

# Financial Review

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## FINANCIAL HIGHLIGHTS

(in millions, except per share data)	For the Year Ended December 31,				
	2004 <sup>1</sup>	2003	2002	2001	2000
<b>CONSOLIDATED OPERATING RESULTS</b>					
Revenues	\$ 37,218	\$ 28,823	\$ 25,020	\$ 23,454	\$ 21,122
Earnings From Operations	\$ 4,101	\$ 2,935	\$ 2,186	\$ 1,566	\$ 1,200
Net Earnings	\$ 2,587	\$ 1,825	\$ 1,352	\$ 913	\$ 736
Return on Shareholders' Equity	31.4%	39.0%	33.0%	24.5%	19.8%
Basic Net Earnings					
per Common Share	\$ 4.13	\$ 3.10	\$ 2.23	\$ 1.46	\$ 1.14
Diluted Net Earnings					
per Common Share	\$ 3.94	\$ 2.96	\$ 2.13	\$ 1.40	\$ 1.09
Common Stock Dividends per Share	\$ 0.03	\$ 0.015	\$ 0.015	\$ 0.015	\$ 0.008
<b>CONSOLIDATED CASH FLOWS FROM (USED FOR)</b>					
Operating Activities	\$ 4,135	\$ 3,003	\$ 2,423	\$ 1,844	\$ 1,521
Investing Activities	\$ (1,644)	\$ (745)	\$ (1,391)	\$ (1,138)	\$ (968)
Financing Activities	\$ (762)	\$ (1,126)	\$ (1,442)	\$ (585)	\$ (739)
<b>CONSOLIDATED FINANCIAL CONDITION</b>					
(As of December 31)					
Cash and Investments	\$ 12,253	\$ 9,477	\$ 6,329	\$ 5,698	\$ 5,053
Total Assets	\$ 27,879	\$ 17,634	\$ 14,164	\$ 12,486	\$ 11,053
Debt	\$ 4,023	\$ 1,979	\$ 1,761	\$ 1,584	\$ 1,209
Shareholders' Equity	\$ 10,717	\$ 5,128	\$ 4,428	\$ 3,891	\$ 3,688
Debt-to-Total-Capital Ratio	27.3%	27.8%	28.5%	28.9%	24.7%

Financial Highlights and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

<sup>1</sup> UnitedHealth Group acquired Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately \$5.0 billion and acquired Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately \$2.7 billion. These acquisitions affect the comparability of 2004 financial information to prior fiscal years. The results of operations and financial condition of Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates. See Note 3 to the consolidated financial statements for a detailed discussion of these acquisitions.

### Business Overview

UnitedHealth Group is a diversified health and well-being company, serving approximately 55 million Americans. Our focus is on improving the American health care system by simplifying the administrative components of health care delivery; promoting evidence-based medicine as the standard for care; and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and informatics; and health care resource organization and care facilitation to make health care work better. We provide individuals with access to quality, cost-effective health care services and resources. We promote the delivery of care, consistent with the best available evidence for effective health care. We provide employers with superb value, service and support, and we deliver value to our shareholders by executing a business strategy founded upon a commitment to balanced growth, profitability and capital discipline.

### 2004 Financial Performance Highlights

UnitedHealth Group had an excellent year in 2004. The company achieved diversified growth across its business segments and generated net earnings of \$2.6 billion and operating cash flows of \$4.1 billion, representing increases of 42% and 38%, respectively, over 2003. Other financial performance highlights include:

- > Diluted net earnings per common share of \$3.94, representing an increase of 33% over 2003.
- > Revenues of \$37.2 billion, a 29% increase over 2003. Excluding the impact of acquisitions, revenues increased 8% over 2003.
- > Operating earnings of more than \$4.1 billion, up 40% over 2003.
- > Consolidated operating margin of 11.0%, up from 10.2% in 2003, driven primarily by improved margins on risk-based products, revenue mix changes and operational and productivity improvements.
- > Return on shareholders' equity of 31.4%.

UnitedHealth Group acquired Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately \$5.0 billion and acquired Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately \$2.7 billion. The results of operations and financial condition of Oxford and MAMSI have been included in UnitedHealth Group's Consolidated Financial Statements since the respective acquisition dates.

## 2004 Results Compared to 2003 Results

### CONSOLIDATED FINANCIAL RESULTS

#### *Revenues*

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

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers' 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 \$8.4 billion, or 29%, in 2004 to \$37.2 billion, primarily as a result of revenues from businesses acquired since the beginning of 2003. Excluding the impact of these acquisitions, consolidated revenues increased by approximately 8% in 2004 as a result of rate increases on premium-based and fee-based services and growth across business segments. Following is a discussion of 2004 consolidated revenue trends for each of our three revenue components.

**Premium Revenues** Consolidated premium revenues in 2004 totaled \$33.5 billion, an increase of \$8.0 billion, or 32%, over 2003. Excluding the impact of acquisitions, premium revenues increased by approximately 8% in 2004. This increase was due in part to average net premium rate increases of approximately 9% on UnitedHealthcare's renewing commercial risk-based business, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products and changes in the commercial product benefit and customer mix. In addition, Ovations' premium revenues increased largely due to increases in the number of individuals it serves through Medicare Advantage products and changes in product mix related to Medicare supplement products, as well as rate increases on all of these products. Premium revenues from AmeriChoice's Medicaid programs and Specialized Care Services' businesses also increased due to advances in the number of individuals served by those businesses.

**Service Revenues** Service revenues in 2004 totaled \$3.3 billion, an increase of \$217 million, or 7%, over 2003. The increase in service revenues was driven primarily by aggregate growth of 4% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2004, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased due to new business growth in the health information and clinical research businesses.

**Investment and Other Income** Investment and other income totaled \$388 million, representing an increase of \$131 million over 2003. Interest income increased by \$134 million in 2004, principally due to the impact of increased levels of cash and fixed-income investments during the year from the acquisitions of Oxford, MAMSI and Golden Rule Financial Corporation (Golden Rule), which was acquired in November 2003. Net capital gains on sales of investments were \$19 million in 2004, a decrease of \$3 million from 2003.

### ***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).

The consolidated medical care ratio decreased from 81.4% in 2003 to 80.6% in 2004. Excluding the AARP business<sup>1</sup>, the medical care ratio decreased 50 basis points from 80.0% in 2003 to 79.5% in 2004. The medical care ratio decrease resulted primarily from net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in product, business and customer mix.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to 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 2004 include approximately \$210 million of favorable medical cost development related to prior fiscal years. Medical costs for 2003 include approximately \$150 million of favorable medical cost development related to prior fiscal years.

On an absolute dollar basis, 2004 medical costs increased \$6.3 billion, or 30%, over 2003 principally due to the impact of the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, medical costs increased by approximately 8% driven primarily by medical cost inflation and a moderate increase in health care consumption.

### ***Operating Costs***

The operating cost ratio (operating costs as a percentage of total revenues) for 2004 was 15.4%, down from 16.9% in 2003. This decrease was driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. The existence of premium revenues within our risk-based products cause them to have lower operating cost ratios than fee-based products, which have no premium revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for 2004 increased \$868 million, or 18%, over 2003 primarily due to the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, operating costs increased by approximately 3%. This increase was driven by a more than 3% increase in the total number of individuals served by Health Care Services and Uniprise in 2004, excluding the impact of acquisitions, and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

### ***Depreciation and Amortization***

Depreciation and amortization in 2004 was \$374 million, an increase of \$75 million, or 25%, over 2003. Approximately \$42 million of this increase is related to intangible assets acquired in business acquisitions in 2004. The remaining increase of \$33 million is due to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2003.

<sup>1</sup>Management 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 the overall benefit of the 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, we have 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.

### *Income Taxes*

Our effective income tax rate was 34.9% in 2004, compared to 35.7% in 2003. The decrease was driven mainly by favorable settlements of prior year income tax returns.

### **BUSINESS SEGMENTS**

The following summarizes the operating results of our business segments for the years ended December 31 (in millions):

<b>REVENUES</b>	<b>2004</b>	<b>2003</b>	<b>Percent Change</b>
Health Care Services	<b>\$ 32,673</b>	\$ 24,807	32%
Uniprise	<b>3,365</b>	3,107	8%
Specialized Care Services	<b>2,295</b>	1,878	22%
Ingenix	<b>670</b>	574	17%
Corporate and Eliminations	<b>(1,785)</b>	(1,543)	nm
Consolidated Revenues	<b>\$ 37,218</b>	\$ 28,823	29%

<b>EARNINGS FROM OPERATIONS</b>	<b>2004</b>	<b>2003</b>	<b>Percent Change</b>
Health Care Services	<b>\$ 2,810</b>	\$ 1,865	51%
Uniprise	<b>677</b>	610	11%
Specialized Care Services	<b>485</b>	385	26%
Ingenix	<b>129</b>	75	72%
Consolidated Earnings From Operations	<b>\$ 4,101</b>	\$ 2,935	40%

nm — not meaningful

### *Health Care Services*

The Health Care Services segment consists of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare coordinates network-based health and well-being services on behalf of multistate, mid-sized and local employers and consumers. Ovations delivers health and well-being services to Americans over the age of 50, including the administration of supplemental health insurance coverage on behalf of AARP. AmeriChoice facilitates and manages health care services for state-sponsored Medicaid programs and their beneficiaries.

Health Care Services had revenues of \$32.7 billion in 2004, representing an increase of \$7.9 billion, or 32%, over 2003, driven primarily by acquisitions since the beginning of 2003. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately \$1.9 billion, or 8%, over 2003. UnitedHealthcare accounted for approximately \$850 million of this increase, driven by average premium rate increases of approximately 9% on renewing commercial risk-based business and growth in the number of individuals served by fee-based products, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations contributed approximately \$770 million to the revenue advance over 2003 driven by growth in the number of individuals served by Ovations' Medicare Advantage products and changes in product mix related to Medicare supplement products it provides to AARP members, as well as rate increases on all of these products. The remaining increase in Health Care Services revenues is attributable to growth in the number of individuals served by AmeriChoice's Medicaid programs and Medicaid premium rate increases.

Health Care Services earnings from operations in 2004 were \$2.8 billion, representing an increase of \$945 million, or 51%, over 2003. This increase primarily resulted from Ovations' and UnitedHealthcare's revenue growth, improved gross margins on UnitedHealthcare's commercial risk-based products and the impact of the acquisitions of Oxford, MAMSI and Golden Rule. UnitedHealthcare's commercial medical care ratio improved to 79.0% in 2004 from 80.0% in 2003. The decrease in the commercial medical care ratio was primarily driven by net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in business and customer mix. Health Care Services' 2004 operating margin was 8.6%, an increase of 110 basis points over 2003. This increase was principally driven by a combination of the improved commercial medical care ratio and changes in business and customer mix.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31<sup>1</sup>:

(in thousands)	2004	2003
Commercial		
Risk-Based	7,655	5,400
Fee-Based	3,305	2,895
Total Commercial	10,960	8,295
Medicare	330	230
Medicaid	1,260	1,105
Total Health Care Services	12,550	9,630

<sup>1</sup> Excludes individuals served by Ovations' Medicare supplement products provided to AARP members.

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2004, increased by nearly 2.7 million, or 32%, over the prior year. Excluding the 2004 acquisitions of Oxford, MAMSI and a smaller regional health plan, the number of individuals served by UnitedHealthcare's commercial business increased by 245,000. This included an increase of 285,000 in the number of individuals served with fee-based products, driven by new customer relationships and existing customers converting from risk-based products to fee-based products, partially offset by a decrease of 40,000 in the number of individuals served with risk-based products resulting primarily from customers converting to self-funded, fee-based arrangements and a competitive commercial risk-based pricing environment.

Excluding the impact of the Oxford acquisition, the number of individuals served by Ovations' Medicare Advantage products increased by 30,000, or 13%, from 2003. AmeriChoice's Medicaid enrollment increased by 155,000, or 14%, due to organic growth in the number of individuals served and the acquisition of a Medicaid health plan in Michigan in February 2004, resulting in the addition of approximately 95,000 individuals served.

### ***Uniprise***

Uniprise provides network-based health and well-being services, business-to-business transaction processing services, consumer connectivity and technology support services to large employers and health plans, and provides health-related consumer and financial transaction products and services. Uniprise revenues in 2004 were \$3.4 billion, representing an increase of 8% over 2003. This increase was driven primarily by growth of 4% in the number of individuals served by Uniprise, excluding the impact of the acquisition of Definity Health Corporation (Definity) in December 2004, and annual service fee rate increases for self-insured customers. Uniprise served 9.9 million individuals and 9.1 million individuals as of December 31, 2004 and 2003, respectively.

Uniprise earnings from operations in 2004 were \$677 million, representing an increase of 11% over 2003. Operating margin for 2004 improved to 20.1% from 19.6% in 2003. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in 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***

Specialized Care Services is a portfolio of specialty health and wellness companies, each serving a specialized market need with a unique offering of benefits, networks, services and resources. Specialized Care Services revenues during 2004 of \$2.3 billion increased by \$417 million, or 22%, over 2003. This increase was principally driven by an increase in the number of individuals served by United Behavioral Health, its behavioral health benefits business, Dental Benefit Providers, its dental services business, and Spectera, its vision care benefits business; rate increases related to these businesses; and incremental revenues related to businesses acquired since the beginning of 2003 of approximately \$100 million.

Earnings from operations in 2004 of \$485 million increased \$100 million, or 26%, over 2003. Specialized Care Services' operating margin increased to 21.1% in 2004, up from 20.5% in 2003. This increase was driven primarily by operational and productivity improvements within Specialized Care Services' businesses and consolidation of the production and service operation infrastructure to enhance productivity and efficiency and to improve the quality and consistency of service, partially offset by a business mix shift toward higher revenue, lower margin products.

#### ***Ingenix***

Ingenix is a leader in the field of health care data analysis and application, serving pharmaceutical companies, health insurers and other payers, physicians and other health care providers, large employers, and governments. Ingenix revenues in 2004 of \$670 million increased by \$96 million, or 17%, over 2003. This was driven primarily by new business growth in the health information and clinical research businesses.

Earnings from operations in 2004 were \$129 million, up \$54 million, or 72%, from 2003. Operating margin was 19.3% in 2004, up from 13.1% in 2003. The increase in earnings from operations and operating margin was primarily due to growth and improving gross margins in the health information and clinical research businesses.

## 2003 Results Compared to 2002 Results

### CONSOLIDATED FINANCIAL RESULTS

#### *Revenues*

Consolidated revenues increased by \$3.8 billion, or 15%, in 2003 to \$28.8 billion. Consolidated revenues increased by approximately 11% as a result of rate increases on premium-based and fee-based services and growth across business segments, and 4% as a result of revenues from businesses acquired since the beginning of 2002. Following is a discussion of 2003 consolidated revenue trends for each of our three revenue components.

**Premium Revenues** Consolidated premium revenues in 2003 totaled \$25.4 billion, an increase of \$3.5 billion, or 16%, over 2002. UnitedHealthcare premium revenues increased by \$1.8 billion, driven primarily by average premium rate increases of 12% to 13% on renewing commercial risk-based business. Premium revenues from Medicaid programs also increased by approximately \$1.0 billion over 2002. Approximately 70% of this increase resulted from the acquisition of AmeriChoice on September 30, 2002, with the remaining 30% driven by growth in the number of individuals served by our AmeriChoice Medicaid programs since the acquisition date. The remaining premium revenue growth in 2003 was primarily driven by growth in the number of individuals served by Ovations' Medicare supplement products provided to AARP members and its Evercare business, along with growth in several of Specialized Care Services' businesses.

**Service Revenues** Service revenues in 2003 totaled \$3.1 billion, an increase of \$224 million, or 8%, over 2002. The increase in service revenues was driven primarily by aggregate growth of 7% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2003.

**Investment and Other Income** Investment and other income totaled \$257 million, representing an increase of \$37 million over 2002, due primarily to increased capital gains on sales of investments. Net capital gains on sales of investments were \$22 million in 2003, compared with net capital losses of \$18 million in 2002. Interest income decreased by \$3 million in 2003, driven by lower yields on investments, partially offset by the impact of increased levels of cash and fixed-income investments.

#### *Medical Costs*

The consolidated medical care ratio decreased from 83.0% in 2002 to 81.4% in 2003. Excluding the AARP business, the medical care ratio decreased 140 basis points from 81.4% in 2002 to 80.0% in 2003. The medical care ratio decrease resulted primarily from net premium rate increases that exceeded overall medical benefit cost increases and changes in product, business and customer mix.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to 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 2003 include approximately \$150 million of favorable medical cost development related to prior fiscal years. Medical costs for 2002 include approximately \$70 million of favorable medical cost development related to prior fiscal years.

On an absolute dollar basis, 2003 medical costs increased \$2.5 billion, or 14%, over 2002. The increase was driven primarily by a rise in medical costs of approximately 10% to 11% due to medical cost inflation and a moderate increase in health care consumption, and incremental medical costs related to businesses acquired since the beginning of 2002.

### ***Operating Costs***

The operating cost ratio for 2003 was 16.9%, down from 17.5% in 2002. This decrease was driven primarily by revenue mix changes, with greater growth from premium revenues than from service revenues, and productivity gains from technology deployment and other cost management initiatives. Our premium-based products have lower operating cost ratios than our fee-based products. The impact of operating cost efficiencies in 2003 was partially offset by the continued incremental costs associated with the development, deployment, adoption and maintenance of new technology releases.

On an absolute dollar basis, operating costs for 2003 increased \$488 million, or 11%, over 2002. This increase was driven by a 6% increase in total individuals served by Health Care Services and Uniprise during 2003, increases in broker commissions and premium taxes due to increased revenues, general operating cost inflation, and additional operating costs associated with change initiatives and acquired businesses.

### ***Depreciation and Amortization***

Depreciation and amortization in 2003 was \$299 million, an increase of \$44 million over 2002. This increase was due to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2002.

### ***Income Taxes***

Our effective income tax rate was 35.7% in 2003, compared to 35.5% in 2002. The change from 2002 was due to changes in business and income mix among states with differing income tax rates.

## **BUSINESS SEGMENTS**

The following summarizes the operating results of our business segments for the years ended December 31 (in millions):

<b>REVENUES</b>	<b>2003</b>	<b>2002</b>	<b>Percent Change</b>
Health Care Services	\$ 24,807	\$ 21,552	15%
Uniprise	3,107	2,725	14%
Specialized Care Services	1,878	1,509	24%
Ingenix	574	491	17%
Corporate and Eliminations	(1,543)	(1,257)	nm
Consolidated Revenues	\$ 28,823	\$ 25,020	15%

  

<b>EARNINGS FROM OPERATIONS</b>	<b>2003</b>	<b>2002</b>	<b>Percent Change</b>
Health Care Services	\$ 1,865	\$ 1,328	40%
Uniprise	610	517	18%
Specialized Care Services	385	286	35%
Ingenix	75	55	36%
Consolidated Earnings From Operations	\$ 2,935	\$ 2,186	34%

nm — not meaningful

### **Health Care Services**

Health Care Services had revenues of \$24.8 billion in 2003, representing an increase of \$3.3 billion, or 15%, over 2002. The majority of the increase resulted from an increase of \$1.9 billion in UnitedHealthcare revenues, an increase of 14% over 2002. The increase in UnitedHealthcare revenues was driven by average premium rate increases of approximately 12% to 13% on renewing commercial risk-based business and 8% growth in the number of individuals served by fee-based products during 2003. Revenues from Medicaid programs in 2003 increased by \$1.0 billion over 2002. Approximately 70% of this increase resulted from the acquisition of AmeriChoice on September 30, 2002, with the remaining 30% driven by growth in the number of individuals served by AmeriChoice Medicaid programs since the acquisition date. Ovation's revenues increased by \$319 million, or 5%, primarily due to increases in the number of individuals served by both its Medicare supplement products provided to AARP members and by its Evercare business.

Health Care Services earnings from operations in 2003 were nearly \$1.9 billion, representing an increase of \$537 million, or 40%, over 2002. This increase primarily resulted from revenue growth and improved gross margins on UnitedHealthcare's risk-based products, growth in the number of individuals served by UnitedHealthcare's fee-based products, and the acquisition of AmeriChoice on September 30, 2002. UnitedHealthcare's commercial medical care ratio improved to 80.0% in 2003 from 81.8% in 2002. The decrease in the commercial medical care ratio was driven primarily by the decrease in net premium rate increases that exceeded overall medical benefit cost increases and changes in business and customer mix. Health Care Services' 2003 operating margin was 7.5%, an increase of 130 basis points over 2002. This increase was driven by a combination of improved medical care ratios and a shift in commercial product mix from risk-based products to higher-margin, fee-based products.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31<sup>1</sup>:

(in thousands)	2003	2002
Commercial		
Risk-Based	5,400	5,070
Fee-Based	2,895	2,715
Total Commercial	8,295	7,785
Medicare	230	225
Medicaid	1,105	1,030
Total Health Care Services	9,630	9,040

<sup>1</sup> Excludes individuals served by Ovation's Medicare supplement products provided to AARP members.

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2003, increased by 510,000, or 7%, over the prior year. This included an increase of 180,000, or 7%, in the number of individuals served with fee-based products, driven by new customer relationships and existing customers converting from risk-based products to fee-based products. In addition, the number of individuals served by risk-based products increased by 330,000. This increase was driven by the acquisition of Golden Rule in November 2003, which resulted in the addition of 430,000 individuals served, partially offset by customers converting to self-funded, fee-based arrangements and UnitedHealthcare's targeted withdrawal of risk-based offerings from unprofitable arrangements with customers using multiple benefit carriers.

Ovation's year-over-year Medicare Advantage enrollment remained relatively stable, with 230,000 individuals served as of December 31, 2003. Medicaid enrollment increased by 75,000, or 7%, due to strong growth in the number of individuals served by AmeriChoice over the past year.

### *Uniprise*

Uniprise revenues in 2003 were \$3.1 billion, representing an increase of 14% over 2002. This increase was driven primarily by growth of 6% in the number of individuals served by Uniprise during 2003, annual service fee rate increases for self-insured customers, and a change in customer funding mix during 2002. Uniprise served 9.1 million individuals and 8.6 million individuals as of December 31, 2003 and 2002, respectively.

Uniprise earnings from operations in 2003 were \$610 million, representing an increase of 18% over 2002. Operating margin for 2003 improved to 19.6% from 19.0% in 2002. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction processing and customer service, billing and enrollment functions.

### *Specialized Care Services*

Specialized Care Services revenues during 2003 of \$1.9 billion increased by \$369 million, or 24%, over 2002. This increase was principally driven by an increase in the number of individuals served by United Behavioral Health, its behavioral 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 in 2003 of \$385 million increased \$99 million, or 35%, over 2002. Specialized Care Services' operating margin increased to 20.5% in 2003, up from 19.0% in 2002. This increase was driven primarily by operational and productivity improvements at United Behavioral Health.

### *Ingenix*

Ingenix revenues in 2003 of \$574 million increased by \$83 million, or 17%, over 2002. This was driven primarily by new business growth in the health information business. Earnings from operations in 2003 were \$75 million, up \$20 million, or 36%, from 2002. Operating margin was 13.1% in 2003, up from 11.2% in 2002. The increase in the operating margin was primarily due to growth in the health information business.

## Financial Condition, Liquidity and Capital Resources at December 31, 2004

### **LIQUIDITY AND CAPITAL RESOURCES**

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 strong financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from operations. 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 cash of regulated subsidiaries that exceed our short-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. Cash 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 for general corporate use. Cash flows generated by these entities, combined with the issuance of commercial paper, long-term debt and the availability of committed credit facilities, further strengthen our operating and financial flexibility. We generally use these cash flows 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 flows generated from operating activities, our primary source of liquidity, are 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 level of profitability of our risk-based business depends in large part on our ability to accurately predict and price for health care and operating cost increases. This risk is partially mitigated by the diversity of our other businesses, the geographic diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs. In 2004, a hypothetical unexpected 1% increase in commercial insured medical costs would have reduced net earnings by approximately \$105 million.

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, debt covenants and other 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 flows from operating activities were \$4.1 billion in 2004, representing an increase over 2003 of \$1.1 billion, or 38%. This increase in operating cash flows resulted primarily from an increase of \$871 million in net income excluding depreciation, amortization and other noncash items. Additionally, operating cash flows increased by \$261 million due to cash generated by working capital changes, driven in part by improved cash collections leading to decreases in accounts receivable and increases in unearned premiums, and an increase in medical costs payable. As premium revenues and related medical costs increase, we generate incremental operating cash flows because we collect premium revenues in advance of the claim payments for related medical costs.

We maintained a strong financial condition and liquidity position, with cash and investments of \$12.3 billion at December 31, 2004. Total cash and investments increased by \$2.8 billion since December 31, 2003, primarily due to \$2.4 billion in cash and investments acquired in the Oxford and MAMSI acquisitions and strong operating cash flows, partially offset by common stock repurchases, cash paid for business acquisitions 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 December 31, 2004, approximately \$227 million of our \$12.3 billion of cash and investments was held by non-regulated subsidiaries. Of this amount, approximately \$37 million was segregated for future regulatory capital needs and the remainder was available for general corporate use, including acquisitions and share repurchases.

#### **FINANCING AND INVESTING ACTIVITIES**

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of December 31, 2004 and 2003, we had commercial paper and debt outstanding of approximately \$4.0 billion and \$2.0 billion, respectively. Our debt-to-total-capital ratio was 27.3% and 27.8% as of December 31, 2004 and December 31, 2003, respectively. We believe the prudent use of debt leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

On July 29, 2004, our Health Care Services business segment acquired Oxford. Under the terms of the purchase agreement, Oxford shareholders received 0.6357 shares of UnitedHealth Group common stock and \$16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately \$5.0 billion, comprised of approximately 52.2 million shares of UnitedHealth Group common stock (valued at approximately \$3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately \$1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of \$240 million issued in exchange for Oxford's outstanding vested common stock options.

On February 10, 2004, our Health Care Services business segment acquired MAMSI. Under the terms of the purchase agreement, MAMSI shareholders received 0.82 shares of UnitedHealth Group common stock and \$18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately \$2.7 billion, comprised of 36.4 million shares of UnitedHealth Group common stock (valued at \$1.9 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and approximately \$800 million in cash.

On December 10, 2004, our Uniprise business segment acquired Definity. Under the terms of the purchase agreement, we paid \$305 million in cash in exchange for all of the outstanding stock of Definity. Available cash and commercial paper issuance financed the Definity purchase price.

In July 2004, we issued \$1.2 billion of commercial paper to fund the cash portion of the Oxford purchase price. In August 2004, we refinanced the commercial paper by issuing \$550 million of 3.4% fixed-rate notes due August 2007, \$450 million of 4.1% fixed-rate notes due August 2009 and \$500 million of 5.0% fixed-rate notes due August 2014.

In February 2004, we issued \$250 million of 3.8% fixed-rate notes due February 2009 and \$250 million of 4.8% fixed-rate notes due February 2014. We used the proceeds from the February 2004 borrowings to finance a majority of the cash portion of the MAMSI purchase price as described above.

In December and March 2003, we issued \$500 million of four-year, fixed-rate notes and \$450 million of 10-year, fixed-rate notes with interest rates of 3.3% and 4.9%, respectively. We used the proceeds from the 2003 borrowings to repay commercial paper and maturing term debt, and for general corporate purposes including working capital, capital expenditures, business acquisitions and share repurchases.

We entered into interest rate swap agreements to convert our interest exposure on a majority of these 2003 and 2004 borrowings from a fixed to a variable rate. The interest rate swap agreements on these borrowings have aggregate notional amounts of \$2.9 billion. At December 31, 2004, the rate used to accrue interest expense on these agreements ranged from 2.3% to 3.3%. 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 Consolidated Statements of Operations.

In June 2004, we executed a \$1.0 billion five-year revolving credit facility to support our commercial paper program. This credit facility replaced our existing \$450 million revolving facility that was set to expire in July 2005, and our \$450 million, 364-day facility that was set to expire in July 2004. As of December 31, 2004, we had no amounts outstanding under this credit facility. Commercial paper increased from \$79 million at December 31, 2003, to \$273 million at December 31, 2004.

Our debt arrangements and credit facility contain various covenants, the most restrictive of which require us to maintain a 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) 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” with a positive outlook by Moody’s. Our commercial paper is rated “A-1” by S&P, “F-1” by Fitch, and “P-2” with a positive outlook 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 approximately 30% or less. A significant downgrade in our debt or commercial paper ratings could adversely affect our borrowing capacity and costs.

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 2004, we repurchased 51.4 million shares at an average price of approximately \$68 per share and an aggregate cost of approximately \$3.5 billion. As of December 31, 2004, we had board of directors’ authorization to purchase up to an additional 54.6 million shares of our common stock. Our common stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of capital. A decision by the company to discontinue share repurchases would significantly increase our liquidity and financial flexibility.

Under our S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities), the remaining issuing capacity of all covered securities is \$500 million. We intend to file a new S-3 shelf registration statement during the first half of 2005 to increase our remaining issuing capacity. 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 24.3 million shares of our common stock in connection with acquisition activities. We filed separate S-4 registration statements for the 36.4 million shares issued in connection with the February 2004 acquisition of MAMSI and for the 52.2 million shares issued in connection with the July 2004 acquisition of Oxford described previously.

#### **CONTRACTUAL OBLIGATIONS, OFF-BALANCE SHEET ARRANGEMENTS AND COMMITMENTS**

The following table summarizes future obligations due by period as of December 31, 2004, under our various contractual obligations, off-balance sheet arrangements and commitments (in millions):

	2005	2006 to 2007	2008 to 2009	Thereafter	Total
Debt and Commercial Paper <sup>1</sup>	\$ 673	\$ 950	\$1,200	\$1,200	\$ 4,023
Operating Leases	126	222	140	149	637
Purchase Obligations <sup>2</sup>	103	69	12	–	184
Future Policy Benefits <sup>3</sup>	107	272	224	1,173	1,776
Other Long-Term Obligations <sup>4</sup>	–	–	58	212	270
Total Contractual Obligations	\$1,009	\$1,513	\$1,634	\$2,734	\$ 6,890

<sup>1</sup> Debt payments could be accelerated upon violation of debt covenants. We believe the likelihood of a debt covenant violation is remote.

<sup>2</sup> Minimum commitments under existing purchase obligations for goods and services.

<sup>3</sup> Estimated payments required under life and annuity contracts.

<sup>4</sup> Includes obligations associated with certain employee benefit programs and minority interest purchase commitments.

Currently, we do not have any other material contractual obligations, off-balance sheet arrangements or commitments that require cash resources; however, we continually evaluate opportunities to expand our operations. This includes internal development of new products, programs and technology applications, and may include acquisitions.

## AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. 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 were approximately \$4.5 billion in 2004, \$4.1 billion in 2003 and \$3.7 billion in 2002.

The underwriting gains or losses related to the AARP business are directly 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 the overall benefit of the 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. As further described in Note 11 to the consolidated financial statements, the RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

## 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. As of December 31, 2004, our regulated subsidiaries had aggregate statutory capital of approximately \$4.1 billion, which is significantly more than the aggregate minimum regulatory requirements.

## Critical Accounting Policies and Estimates

Critical accounting policies are those policies that require management to make the most challenging, subjective or complex 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. We believe our most critical accounting policies are those described below. For a detailed discussion of these and other accounting policies, see Note 2 to the consolidated financial statements.

## 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, and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical care services incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such 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.

Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to 12 months from the date of service. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we increase or decrease the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. 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 prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Historically, the net impact of estimate developments has represented less than one-half of 1% of annual medical costs, less than 4% of annual earnings from operations and less than 3% of medical costs payable.

In order to evaluate the impact of changes in medical cost 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)
2001	\$ 30	\$ (40)	\$ 17,644	\$ 17,604	\$ 1,566	\$ 1,606
2002	\$ 70	\$ (80)	\$ 18,192	\$ 18,112	\$ 2,186	\$ 2,266
2003	\$ 150	\$ (60)	\$ 20,714	\$ 20,654	\$ 2,935	\$ 2,995
2004	\$ 210	(c)	\$ 27,000	(c)	\$ 4,101	(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) Not yet determinable as the amount of prior period development recorded in 2005 will change as our December 31, 2004 medical costs payable estimate develops throughout 2005.

Our estimate of medical costs payable represents management's best estimate of the company's liability for unpaid medical costs as of December 31, 2004, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover the company's liability for unpaid claims as of December 31, 2004; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our December 31, 2004 estimates of medical costs payable and actual costs payable, excluding the AARP business, 2004 earnings from operations would increase or decrease by \$46 million and diluted net earnings per common share would increase or decrease by approximately \$0.05 per share.

### **LONG-LIVED ASSETS**

As of December 31, 2004, we had long-lived assets, including goodwill, other intangible assets, property, equipment and capitalized software, of \$11.8 billion. We review our goodwill for impairment annually at the reporting unit level, and we review our remaining long-lived assets for impairment when events and changes in circumstances indicate we might not recover their carrying value. To determine the fair value of the respective assets and assess the recoverability of our long-lived assets, we must make assumptions about a wide variety of internal and external factors including estimated future utility and estimated future cash flows, which in turn are based on estimates of future revenues, expenses and operating margins. If these estimates or their related assumptions change in the future, we may be required to record impairment charges for these assets that could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs.

### **INVESTMENTS**

As of December 31, 2004, we had approximately \$8.3 billion of investments, primarily held in marketable debt securities. Our investments are principally classified as available for sale and are recorded at fair value. We exclude unrealized gains and losses on investments available for sale from earnings and report them together, net of income tax effects, as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2004, our investments had gross unrealized gains of \$215 million and gross unrealized losses of \$11 million. If any of our investments experience a decline in fair value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in our Consolidated Statements of Operations. Management judgment is involved in evaluating whether a decline in an investment's fair value is other than temporary. New information and the passage of time can change these judgments. We revise impairment judgments when new information becomes known and record any resulting impairment charges at that time. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

### **REVENUES**

Revenues are principally derived from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services, as recorded in our records. Employer groups generally provide us with changes to their eligible population one month in arrears. Each billing includes an adjustment for prior month changes in eligibility status that were not reflected in our previous billing. We estimate and adjust the current period's revenues and accounts receivable accordingly. Our estimates are based on historical trends, premiums billed, the level of contract renewal activity and other relevant information. We revise estimates of revenue adjustments each period, and record changes in the period they become known.

### **CONTINGENT LIABILITIES**

Because of the nature of our businesses, we are routinely involved in various disputes, legal proceedings and governmental audits and investigations. We record liabilities for our estimates of the probable costs resulting from these matters. Our estimates are developed in consultation with outside legal counsel and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverages, if any, for such matters. We do not believe any matters currently threatened or pending will have a material adverse effect on our consolidated financial position or results of operations. It is possible, however, that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions.

## 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. These include 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.

## Legal Matters

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. We record liabilities for our estimates 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 matters incidental to our business.

*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 business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure 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. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. Through a series of motions and appeals, all direct claims against UnitedHealthcare have been compelled to arbitration. The trial court has denied UnitedHealthcare's further motion to compel the secondary RICO claims to arbitration and the Eleventh Circuit affirmed that order. A trial date has been set for September 2005. The trial court has ordered that the trial be bifurcated into separate liability and damage proceedings.

*The American Medical Association et al. v. Metropolitan Life Insurance Company, United HealthCare Services, Inc. and UnitedHealth Group.* On March 15, 2000, the American Medical Association filed a lawsuit against the company 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. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations.

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.

### Quantitative and Qualitative Disclosures about Market Risks

Market risk represents the risk of changes in the fair value of a financial instrument caused by changes in interest rates or equity prices. The company's primary market risk is exposure to changes in interest rates that could impact the fair value of our investments and long-term debt.

Approximately \$12.0 billion of our cash equivalents and investments at December 31, 2004 were debt securities. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed-income investment portfolio at December 31, 2004, the fair value of our fixed-income investments would decrease or increase by approximately \$355 million. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

To mitigate the financial impact of changes in interest rates, we have entered into interest rate swap agreements to more closely match the interest rates of our long-term debt with those of our cash equivalents and short-term investments. Including the impact of our interest rate swap agreements, approximately \$3.2 billion of our commercial paper and debt had variable rates of interest and \$825 million had fixed rates as of December 31, 2004. A hypothetical 1% increase or decrease in interest rates would not be material to the fair value of our commercial paper and debt.

At December 31, 2004, we had \$207 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.

## 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 December 31, 2004, there were no significant concentrations of credit risk.

## Cautionary Statements

The statements contained in Results of Operations and other sections of this Annual Report include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this report, the words and phrases “believes,” “anticipates,” “intends,” “will likely result,” “estimates,” “projects” and similar expressions are intended to identify such forward-looking statements. These forward-looking statements involve risks and uncertainties that may cause the company’s actual results to differ materially from the results discussed in the forward-looking statements. Statements that are not strictly historical are “forward-looking” and known and unknown risks may cause actual results and corporate developments to differ materially from those expected. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update each statement in future filings or communications, 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. Any or all forward-looking statements in this report and in any other public statements we make may turn out to be inaccurate. They can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties.

Many factors will be important in determining future results. Consequently, no forward-looking statement can be guaranteed. Actual future results may vary materially from those expressed in our prior communications. Factors that could cause results and developments to differ materially from expectations include, without limitation, (a) increases in medical costs that are higher than we anticipated in establishing our premium rates, including increased consumption of or costs of medical services; (b) increases in costs associated with increased litigation, legislative activity and government regulation and review of our industry; (c) possible impairment of the value of our intangible assets if future results do not adequately support goodwill and intangible assets recorded for businesses that we acquire; (d) heightened competition as a result of new entrants into our market, and consolidation of health care companies and suppliers; (e) failure to maintain effective and efficient information systems, which could result in the loss of existing customers, difficulties in attracting new customers, difficulties in determining medical costs estimates and appropriate pricing, customer and physician and health care provider disputes, regulatory violations, increases in operating costs or other adverse consequences; (f) events that may negatively affect our contract with AARP; (g) misappropriation of our proprietary technology; (h) our ability to execute contracts on favorable terms with physicians, hospitals and other service providers; (i) increased competition and other uncertainties resulting from changes in Medicare laws; and (j) potential effects of terrorism, particularly bioterrorism, including increased use of health care services, disruption of information and payment systems, and increased health care costs. Additional information about these risks, uncertainties and other matters can be found in our Annual Report on Form 10-K for the year ended December 31, 2004.