, is principally from net earnings, excluding depreciation and amortization. As a result, any future decline in our profitability may have a negative impact on our liquidity. The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. We believe that our strategies and actions toward maintaining financial flexibility mitigate much of this risk.

Cash and Investments

Cash flow from operations was \$1.5 billion and \$1.0 billion for the six months ended June 30, 2003 and 2002, respectively, representing an increase of \$460 million, or 45%. This increase in operating cash flows resulted from an increase of \$176 million in net income excluding depreciation, amortization and other non cash items and an increase of \$284 million due to cash generated by working capital changes.

We maintained a strong financial condition and liquidity position, with cash and investments of nearly \$7.0 billion at June 30, 2003. Total cash and investments increased by \$625 million since December 31, 2002, primarily resulting from strong cash flows from operations partially offset by common stock repurchases and capital expenditures.

As further described under "Regulatory Capital and Dividend Restrictions," many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At June 30, 2003, approximately \$888 million of our \$7.0 billion of cash and investments was held by non-regulated subsidiaries. Of this amount, \$730 million was available for general corporate use, including acquisitions and share repurchases. The remaining \$158 million consists primarily of public and non-public equity securities held by UnitedHealth Capital, our investment capital business.

Financing and Investing Activities

We use commercial paper and debt to maintain adequate operating and financial flexibility. As of both June 30, 2003, and December 31, 2002, we had commercial paper and debt outstanding of approximately \$1.8 billion. Our debt-to-total-capital ratio was 27.2% and 28.5% as of June 30, 2003 and December 31, 2002, respectively. We expect to maintain our debt-to-total-capital ratio at 30% or less. We believe the prudent use of leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

As of June 30, 2003 we had no outstanding commercial paper. The interest rates on our floating-rate notes are reset quarterly to the three-month LIBOR plus 0.3% for the notes due November 2003 and to the three-month LIBOR plus 0.6% for the notes due November 2004. As of June 30, 2003, the applicable rates on the notes were 1.6% and 1.9%, respectively.

In March 2003, we issued \$450 million of 4.9% fixed-rate notes due April 2013. In January 2002, we issued \$400 million of 5.2% fixed-rate notes due January 2007. We used proceeds from these borrowings to repay commercial paper and for general corporate purposes including working capital, capital expenditures, business acquisitions and share repurchases. When we issued these notes, we entered into interest rate swap agreements that qualify as fair value hedges to convert a portion of our interest rate exposure from a fixed to a variable rate. The interest rate swap agreements have aggregate notional amounts of \$225 million, maturing April 2013 and \$200 million, maturing January 2007. The variable rates are benchmarked to the six-month LIBOR rate and are reset on a semiannual basis in arrears. At June 30, 2003, the rate used to accrue interest expense on these swaps ranged from 1.2% to 1.3%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Condensed Consolidated Statements of Operations.

We have credit arrangements for \$900 million that support our commercial paper program. These credit arrangements include a \$450 million revolving facility that expires in July 2005, and a \$450 million, 364-day facility that expires in July 2004. We also have the capacity to issue approximately \$200 million of extendible commercial notes (ECNs). As of June 30, 2003, we had no amounts outstanding under our credit facilities or ECNs.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

Our senior debt is rated "A" by Standard & Poor's (S&P) and Fitch, and "A3" by Moody's. Our commercial paper and ECN programs are rated "A-1" by S&P, "F-1" by Fitch, and "P-2" by Moody's. Consistent with our intention of maintaining our senior debt ratings in the "A" range, we intend to maintain our debt-to-total-capital ratio at 30% or less. A significant downgrade in our debt and commercial paper ratings could adversely affect our borrowing capacity and costs.

On May 7, 2003, the Company's Board of Directors declared a two-for-one split of the Company's common stock in the form of a 100 percent common stock dividend. The stock dividend was issued on June 18, 2003, to shareholders of record on June 2, 2003. All share and per share amounts have been restated to reflect the stock split.

In July 2003, the Securities and Exchange Commission declared our recently filed S-3 and S-4 shelf registration statements effective. Under the S-3 shelf registration statement (for common stock, preferred stock, debt securities, and other securities), the remaining issuing capacity of all covered securities is \$1.25 billion. We may publicly offer securities from time to time at prices and terms to be determined at the time of offering. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of approximately 24.3 million shares of our common stock in connection with acquisition activities.

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the six months ended June 30, 2003, we repurchased 18.5 million shares at an aggregate cost of approximately \$808 million. In July 2003, the board of directors renewed the stock repurchase program and authorized the Company to repurchase up to 60 million shares of common stock under the program.

Regulatory Capital and Dividend Restrictions

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the

“A” range, we maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require.

Critical Accounting Policies and Estimates

Critical accounting policies are those policies that require management to make the most challenging judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting policies involve judgments and uncertainties that are sufficiently sensitive to result in materially different results under different assumptions and conditions. The following provides a summary of our accounting policies and estimation procedures surrounding medical costs. For a detailed description of all our critical accounting policies, see the Results of Operations section of the consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2002.

Medical Costs

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers but for which claims have either not yet been received or processed. Depending on the health care provider and type of service, the typical billing lag for services can range from 2 to 90 days from date of service. Substantially all claims related to medical care services are known and settled within nine to twelve months from the date of service.

We estimate and maintain liabilities for these incurred but not reported (IBNR) services. These estimates are established pursuant to an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider such factors as time from date of service to claim receipt, claim backlogs, seasonal variances in medical care consumption, provider contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, benefit plan changes, and business mix changes related to products, customers, and geography.

Each quarter, the company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimate recorded in prior periods becomes more exact, the amount of the estimate will increase or decrease with the change in estimate being included in medical costs in the period in which the change is identified. Accordingly, in every reporting period our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of medical costs is less than the previous estimate, reported medical costs in the current period will be decreased (favorable development). If the revised estimate of medical costs is more than the previous estimate, reported medical costs in the current period will be increased (unfavorable development). Historically, the net impact of estimate developments has represented less than three-tenths of one percent of annual medical costs, less than three percent of annual earnings from operations and less than three percent of medical costs payable. The effects of estimate changes have not been significant to the company’s annual operating results or financial position in each of the last four years.

In order to evaluate the impact of changes in medical costs payable estimates for any particular discrete period, one should consider both the amount of development recorded in the current period pertaining to prior periods and the amount of development recorded in subsequent periods pertaining to the current period. The

accompanying table provides a summary of the net impact of favorable development on medical costs and earnings from operations (in millions).

	Favorable Development	Net Impact on Medical Costs(a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted(b)	As Reported	As Adjusted(b)
1999	\$20	\$ 5	\$15,043	\$15,048	\$ 943	\$ 938
2000	\$15	\$(15)	\$16,155	\$16,140	\$1,200	\$1,215
2001	\$30	\$(40)	\$17,644	\$17,604	\$1,566	\$1,606
2002	\$70	\$(40)(c)	\$18,192	\$18,152(c)	\$2,186	\$2,226(c)

(a) The amount of favorable development recorded in the current year pertaining to the prior year less the amount of favorable development recorded in the subsequent year pertaining to the current year.

(b) Represents reported amounts adjusted to reflect the net impact of medical cost development.

(c) For the six month period ended June 30, 2003, the company recorded favorable medical cost development of \$110 million pertaining to 2002. The amount of prior period development in 2003 may change as our December 31, 2002 medical costs payable estimate continues to develop throughout 2003.

Inflation

The current national health care cost inflation rate significantly exceeds the general inflation rate. We use various strategies to lessen the effects of health care cost inflation. This includes setting commercial premiums based on anticipated health care costs and coordinating care with physicians and other health care providers. Through contracts with physicians and other health care providers, we emphasize preventive health care, appropriate use of health care services consistent with clinical performance standards, education and closing gaps in care.

We believe our strategies to mitigate the impact of health care cost inflation on our operating results have been and will continue to be successful. However, other factors including competitive pressures, new health care and pharmaceutical product introductions, demands from physicians and other health care providers and consumers, major epidemics and applicable regulations may affect our ability to control the impact of health care cost inflation. Because of the narrow operating margins of our risk-based products, changes in medical cost trends that were not anticipated in establishing premium rates can create significant changes in our financial results.

Concentrations of Credit Risk

Investments in financial instruments such as marketable securities and accounts receivable may subject UnitedHealth Group to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our board of directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. Government and Agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups that constitute our customer base. As of June 30, 2003, there were no significant concentrations of credit risk.

Item 3. Quantitative and Qualitative Disclosures about Market Risk

Market risk represents the risk of changes in value of a financial instrument caused by changes in interest rates and equity prices.

Approximately \$6.8 billion of our cash and investments at June 30, 2003, was invested in fixed income securities. We manage our investment portfolio within risk parameters approved by our board of directors; however, our fixed income securities are subject to the effects of market fluctuations in interest rates. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed

income portfolio at June 30, 2003, the fair value of our fixed income investments would decrease or increase by approximately \$200 million.

At June 30, 2003, we had \$158 million of equity investments, primarily held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of June 30, 2003, an evaluation was carried out under the supervision and with the participation of the Company's management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934). Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that the design and operation of these disclosure controls and procedures were effective.

Changes in Internal Controls Over Financial Reporting

There were no significant changes in our internal control over financial reporting that occurred during the quarter ended June 30, 2003 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

In September 1999, a group of plaintiffs' trial lawyers publicly announced that they were targeting the managed care industry by way of class action litigation. Since that time, several claims against us have been alleged that generally challenge managed care practices, including cost containment mechanisms, disclosure obligations and payment methodologies. These claims are described in the following paragraph. We intend to defend vigorously all of these claims.

In Re: Managed Care Litigation: MDL No. 1334. Beginning in 1999, a series of class action lawsuits were filed against us and virtually all major entities in the health benefits businesses. A multi-district litigation panel has consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District Court of Florida, Miami division. The first of these suits was initiated in February 2000. In December 2000, the UnitedHealth Group litigation was consolidated with litigation involving other industry members for the coordination of pre-trial proceedings. The litigation has been divided into two tracks, with one track comprising consumer claims and the other health care provider claims. Generally, the claims made in this consolidated litigation allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. The litigation also asserts breach of state prompt payment laws and breach of contract claims alleging that UnitedHealth Group affiliates fail to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. Following the Court's initial decisions on industry members' motions to dismiss the complaints, amended complaints were filed in both tracks. On September 26, 2002, the trial court denied the consumer track plaintiffs' motion for class certification while granting the health care provider track plaintiffs' certification motion. Discovery commenced in both tracks of the litigation on September 30, 2002. The Eleventh Circuit granted the industry defendants' petition seeking review of the district court's certification order in the health care provider track litigation. On April 7, 2003, the United States Supreme Court reversed the Eleventh Circuit's arbitration decision and found that the health care provider track plaintiffs' RICO claims against PacifiCare and UnitedHealthcare should be arbitrated. On

May 1, 2003, the district court entered an order dismissing the consumer track litigation following a de minimis settlement.

The American Medical Association et al. v. Metropolitan Life Insurance Company, United HealthCare Services, Inc. and UnitedHealth Group. This lawsuit was filed on March 15, 2000, in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. We are engaged in discovery in this matter.

Because of the nature of our business, we are routinely subject to lawsuits alleging various causes of action. Some of these suits may include claims for substantial non-economic, treble or punitive damages. We record liabilities for our estimate of probable costs resulting from these matters. Although the results of pending litigation are always uncertain, we do not believe the results of any such actions, including those described above, or any other types of actions, currently threatened or pending, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

Item 4. *Submission of Matters to a Vote of Security Holders*

At the Company's Annual Meeting of Shareholders held on May 7, 2003 (the "Annual Meeting"), the Company's shareholders voted on three items: the election of directors, the ratification of the appointment of Deloitte & Touche LLP as independent public auditors for the Company, and a shareholder proposal requesting the expensing of stock options.

The four directors elected at the Annual Meeting were: James A. Johnson, with 259,999,678 votes cast for his election and 5,961,738 votes withheld; Douglas W. Leatherdale with 260,081,090 votes cast for his election and 5,880,326 votes withheld; William W. McGuire, M.D., with 261,510,453 votes cast for his election and 4,450,963 votes withheld; and Mary O. Mundinger with 256,367,422 votes cast for her election and 9,593,994 votes withheld. The directors whose terms of office continued after the Annual Meeting were: William C. Ballard, Jr., Richard T. Burke, Stephen J. Hemsley, Thomas H. Kean, Robert L. Ryan, Donna E. Shalala, William G. Spears and Gail R. Wilensky.

The appointment of Deloitte & Touche LLP as independent public auditors for the Company for the year ending December 31, 2003 was ratified with 256,366,950 votes cast for ratification, 8,115,733 votes cast against ratification and 1,478,733 votes abstaining. There were no broker non-votes on this matter.

The Shareholder Proposal was not ratified with 124,177,655 votes against the proposal, 115,297,075 votes for the proposal, and 5,473,637 votes abstaining. There were 21,013,049 broker non-votes cast on this matter.

Item 6. Exhibits and Reports on Form 8-K

(a) The following exhibits are filed in response to Item 601 of Regulation S-K.

<u>Exhibit Number</u>	<u>Description</u>
Exhibit 10	— Amendments to Pharmacy Benefit Management Agreement between United HealthCare Services, Inc. and Merck Medco Managed Care, LLC
Exhibit 15	— Letter Re Unaudited Interim Financial Information
Exhibit 31	— Certifications Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
Exhibit 32	— Certifications Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
Exhibit 99	— Cautionary Statements

(b) *Reports on Form 8-K*

The Company filed two Current Reports on Form 8-K during the quarter ended June 30, 2003. These reports were filed on May 8, 2003 and May 21, 2003. The May 8, 2003 report provided information regarding a declaration by the Board of Directors of a two-for-one stock split of the Company's common stock in the form of a 100 percent common stock dividend issuable on June 18, 2003 to shareholders of record on June 2, 2003. The May 21, 2003 report provided information pursuant to Regulation FD relating to presentations by officers of the Company at investor meetings and conferences.

SIGNATURES

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

UNITEDHEALTH GROUP INCORPORATED

/s/ STEPHEN J. HEMSLEY
Stephen J. Hemsley

President and
Chief Operating Officer

Dated: August 13, 2003

/s/ PATRICK J. ERLANDSON
Patrick J. Erlandson

Chief Financial Officer and
Chief Accounting Officer

Dated: August 13, 2003

EXHIBITS

<u>Exhibit Number</u>	<u>Description</u>
Exhibit 10	— Amendments to Pharmacy Benefit Management Agreement between United HealthCare Services, Inc. and Merck Medco Managed Care, LLC
Exhibit 15	— Letter Re Unaudited Interim Financial Information
Exhibit 31	— Certifications Pursuant to Section 302 of the Sarbanes-Oxley Act of 2003
Exhibit 32	— Certifications Pursuant to Section 906 of the Sarbanes-Oxley Act of 2003
Exhibit 99	— Cautionary Statements

AMENDMENT TO
 UNITED HEALTHCARE SERVICES, INC.
 AND
 UNITEDHEALTH NETWORKS, INC.
 PHARMACY BENEFIT MANAGEMENT AGREEMENT

This Amendment is made to the agreement ("Agreement") between United HealthCare Services, Inc. and UnitedHealth Networks, Inc., collectively referred to as "United", and the entity named below ("MMMC"). The Agreement currently sets forth the terms and conditions under which MMMC or an affiliate shall provide or arrange for the provision of health care services to individuals covered by a United's affiliated Health Plan pursuant to its Medicare contract with the Health Care Financing Administration ("HCFA"). The parties understand and agree that the Balanced Budget Act of 1997 ("BBA") established a new program known as Medicare+Choice, which replaced Health Plan's existing Medicare risk program. The purpose of this Amendment is to incorporate all provisions necessary to meet the HCFA requirements for Medicare+Choice. This Amendment is effective on August 1, 1999.

1. The Agreement shall be amended by the addition of the attached Health Plan Medicare+Choice Requirements Addendum.
2. All other provisions of the Agreement shall remain in full force and effect.

UNITED HEALTHCARE SERVICES, INC.

MERCK MEDCO MANAGED CARE, L.L.C.

Signature /s/ Robert Sheehy

Signature Illegible

Title President

Title Senior Vice President-
 Regulatory and Managed Care
 Programs

Date 1/29/01

Date 1/24/01

UNITEDHEALTH NETWORKS, INC.

Signature /s/ Brian Beutner

Title Secretary

Date 1/26/01

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission.

HEALTH PLAN
MEDICARE+CHOICE REQUIREMENTS ADDENDUM

In addition to PBM's obligations under the Agreement, PBM agrees, and shall require PBM Contracting Providers to agree, as participating providers under a United affiliated Health Plan's contract with HCFA to be a Medicare+Choice managed care organization (hereafter the "M divided by C Contract"), to abide by all applicable provisions of the M+C Contract and to fulfill PBM's and PBM Contracting Provider's obligations under the Agreement in a manner consistent with a United affiliated Health Plan's (hereafter the "Health Plan") obligations under the M divided by C Contract. For purposes of this Addendum, "Medicare Member" means a Health Plan's Member who is enrolled in a Medicare+Choice plan through Health Plan. PBM and PBM Contracting Provider compliance with the M+C Contract specifically includes, but is not limited to, the following requirements:

1. Prompt Payment. Health Plan shall pay "clean" claims for Covered Services within forty-five (45) days of receipt and approve or deny all claims that are not "clean" claims within sixty (60) days from the date of the request.
2. Medicare Compliance. PBM shall, and shall require PBM Contracting Providers to, comply with all applicable Medicare laws and regulations and HCFA instructions.
3. Audits and Information. In addition to PBM's and PBM Contracting Provider's obligations under Section 5.3.2, PBM shall, and shall require PBM Contracting Providers to, permit audits and inspection by HCFA and/or its designees, and cooperate, assist and provide information to HCFA and/or its designees as requested from time to time. This provision shall survive termination of the Agreement.
4. Maintenance of Records. In addition to PBM's and PBM Contracting Providers' obligations under Section 5.3.2, PBM shall, and shall require PBM Contracting Providers to, retain books, contracts, documents, papers and records, including without limitation, medical records, patient care documentation, and other records that pertain to any aspect of services performed, financial solvency, reconciliation of benefit liabilities and determination of amounts payable under Health Plan's M divided by C Contract for a minimum of six (6) years from the end of the applicable one-year contract period in the M divided by C Contract or the completion of an audit, or in certain instances described in applicable Medicare+Choice regulations, for periods in excess of six (6) years, if appropriate. PBM shall, and shall require PBM Contracting Providers to, maintain such records accurately and update them on a regular basis. PBM and PBM's employees and agents shall, and shall require PBM Contracting Providers to, maintain the confidentiality of all Medicare Member records in accordance with the applicable laws and regulations, and shall safeguard Medicare Members' privacy. This provision shall survive termination of the Agreement.
5. Data Collection. PBM shall submit to Health Plan, upon request, all data necessary for Health Plan to fulfill its reporting obligations pursuant to 42 C.F.R.SS.422.516. PBM must submit to Health Plan all data, including medical records, necessary to characterize the content and purpose of each encounter with a Medicare Member. PBM must certify (based

on best knowledge, information and belief) the accuracy, completeness and truthfulness of such data on certification forms provided by Health Plan. PBM shall hold harmless and indemnify Health Plan for any fines or penalties it may incur due to PBM's submission of inaccurate or incomplete data.

6. Accountability. PBM acknowledges, and shall require PBM Contracting Providers to acknowledge, that Health Plan oversees and is responsible to HCFA for any functions or responsibilities provided or performed by PBM or PBM Contracting Providers pursuant to the M+C Contract, as applicable.
7. Delegation. If any service or activity to be performed by PBM under this Agreement is delegated, to the extent permitted by and in accordance with this Agreement, to a downstream entity, such entity shall enter into a contract with PBM obligating such entity to perform such service or activity consistent with and in compliance with the terms of this Agreement and the M+C Contract.
8. Continued Care. In addition to PBM's and PBM Contracting Providers' obligations pursuant to Section 3.8 of the Agreement, PBM shall, and shall require PBM Contracting Providers to, provide Covered Services to Medicare Members (i) for all Medicare Members, for the duration of the M+C Contract period for which HCFA payments have been made; and (ii) for Medicare Members who are hospitalized on the date the M+C Contract terminates or in the event of Health Plan's or PBM's insolvency, through discharge. This provision shall survive termination of the Agreement.
9. Compliance with Pharmacy Services Manual. PBM shall require PBM Contracting Providers to comply with PBM's Pharmacy Services Manual, including, without limitation, the Medicare Plus Choice Requirements addendum (the "Pharmacy Attachment"). PBM shall comply with those requirements of the Pharmacy Attachment applicable to the performance of PBM's obligations under this Agreement, including, without limitation, where an obligation is placed upon PBM Contracting Providers but such obligation may be performed or could be violated by PBM. In the event of a conflict between any provision in this ADDENDUM and the Pharmacy Attachment, this ADDENDUM shall govern.

AMENDMENT TO
UNITED HEALTHCARE SERVICES, INC.
PHARMACY BENEFIT MANAGEMENT AGREEMENT

This Amendment is made to the Pharmacy Benefit Management Agreement ("Agreement") between United HealthCare Services, Inc., UnitedHealth Networks, Inc. (collectively "United") and Merck-Medco Managed Care, L.L.C. ("PBM") dated November 11, 1998.

WHEREAS, the Agreement sets forth the obligations of the parties in order for United to make available pharmacy benefit management and related services to Health Plans and other non-Health Plan business and PBM agreed to provide such services; and

WHEREAS, the parties desire to amend the Agreement in order to add PAID Prescriptions, L.L.C. ("PAID") as a signatory to the Agreement.

NOW THEREFORE, in consideration of the terms and conditions set forth in this Addendum, the parties agree as follows:

1. PAID is a subsidiary of PBM and acts as a Third Party Administrator ("TPA") for PBM on behalf of United. PAID is licensed in certain states as a TPA as required by applicable law.
2. The parties agree that PAID is added as a signatory to the Agreement shall perform the TPA functions in the Agreement.
3. All other provisions of the Agreement shall remain in full force and effect.

United HealthCare Services, Inc.

Signature: /s/ William Munsell

Title: COO

Date: 3/28/01

United HealthNetworks, Inc.

Signature: Illegible

Title: Vice President

Date: 3/28/01

Marck-Medco Managed Care, L.L.C.

Signature: Illegible

Title: Vice President

Date: 4/12/01

PAID Prescriptions, L.L.C.

Signature: Illegible

Title: Vice President

Date: 4/12/01

LETTER AGREEMENT

United HealthCare Services, Inc.
9900 Bren Road East,
P.O. Box 1459 Minnetonka, MN 55343
Attention: William A. Munsell

Re: Pharmacy Benefit Management Management Agreement (the "Agreement")
between United HealthCare Services, Inc., on behalf of itself and its
affiliates from time to time, ("United HealthCare") and Merck-Medco
Managed Care, LLC, ("PBM").

United HealthCare and PBM agree to make the following changes to the
Agreement:

1. ***
2. ***
3. Rebate Contracting.
 - (a) PBM agrees to work with United HealthCare to negotiate new or amended rebate agreements with drug manufacturers by June 30, 2002 that will result in United HealthCare earning *** of incremental rebates (from amounts that would have been earned from manufacturers absent such new or amended agreements) on an annualized basis. As a condition to PBM's guarantee of such incremental rebates, United HealthCare agrees to use its best efforts to coordinate its formulary initiatives with PBM's negotiations with drug manufacturers for PBM's book of business generally.
 - (b) The *** included in (a) above shall be increased to *** in the event that United HealthCare *** in a preferred status by January 1, 2002 and maintains it on the PDL in a preferred status until at least June 30, 2003.
 - (c) ***
 - (d) If requested by United HealthCare, PBM will prepay the amounts set forth in (a) or (b) above by December 31, 2001.
4. ***
5. Effect of this Letter Agreement.

Except as specifically modified by this Letter Agreement, the Agreement and the letter agreement between the parties dated September 9, 1998 shall remain in effect.

6. Defined Terms.

Except as otherwise defined in this Letter Agreement, capitalized terms shall have the meanings set forth in the Agreement.

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission.

Except as otherwise defined in this Letter Agreement,
capitalized terms shall have the meanings set forth in the Agreement.

ACCEPTED AND AGREED:

UNITED HEALTHCARE
SERVICES, INC.

MERCK-MEDCO MANAGED
CARE, LLC.

BY: /s/ William A. Munsell

(signature)

BY: /s/ Glenn Taylor

(signature)

NAME: William A. Munsell

NAME: Glenn Taylor

TITLE: President, United Health Networks

TITLE: President -- United
Health Group Division

DATE: June 29, 2001

DATE: June 29, 2001

*** Represents text deleted pursuant to a confidentiality treatment request
filed with the Securities and Exchange Commission.

EXHIBIT A

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission.

AMENDMENT

United HealthCare Services, Inc. ("United HealthCare") and Merck-Medco Managed Care, LLC ("PBM") hereby agree to amend that certain letter agreement, executed June 29, 2001 by and between the parties, a copy of which is attached to this amendment as Attachment I (the "Letter Agreement"), as follows:

1. United Healthcare shall not be required to reinstall Prescriber Panel Edits*** Accordingly, PBM hereby waives section 2(c) of the Letter Agreement.
2. The programs relating to *** (collectively, the "Programs") set forth on Exhibit A to the Letter Agreement are hereby deleted. Accordingly, the attached Exhibit A Restatement dated October 26, 2001 hereby replaces Exhibit A to the Letter Agreement.
3. ***
4. ***
5. Except as otherwise defined in this Amendment, capitalized terms shall have the meanings set forth in the Pharmacy Benefit Management Agreement between United HealthCare and PBM that was executed by United HealthCare on November 11, 1998 (the "Agreement"). Except as specifically modified by this Amendment, the Agreement and the Letter Agreement shall remain in effect.

ACCEPTED AND AGREED as of the 26th day of October 2001.

United HealthCare Services, Inc.

Merck-Medco Managed Care, LLC

By: /s/ William Munsell

By: Glenn Taylor

Title: Vice President

Title: Sr. Vice President

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission.

EXHIBIT A RESTATEMENT
OCTOBER 26, 2001

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission.

AMENDMENT

United HealthCare Services, Inc., on behalf of itself and its affiliates from time to time (collectively, "United HealthCare") and Merck-Medco Managed Care, LLC ("PBM") hereby agree to make the following changes to the Pharmacy Benefit Management Agreement between United HealthCare and PBM that was executed by United HealthCare on November 11, 1998 (the "Agreement"):

1. Section 4.6 of the Agreement is hereby revised to read as follows:

"4.6 MINIMUM PDL ENROLLMENT. Effective as of December 11, 2001 and continuing throughout the term of this Agreement, United HealthCare agrees that it shall maintain a minimum of *** Covered Persons (including, as a subset thereof, at least *** non-Health Plan Covered Persons) receiving services under this Agreement including participating in United HealthCare's PDL.***"

2. Section 3.15 is hereby deleted from the Agreement.

3. Except as otherwise defined in this Amendment, capitalized terms shall have the meanings set forth in the Agreement. Except as specifically modified by this Amendment, the Agreement as heretofore amended shall remain in effect.

ACCEPTED AND AGREED as of the 19th day of December 2001.

United HealthCare Services, Inc.

Merck-Medco Managed Care, LLC

By: /s/ William A. Munsell

By: /s/ Glenn Taylor

Name: William A. Munsell

Name: Glenn Taylor

Title: Vice President

Title: Sr. Vice President

*** Represents text deleted pursuant to a confidentiality treatment request filed with the Securities and Exchange Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

LETTER RE UNAUDITED INTERIM FINANCIAL INFORMATION

August 13, 2003

UnitedHealth Group Incorporated:

We have made a review, in accordance with standards established by the American Institute of Certified Public Accountants, of the unaudited interim financial information of UnitedHealth Group Incorporated and Subsidiaries for the period ended June 30, 2003, as indicated in our report dated July 17, 2003; because we did not perform an audit, we expressed no opinion on that information.

We are aware that our report referred to above, which is included in your Quarterly Report on Form 10-Q for the quarter ended June 30, 2003, is incorporated by reference in Registration Statement File Nos. 333-66013, 33-22310, 33-50282, 33-59083, 33-59623, 33-63885, 33-67918, 33-68300, 33-75846, 333-02525, 333-04875, 333-25923, 333-44613, 333-45289, 333-50461, 333-66013, 333-71007, 333-81337, 333-87243, 333-88506, 333-90247, 333-46284, 333-55666, 333-100027, 333-105875, and 333-105877.

We also are aware that the aforementioned report, pursuant to Rule 436(c) under the Securities Act of 1933, is not considered a part of the Registration Statement prepared or certified by an accountant or a report prepared or certified by an accountant within the meaning of Sections 7 and 11 of that Act.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota

CERTIFICATIONS PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

Certification of Principal Executive Officer

I, William W. McGuire, M.D., Chairman and Chief Executive Officer of UnitedHealth Group Incorporated, certify that:

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

/s/ WILLIAM W. MCGUIRE, M.D.
William W. McGuire, M.D.
Chairman and Chief Executive Officer

Date: August 13, 2003

Certification of Principal Financial Officer

I, Patrick J. Erlandson, Chief Financial Officer of UnitedHealth Group Incorporated, certify that:

1. I have reviewed this quarterly report on Form 10-Q of UnitedHealth Group Incorporated (the “registrant”);

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and we have:

a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

c) disclosed in this report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant’s other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

/s/ PATRICK J. ERLANDSON

Patrick J. Erlandson
Chief Financial Officer

Date: August 13, 2003

CAUTIONARY STATEMENTS

The statements contained in this Quarterly Report on Form 10-Q include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (the “PSLRA”). When used in this Quarterly Report on Form 10-Q and in future filings by us with the Securities and Exchange Commission, in our press releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words or phrases “believes,” “anticipates,” “intends,” “will likely result,” “estimates,” “projects” or similar expressions are intended to identify such forward-looking statements. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

The following discussion contains certain cautionary statements regarding our business that investors and others should consider. This discussion is intended to take advantage of the “safe harbor” provisions of the PSLRA. Except to the extent otherwise required by federal securities laws, in making these cautionary statements, we do not undertake to address or update each factor in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected our past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Quarterly Report on Form 10-Q and in any other public statements we make may turn out to be wrong. They can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining future results. Consequently, no forward-looking statement can be guaranteed. Actual future results may vary materially from expectations expressed in our prior communications.

Health Care Costs. We use a large portion of our premium revenues to pay the costs of health care services delivered to our customers. Accordingly, the profitability of our risk-based products depends in large part on our ability to accurately predict, price for, and effectively manage health care costs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue is typically fixed in price for a 12-month period and is generally priced three months before contract commencement. Services are delivered and related costs are incurred when the contract commences. Although we base the premiums we charge on our estimate of future health care costs over the fixed premium period, inflation, regulations and other factors may cause actual health care costs to exceed what was estimated and reflected in premiums. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. Relatively small differences between predicted and actual medical costs as a percentage of premium revenues can result in significant changes in our financial results because of the relatively narrow operating margins of our risk-based arrangements. In addition, the financial results we report for any particular period include estimates of costs incurred for which the underlying claims have not been received by us or for which the claims have been received but not processed. If these estimates prove too high or too low, our earnings may be adjusted later based on actual costs.

Industry Factors. The health and well-being industries receive significant negative publicity and have been the subject of large jury verdicts. This publicity has been accompanied by litigation, legislative activity, regulation and governmental review of industry practices. These factors may adversely affect our ability to market our products or services, may require us to change our products and services, and may increase the regulatory burdens under which we operate, further increasing our costs of doing business and adversely affecting our profitability.

Competition. In many of our geographic or product markets, we compete with a number of other entities, some of which may have certain characteristics or capabilities that give them a competitive advantage. We believe the barriers to entry in certain markets are not substantial, so the addition of new competitors can occur relatively easily, and consumers enjoy significant flexibility in moving to competitors. Some of our

customers may decide to perform for themselves functions or services we provide, which would decrease our revenues. Some of our contracted physicians and other health care providers may decide to market products and services to our customers in competition with us. In addition, significant merger and acquisition activity has occurred in the industry in which we operate as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems industries. To the extent that there is strong competition or that competition intensifies in any market, our ability to retain or increase customers or contracted physicians and other health care providers, or maintain or increase our revenue growth, pricing flexibility, control over medical cost trends and marketing expenses may be adversely affected.

AARP Contract. Under our long-term contract with AARP, we provide Medicare Supplement and Hospital Indemnity health insurance and other products to AARP members. As of June 30, 2003, our portion of AARP's insurance program represented approximately \$3.8 billion in annual net premium revenue from approximately 3.6 million AARP members. The success of our AARP arrangement depends, in part, on our ability to service these customers, develop additional products and services, price the products and services competitively, and respond effectively to federal and state regulatory changes. Additionally, events that adversely affect AARP or one of its other business partners for its member insurance program could have an adverse effect on the success of our arrangement with AARP.

Government Programs. In response to medical cost increases that exceeded Medicare program reimbursement rate growth, we have withdrawn our Medicare+Choice product offerings from a number of counties and filed significant benefit adjustments in other counties. These and other actions have reduced Medicare+Choice enrollment and may result in further or complete withdrawal of Medicare+Choice product offerings, when and as permitted by our contracts with the CMS. Under current regulations, we are precluded from re-entering the counties from which we have withdrawn our Medicare+Choice product offerings until two years after the effective date of withdrawal.

The financial results of our Medicare+Choice, Medicaid and State Children's Health Insurance Program (SCHIP) operations depend on a number of factors, including program reimbursement increases, government regulations, benefit design, physician and other health care provider contracting, state budgetary pressures (Medicaid and SCHIP) and other factors. There can be no assurance that any or all of our government program operations will be profitable in future periods.

Government Regulation. Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. We must obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to consummate our acquisitions and dispositions. Delays in obtaining or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

We participate in federal, state and local government health care coverage programs. These programs generally are subject to frequent change, including changes that may reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or health care costs under such programs. Such changes have adversely affected our financial results and willingness to participate in such programs in the past and may do so in the future.

State legislatures and Congress continue to focus on health care issues. Legislative and regulatory proposals at state and federal levels may affect certain aspects of our business, including contracting with physicians, hospitals and other health care professionals; physician reimbursement methods and payment rates; coverage determinations; claim payments and processing; use and maintenance of individually identifiable health information; medical malpractice litigation; and government-sponsored programs. We cannot predict if any of these initiatives will ultimately become binding law or regulation, or, if enacted, what their terms will be, but their enactment could increase our costs, expose us to expanded liability, require us to revise the ways in which we conduct business or put us at risk for a loss of business.

We are also subject to various governmental investigations, audits and reviews. Such oversight could result in our loss of licensure or our right to participate in certain programs, or the imposition of civil or criminal fines, penalties and other sanctions. In addition, disclosure of any adverse investigation or audit results or sanctions could damage our reputation in various markets and make it more difficult for us to sell our products and services. We are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the CMS, state and health insurance departments and state attorneys general, the Office of Personnel Management, the Office of the Inspector General and U.S. Attorneys. Although the results of pending matters are always uncertain, we do not believe the results of any of the current investigations, audits or reviews, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

Our operations are conducted through our subsidiaries. These companies are subject to state regulations that, among other things, may require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Generally, the amount of dividend distributions that may be paid by our regulated subsidiaries, without prior approval by state regulatory authorities, is limited based on the subsidiary's level of statutory net income, statutory capital and surplus. We use cash generated from operations, commercial paper and debt to maintain adequate operating and financial flexibility. The agencies that assess our creditworthiness also consider statutory capital levels when establishing our debt ratings. We maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require.

Physician, Hospital and Other Health Care Provider Relations. One of the significant techniques we use to contain health care costs and facilitate care delivery is to contract with physicians, hospitals, pharmaceutical benefit managers and pharmaceutical manufacturers, and other health care providers for favorable prices. A number of organizations are advocating for legislation that would exempt certain of these physicians and health care professionals from federal and state antitrust laws. In any particular market, these physicians and health care professionals could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part.

Litigation and Insurance. Sometimes we become a party to the types of legal actions that can affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, and intellectual property-related litigation. In addition, because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design, management and offerings of our services. These matters include, but are not limited to, claims related to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. In 1999, a number of class action lawsuits were filed against us and virtually all major entities in the health benefits business. The suits are purported class actions on behalf of certain customers and physicians for alleged breaches of federal statutes, including ERISA and the Racketeer Influenced Corrupt Organization Act ("RICO"). We will incur expenses in the defense of these matters, even if they are without merit.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic, punitive and compensatory damages may be sought. We currently have insurance coverage for some of these potential liabilities. Other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of insurance may not be enough to cover the damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance. The cost of general business insurance coverage has increased significantly following the events of September 11, 2001. As a result, we have increased the amount of risk that we self-insure, particularly with respect to routine matters incidental to our business. We record liabilities for our estimates of the probable costs resulting from self-insured matters. Although we believe the liabilities established for these risks are adequate, there can be no assurance that the level of actual losses will not exceed the liabilities recorded.

Data Integrity and Information Systems. Our businesses depend significantly on effective information systems and the integrity of the data we use to run these businesses. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate and have upgraded and expanded our information systems capabilities. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could lose existing customers, have difficulty in attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory problems, have increases in operating expenses or suffer other adverse consequences. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. For example, the administrative simplification provisions of HIPAA and the Department of Labor's ERISA claim processing regulations required changes to our systems.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. Although there are a limited number of service organizations with the size, scale and capabilities to effectively provide certain of these services, especially with regard to pharmacy benefits processing and management, we believe that other organizations could provide similar services on comparable terms. A change in service providers, however, could result in a decline in service quality and effectiveness or less favorable contract terms which could adversely affect our operating results.

Proprietary Information and Privacy Regulations. The use of individually identifiable data by our businesses is regulated at international, federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Varying state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and HIPAA. HIPAA also imposes guidelines on our business associates (as this term is defined in the HIPAA regulations). Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Compliance with emerging proposals and new regulations may result in cost increases due to necessary systems changes, the development of new administrative processes, and the effects of potential noncompliance by our business associates. They also may impose further restrictions on our use of patient identifiable data that is housed in one or more of our administrative databases.

The success of our knowledge and information-related businesses also depends significantly on our ability to maintain proprietary rights to our databases and related products. We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation could have an adverse effect on the ability of our businesses to market and sell products and services and on our consolidated results of operations.

Administration and Management. Efficient and cost-effective administration of our operations is essential to our profitability and competitive positioning. Staff-related and other operating expenses may increase from time to time due to business or product start-ups or expansions, growth or changes in business or the mix of products purchased by customers, acquisitions, regulatory requirements or other reasons. Unanticipated expense increases may adversely affect our financial results. We believe we currently have an experienced, capable management and technical staff. The market for management and technical personnel, including information systems professionals, in the health care industry is very competitive. Loss of key employees or a

number of managers or technical staff could adversely affect our ability to administer and manage our business.

Marketing. We market our products and services through both employed sales people and independent sales agents. The departure of key sales employees or agents or a large subset of these individuals could impair our ability to retain existing customers. Some of our customers or potential customers consider our debt ratings, accreditation or certification by various private or governmental bodies or rating agencies necessary or important. Some of our health plans or other business units may not have obtained or maintained, or may not desire or be able to obtain or maintain, such ratings, accreditation or certification, which could adversely affect our ability to obtain or acquire or retain business from these customers and potential customers.

Acquisitions and Dispositions. We have an active ongoing acquisition and disposition program under which we may engage in transactions involving the acquisition or disposition of assets, products or businesses, some or all of which may be material. These transactions may entail risks and uncertainties and may affect ongoing business operations because of unknown liabilities, unforeseen administrative needs or the use of resources to integrate the acquired operations. Failure to identify liabilities, anticipate additional administrative needs or effectively integrate acquired operations could result in reduced revenues, increased administrative and other costs and customer dissatisfaction.

Terrorist Attacks. The terrorist attacks launched on September 11, 2001, the war on terrorism, the threat of future acts of terrorism and the related concerns of customers and providers have negatively affected, and may continue to negatively affect, the U.S. economy in general and our industry specifically. Depending on the government's actions and the responsiveness of public health agencies and insurance companies, future acts of terrorism and bio-terrorism could adversely affect us through, among other things, increased use of health care services including, without limitation, hospital and physician services; loss of membership in health plans we administer as a result of lay-offs or other reductions of employment; adverse effects upon the financial condition or business of employers who sponsor health care coverage for their employees; disruption of our information and payment systems; increased health care costs due to restrictions on our ability to carve out certain categories of risk, such as acts of terrorism; and disruption of the financial and insurance markets in general.

Financial Outlook. From time to time in press releases and otherwise, we may publish forecasts or other forward-looking statements regarding our future results, including estimated revenues, earnings per share and other operating and financial metrics. Any forecast of our future performance reflects various assumptions. These assumptions are subject to significant uncertainties, and any number of them may prove to be incorrect. Further, the achievement of any forecast depends on numerous factors (including those described in this discussion), many of which are beyond our control. As a result, we cannot assure that our performance will be consistent with any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire publicly available mix of historical and forward-looking information, as well as other available information affecting us and our services, when evaluating our prospective consolidated results of operations.

General Economic Conditions. Changes in economic conditions could affect our business and results of operations. The state of the economy affects our employer group renewal prospects and our ability to increase prices in some of our businesses. Although we are continuously striving to diversify our product offerings to address the changing needs of consumers, there can be no assurance that the effects of the current or a future downturn in economic conditions will not cause our existing customers to seek health coverage alternatives that we do not offer or will not result in significant loss of customers, or decreased margins on our continuing customers.

Stock Market. The market prices of the securities of the publicly-held companies in the industry in which we operate have shown volatility and sensitivity in response to many factors, including general market trends, public communications regarding managed care, litigation and judicial decisions, legislative or regulatory actions, health care cost trends, pricing trends, competition, earnings, membership reports of particular industry participants and acquisition activity. We cannot assure the level or stability of the price of our securities at any time or the effect of the foregoing or any other factors on such prices.