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

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2019

☐ **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 001-38961

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	**82-2152098**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
3055 Lebanon Pike, Suite 1000 Nashville, TN	**37214**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $.001 per share	**CHNG**	**The Nasdaq Stock Market LLC**
6.00% Tangible Equity Units	**CHNGU**	**The Nasdaq Stock Market LLC**

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒	Smaller reporting company ☐
	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

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

Class	Outstanding as of November 11, 2019
Common Stock, $0.001 par value	**124,948,388**

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2019

☐ **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 001-38961

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware **(State or Other Jurisdiction of Incorporation or Organization)**	**82-2152098** **(I.R.S. Employer Identification No.)**
3055 Lebanon Pike, Suite 1000 **Nashville, TN** **(Address of Principal Executive Offices)**	**37214** **(Zip Code)**

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $.001 per share	**CHNG**	**The Nasdaq Stock Market LLC**
6.00% Tangible Equity Units	**CHNGU**	**The Nasdaq Stock Market LLC**

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one): ☐

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒	Smaller reporting company ☐
	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

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

Class	Outstanding as of August 12, 2019
Common Stock, $0.001 par value	124,850,450

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

As filed with the Securities and Exchange Commission on June 14, 2019

Registration No. 333-230345

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

Amendment No. 4
to
FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	7389	82-2152098
(State or other jurisdiction of incorporation or organization)	(Primary Standard Industrial Classification Code Number)	(I.R.S. Employer Identification No.)

3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Address, including zip code, and telephone number, including area code, of Registrant's principal executive offices)

Neil E. de Crescenzo
President and Chief Executive Officer
Change Healthcare Inc.
3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Name, address, including zip code, and telephone number, including area code, of agent for service)

Copies to:

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Craig E. Marcus
Tara Fisher
Ropes & Gray LLP
Prudential Tower
800 Boylston Street
Boston, Massachusetts 02199
Telephone: (617) 951-7000

Approximate date of commencement of the proposed sale of the securities to the public: As soon as practicable after the Registration Statement is declared effective.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. ☐

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Amount to be Registered	Proposed Maximum Aggregate Offering Price Per Share or Unit	Proposed Maximum Aggregate Offering Price	Amount of Registration Fee(3)
Common Stock, par value $0.001 per share	49,285,713(1)	$19.00(2)	$936,428,547	$113,495.14
Tangible Equity Units(4)(5)	5,750,000	$50.00	$287,500,000	$34,845.00
Stock Purchase Contracts				
Amortizing Notes				
Total			$1,223,928,547	$148,340.14

(1) Includes 6,428,571 shares of common stock that are subject to the underwriters' option to purchase additional shares.

(2) Estimated solely for the purpose of determining the amount of the registration fee in accordance with Rule 457(a) under the Securities Act of 1933.

(3) The Registrant previously paid $12,120 of the registration fee, with respect to $100,000,000 of the proposed maximum aggregate offering price of Common Stock, par value $0.001 per share, in connection with the initial filing of this registration statement and $12,120 of the registration fee, with respect to $100,000,000 of the proposed maximum aggregate offering price of the Tangible Equity Units, in connection with the filing of Amendment No. 2 of this registration statement.

(4) Includes 750,000 Tangible Equity Units that are subject to the underwriters' option to purchase additional Tangible Equity Units. Each Tangible Equity Unit is composed of a stock purchase contract and an amortizing note. This registration statement also registers an estimated 16,428,325 shares of the Registrant's common stock that are issuable upon settlement of the purchase contracts that are a component of the Tangible Equity Units registered hereby, at the initial rate of 2.8571 shares of common stock per purchase contract, based on the assumed initial public offering price of $17.50 per share of common stock, which is the midpoint of the price range set forth on the cover page of the common stock prospectus which forms a part of this registration statement and assuming the maximum number of shares issuable upon automatic settlement of such purchase contracts. Under Rule 457(i), there is no additional filing fee payable with respect to the shares of common stock issuable upon settlement of the purchase contracts because no additional consideration will be received in connection with the settlement. The number of shares of the Registrant's common stock issuable upon such settlement will vary based on the public offering price of the common stock registered hereby.

(5) The number of shares of the Registrant's common stock issuable upon settlement of the purchase contracts is subject to anti-dilution adjustments upon the occurrence of certain events described herein. Pursuant to Rule 416 under the Securities Act, the number of shares of the Registrant's common stock to be registered includes an indeterminable number of shares of common stock that may become issuable upon settlement of the purchase contracts as a result of such anti-dilution adjustment, solely to the extent permitted by Rule 416.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

Legal Proceedings

In April 2018, we responded to a notice and data request from OCR, the enforcement agency of HHS charged with investigating healthcare related privacy complaints and other potential HIPAA violations, alleging that a former employee's protected health information had been improperly accessed. In May 2019, we received a no-action letter from OCR stating that OCR has closed its investigation with no further OCR action required.

In May 2016, our Miamisburg, Ohio office was served a subpoena by the OIG of HHS requesting documents related to our billing and coding of advanced life support and basic life support ambulance transport services. In May 2019, we settled this matter with the U.S. Department of Justice for an immaterial amount.

We are subject to claims, lawsuits and legal proceedings in the ordinary course of business. While it is not possible to ascertain the ultimate outcome of such matters, in management's opinion, the liabilities, if any, in excess of amounts provided or covered by insurance for these matters are not expected to have a material adverse effect on our financial condition, results of operations or liquidity.

5. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

14. Legal Proceedings

In addition to commitments and obligations in the ordinary course of business, the Joint Venture is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Joint Venture receives subpoenas or requests for information from various government agencies. The Joint Venture generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Joint Venture. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Joint Venture and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Joint Venture is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Joint Venture does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Joint Venture's consolidated financial position, results of operations or liquidity.

12. Legal Proceedings

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

19. Commitments and Contingent Liabilities

In addition to commitments and obligations in the ordinary course of business, we are subject to various claims, including claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. As described below, many of these proceedings are at preliminary stages and many seek an indeterminate amount of damages.

When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimates.

We are party to the legal proceedings described below. Unless otherwise stated, we are currently unable to estimate a range of reasonably possible losses for the unresolved proceedings described below. Should any one or a combination of more than one of these proceedings be successful, or should we determine to settle any or a combination of these matters, we may be required to pay substantial sums, become subject to the entry of an injunction or be forced to change the manner in which we operate our business, which could have a material adverse impact on our financial position or results of operations.

Litigation and Claims

On May 17, 2013, McKesson Corporation was served with a complaint filed in the United States District Court for the Northern District of California by True Health Chiropractic Inc., alleging that McKesson sent unsolicited marketing faxes in violation of the Telephone Consumer Protection Act of 1991 (“TCPA”), as amended by the Junk Fax Protection Act of 2005 or JFPA, *True Health Chiropractic Inc., et al. v. McKesson Corporation, et al.* , CV-13-02219 (HG). True Health Chiropractic later amended its complaint, adding McLaughlin Chiropractic Associates as an additional named plaintiff and McKesson Technologies, Inc. as a defendant. Plaintiffs purport to represent all persons who were sent marketing faxes that did not contain proper opt-out notices and from whom McKesson Technologies, Inc. did not obtain prior express permission from June 2009 to the present. In July 2015, Plaintiffs filed a motion for class certification, however, on August 22, 2016, the United States District Court for the Northern District of California denied Plaintiffs’ motion which meant that Plaintiffs could only proceed on their individual claims and could not represent a class. Plaintiffs appealed that ruling to the United States Court of Appeals for the Ninth Circuit on September 6, 2016. The Court of Appeals has tentatively scheduled oral argument on the appeal to take place during the weeks of October 10, 2017 or October 17, 2017. The United States District Court for the Northern District of California administratively closed its docket for the underlying proceedings on February 1, 2017.

In August 2015, our parent, McKesson, and its subsidiaries and affiliates, including McKesson Technologies, Inc., were granted waivers from the opt-out requirement from the Federal Communications Commission (“FCC”). On March 31, 2017, the United States Court of Appeals for the District of Columbia Circuit held that the FCC did not have authority to require an opt-out notice on solicited faxes which mooted McKesson Technologies’ need for the FCC waiver for any solicited faxes that did not contain opt-out language. Plaintiffs plan to file a petition for certiorari appealing the Circuit Court’s ruling with the United States Supreme Court.

Government Subpoenas and Investigations

From time-to-time, Core MTS receives subpoenas or requests for information from various government agencies. Core MTS generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by Core MTS. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against Core MTS and other members of the health care industry, as well as to settlements.

Other Matters

Core MTS is involved in various other litigation, governmental proceedings and claims, not described above, that arise in the normal course of business. While it is not possible to determine the ultimate outcome or the duration of such litigation, governmental proceedings or claims, Core MTS believes, based on current knowledge and the advice of counsel, that such litigation, proceedings and claims will not have a material impact on Core MTS's financial position or results of operations.

As filed with the Securities and Exchange Commission on May 14, 2019

Registration No. 333-230345

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

Amendment No. 2
to
FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	7389	82-2152098
(State or other jurisdiction of incorporation or organization)	(Primary Standard Industrial Classification Code Number)	(I.R.S. Employer Identification No.)

3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Address, including zip code, and telephone number, including area code, of Registrant's principal executive offices)

Neil E. de Crescenzo
President and Chief Executive Officer
Change Healthcare Inc.
3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Name, address, including zip code, and telephone number, including area code, of agent for service)

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Telephone: (617) 951-7000

Approximate date of commencement of the proposed sale of the securities to the public: As soon as practicable after the Registration Statement is declared effective.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. ☐

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)(2)	Amount of Registration Fee(3)
Common Stock, par value $0.001 per share	$100,000,000	$12,120
% Tangible Equity Units(4)	$100,000,000	$12,120
Stock Purchase Contracts		
Amortizing Notes		
Total	$	$

(1) Estimated solely for the purpose of determining the amount of the registration fee in accordance with Rule 457(o) under the Securities Act of 1933.

(2) Includes shares of common stock that are subject to the underwriters' option to purchase additional shares.

(3) The Registrant previously paid $12,120 of the registration fee, with respect to $100,000,000 of the proposed maximum aggregate offering price of Common Stock, par value $0.001 per share, in connection with the initial filing of this registration statement.

(4) Includes Tangible Equity Units that are subject to the underwriters' option to purchase additional Tangible Equity Units. Each Tangible Equity Unit is composed of a stock purchase contract and an amortizing note. This registration statement also registers the shares of the Registrant's common stock that are issuable upon settlement of the purchase contracts that are a component of the Tangible Equity Units registered hereby, at the initial rate of shares of common stock per purchase contract assuming the maximum number of shares issuable upon automatic settlement of such purchase contracts. Under Rule 457(i), there is no additional filing fee payable with respect to the shares of common stock issuable upon settlement of the purchase contracts because no additional consideration will be received in connection with the settlement. The number of shares of the Registrant's common stock issuable upon such settlement will vary based on the public offering price of the common stock registered hereby and is subject to adjustment upon the occurrence of certain events described herein. Pursuant to Rule 416 under the Securities Act, the number of shares of the Registrant's common stock to be registered includes an indeterminable number of shares of common stock that may become issuable upon settlement of the purchase contracts as a result of such adjustments.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

Legal Proceedings

In April 2018, we responded to a notice and data request from OCR, the enforcement agency of HHS charged with investigating healthcare related privacy complaints and other potential HIPAA violations, alleging that a former employee's protected health information had been improperly accessed. We have been responsive to OCR requests for information regarding this matter. While we believe we have meritorious arguments, the outcome of the investigation is still uncertain and it is not possible at this time for us to estimate potential liability. We intend to continue defending ourselves vigorously in this matter.

In May 2016, our Miamisburg, Ohio office was served a subpoena by the OIG of HHS requesting documents related to our billing and coding of advanced life support and basic life support ambulance transport services. In December 2017, we entered into a Tolling Agreement with the U.S. Department of Justice in connection with the subpoena, which the parties have extended in furtherance of continued settlement negotiations. We intend to continue to assert a vigorous defense and do not expect any ultimate outcome of this matter to result in a material liability.

We are subject to claims, lawsuits and legal proceedings in the ordinary course of business. While it is not possible to ascertain the ultimate outcome of such matters, in management's opinion, the liabilities, if any, in excess of amounts provided or covered by insurance for these matters are not expected to have a material adverse effect on our financial condition, results of operations or liquidity.

5. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

14. Legal Proceedings

In addition to commitments and obligations in the ordinary course of business, the Company is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

6. Legal Proceedings

The Company is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements.

Other Matters
Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of ongoing matters has yet to be determined, the Company does not believe that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

12. Legal Proceedings

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

19. Commitments and Contingent Liabilities

In addition to commitments and obligations in the ordinary course of business, we are subject to various claims, including claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. As described below, many of these proceedings are at preliminary stages and many seek an indeterminate amount of damages.

When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimates.

We are party to the legal proceedings described below. Unless otherwise stated, we are currently unable to estimate a range of reasonably possible losses for the unresolved proceedings described below. Should any one or a combination of more than one of these proceedings be successful, or should we determine to settle any or a combination of these matters, we may be required to pay substantial sums, become subject to the entry of an injunction or be forced to change the manner in which we operate our business, which could have a material adverse impact on our financial position or results of operations.

Litigation and Claims

On May 17, 2013, McKesson Corporation was served with a complaint filed in the United States District Court for the Northern District of California by True Health Chiropractic Inc., alleging that McKesson sent unsolicited marketing faxes in violation of the Telephone Consumer Protection Act of 1991 ("TCPA"), as amended by the Junk Fax Protection Act of 2005 or JFPA, *True Health Chiropractic Inc., et al. v. McKesson Corporation, et al.* , CV-13-02219 (HG). True Health Chiropractic later amended its complaint, adding McLaughlin Chiropractic Associates as an additional named plaintiff and McKesson Technologies, Inc. as a defendant. Plaintiffs purport to represent all persons who were sent marketing faxes that did not contain proper opt-out notices and from whom McKesson Technologies, Inc. did not obtain prior express permission from June 2009 to the present. In July 2015, Plaintiffs filed a motion for class certification, however, on August 22, 2016, the United States District Court for the Northern District of California denied Plaintiffs' motion which meant that Plaintiffs could only proceed on their individual claims and could not represent a class. Plaintiffs appealed that ruling to the United States Court of Appeals for the Ninth Circuit on September 6, 2016. The Court of Appeals has tentatively scheduled oral argument on the appeal to take place during the weeks of October 10, 2017 or October 17, 2017. The United States District Court for the Northern District of California administratively closed its docket for the underlying proceedings on February 1, 2017.

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Other Matters

Core MTS is involved in various other litigation, governmental proceedings and claims, not described above, that arise in the normal course of business. While it is not possible to determine the ultimate outcome or the duration of such litigation, governmental proceedings or claims, Core MTS believes, based on current knowledge and the advice of counsel, that such litigation, proceedings and claims will not have a material impact on Core MTS's financial position or results of operations.

As filed with the Securities and Exchange Commission on May 14, 2019

Registration No. 333-230345

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

Amendment No. 2
to
FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	7389	82-2152098
(State or other jurisdiction of incorporation or organization)	(Primary Standard Industrial Classification Code Number)	(I.R.S. Employer Identification No.)

3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Address, including zip code, and telephone number, including area code, of Registrant's principal executive offices)

Neil E. de Crescenzo
President and Chief Executive Officer
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3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
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Approximate date of commencement of the proposed sale of the securities to the public: As soon as practicable after the Registration Statement is declared effective.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. ☐

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Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)(2)	Amount of Registration Fee(3)
Common Stock, par value $0.001 per share	$100,000,000	$12,120
% Tangible Equity Units(4)	$100,000,000	$12,120
Stock Purchase Contracts		
Amortizing Notes		
Total	$	$

(1) Estimated solely for the purpose of determining the amount of the registration fee in accordance with Rule 457(o) under the Securities Act of 1933.
(2) Includes shares of common stock that are subject to the underwriters' option to purchase additional shares.
(3) The Registrant previously paid $12,120 of the registration fee, with respect to $100,000,000 of the proposed maximum aggregate offering price of Common Stock, par value $0.001 per share, in connection with the initial filing of this registration statement.
(4) Includes Tangible Equity Units that are subject to the underwriters' option to purchase additional Tangible Equity Units. Each Tangible Equity Unit is composed of a stock purchase contract and an amortizing note. This registration statement also registers the shares of the Registrant's common stock that are issuable upon settlement of the purchase contracts that are a component of the Tangible Equity Units registered hereby, at the initial rate of shares of common stock per purchase contract assuming the maximum number of shares issuable upon automatic settlement of such purchase contracts. Under Rule 457(i), there is no additional filing fee payable with respect to the shares of common stock issuable upon settlement of the purchase contracts because no additional consideration will be received in connection with the settlement. The number of shares of the Registrant's common stock issuable upon such settlement will vary based on the public offering price of the common stock registered hereby and is subject to adjustment upon the occurrence of certain events described herein. Pursuant to Rule 416 under the Securities Act, the number of shares of the Registrant's common stock to be registered includes an indeterminable number of shares of common stock that may become issuable upon settlement of the purchase contracts as a result of such adjustments.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

Legal Proceedings

In April 2018, we responded to a notice and data request from OCR, the enforcement agency of HHS charged with investigating healthcare related privacy complaints and other potential HIPAA violations, alleging that a former employee's protected health information had been improperly accessed. We have been responsive to OCR requests for information regarding this matter. While we believe we have meritorious arguments, the outcome of the investigation is still uncertain and it is not possible at this time for us to estimate potential liability. We intend to continue defending ourselves vigorously in this matter.

In May 2016, our Miamisburg, Ohio office was served a subpoena by the OIG of HHS requesting documents related to our billing and coding of advanced life support and basic life support ambulance transport services. In December 2017, we entered into a Tolling Agreement with the U.S. Department of Justice in connection with the subpoena, which the parties have extended in furtherance of continued settlement negotiations. We intend to continue to assert a vigorous defense and do not expect any ultimate outcome of this matter to result in a material liability.

We are subject to claims, lawsuits and legal proceedings in the ordinary course of business. While it is not possible to ascertain the ultimate outcome of such matters, in management's opinion, the liabilities, if any, in excess of amounts provided or covered by insurance for these matters are not expected to have a material adverse effect on our financial condition, results of operations or liquidity.

5. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

14. Legal Proceedings

In addition to commitments and obligations in the ordinary course of business, the Company is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

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19. Commitments and Contingent Liabilities

In addition to commitments and obligations in the ordinary course of business, we are subject to various claims, including claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. As described below, many of these proceedings are at preliminary stages and many seek an indeterminate amount of damages.

When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimates.

We are party to the legal proceedings described below. Unless otherwise stated, we are currently unable to estimate a range of reasonably possible losses for the unresolved proceedings described below. Should any one or a combination of more than one of these proceedings be successful, or should we determine to settle any or a combination of these matters, we may be required to pay substantial sums, become subject to the entry of an injunction or be forced to change the manner in which we operate our business, which could have a material adverse impact on our financial position or results of operations.

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Other Matters

Core MTS is involved in various other litigation, governmental proceedings and claims, not described above, that arise in the normal course of business. While it is not possible to determine the ultimate outcome or the duration of such litigation, governmental proceedings or claims, Core MTS believes, based on current knowledge and the advice of counsel, that such litigation, proceedings and claims will not have a material impact on Core MTS's financial position or results of operations.

As filed with the Securities and Exchange Commission on April 5, 2019

Registration No. 333-230345

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

Amendment No. 1
to
FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	**7389**	**82-2152098**
(State or other jurisdiction of incorporation or organization)	**(Primary Standard Industrial Classification Code Number)**	**(I.R.S. Employer Identification No.)**

3055 Lebanon Pike, Suite 1000
Nashville, Tennessee 37214
Telephone: 615-932-3000
(Address, including zip code, and telephone number, including area code, of Registrant's principal executive offices)

Neil E. de Crescenzo
President and Chief Executive Officer
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Nashville, Tennessee 37214
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Approximate date of commencement of the proposed sale of the securities to the public: As soon as practicable after the Registration Statement is declared effective.

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Large accelerated filer ☐ Accelerated filer ☐

Non-accelerated filer ☐ Smaller reporting company ☐

Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)(2)	Amount of Registration Fee(3)
Common Stock, par value $0.001 per share	$100,000,000	$12,120

(1) Estimated solely for the purpose of determining the amount of the registration fee in accordance with Rule 457(o) under the Securities Act of 1933.
(2) Includes shares of common stock that are subject to the underwriters' option to purchase additional shares.
(3) Previously paid.

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Table of Contents

As filed with the Securities and Exchange Commission on March 15, 2019

Registration No. 333-

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

FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	7389	82-2152098
(State or other jurisdiction of incorporation or organization)	(Primary Standard Industrial Classification Code Number)	(I.R.S. Employer Identification No.)

3055 Lebanon Pike, Suite 1000
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Telephone: 615-932-3000
(Address, including zip code, and telephone number, including area code, of Registrant's principal executive offices)

Neil E. de Crescenzo
President and Chief Executive Officer
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Approximate date of commencement of the proposed sale of the securities to the public: As soon as practicable after the Registration Statement is declared effective.

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Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Emerging growth company ☒

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 7(a)(2)(B) of the Securities Act. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)(2)	Amount of Registration Fee
Common Stock, par value $0.001 per share	$100,000,000	$12,120

(1) Estimated solely for the purpose of determining the amount of the registration fee in accordance with Rule 457(o) under the Securities Act of 1933.
(2) Includes shares of common stock that are subject to the underwriters' option to purchase additional shares.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

Legal Proceedings

In April 2018, we responded to a notice and data request from OCR, the enforcement agency of HHS charged with investigating healthcare related privacy complaints and other potential HIPAA violations, alleging that a former employee's protected health information had been improperly accessed. We have been responsive to OCR requests for information regarding this matter. While we believe we have meritorious arguments, the outcome of the investigation is still uncertain and it is not possible at this time for us to estimate potential liability. We intend to continue defending ourselves vigorously in this matter.

In May 2016, our Miamisburg, Ohio office was served a subpoena by the OIG of HHS requesting documents related to our billing and coding of advanced life support and basic life support ambulance transport services. In December 2017, we entered into a Tolling Agreement with the U.S. Department of Justice in connection with the subpoena, which the parties have extended in furtherance of continued settlement negotiations. We intend to continue to assert a vigorous defense and do not expect any ultimate outcome of this matter to result in a material liability.

We are subject to claims, lawsuits and legal proceedings in the ordinary course of business. While it is not possible to ascertain the ultimate outcome of such matters, in management's opinion, the liabilities, if any, in excess of amounts provided or covered by insurance for these matters are not expected to have a material adverse effect on our financial condition, results of operations or liquidity.

5. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

14. Legal Proceedings

In addition to commitments and obligations in the ordinary course of business, the Company is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

19. Commitments and Contingent Liabilities

In addition to commitments and obligations in the ordinary course of business, we are subject to various claims, including claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of our business. As described below, many of these proceedings are at preliminary stages and many seek an indeterminate amount of damages.

When a loss is considered probable and reasonably estimable, we record a liability in the amount of our best estimate for the ultimate loss. However, the likelihood of a loss with respect to a particular contingency is often difficult to predict and determining a meaningful estimate of the loss or a range of loss may not be practicable based on the information available and the potential effect of future events and decisions by third parties that will determine the ultimate resolution of the contingency. Moreover, it is not uncommon for such matters to be resolved over many years, during which time relevant developments and new information must be reevaluated at least quarterly to determine both the likelihood of potential loss and whether it is possible to reasonably estimate a range of possible loss. When a loss is probable but a reasonable estimate cannot be made, disclosure of the proceeding is provided.

Disclosure also is provided when it is reasonably possible that a loss will be incurred or when it is reasonably possible that the amount of a loss will exceed the recorded provision. We review all contingencies at least quarterly to determine whether the likelihood of loss has changed and to assess whether a reasonable estimate of the loss or range of loss can be made. As discussed above, development of a meaningful estimate of loss or a range of potential loss is complex when the outcome is directly dependent on negotiations with or decisions by third parties, such as regulatory agencies, the court system and other interested parties. Such factors bear directly on whether it is possible to reasonably estimate a range of potential loss and boundaries of high and low estimates.

We are party to the legal proceedings described below. Unless otherwise stated, we are currently unable to estimate a range of reasonably possible losses for the unresolved proceedings described below. Should any one or a combination of more than one of these proceedings be successful, or should we determine to settle any or a combination of these matters, we may be required to pay substantial sums, become subject to the entry of an injunction or be forced to change the manner in which we operate our business, which could have a material adverse impact on our financial position or results of operations.

Litigation and Claims

On May 17, 2013, McKesson Corporation was served with a complaint filed in the United States District Court for the Northern District of California by True Health Chiropractic Inc., alleging that McKesson sent unsolicited marketing faxes in violation of the Telephone Consumer Protection Act of 1991 (“TCPA”), as amended by the Junk Fax Protection Act of 2005 or JFPA, *True Health Chiropractic Inc., et al. v. McKesson Corporation, et al.* , CV-13-02219 (HG). True Health Chiropractic later amended its complaint, adding McLaughlin Chiropractic Associates as an additional named plaintiff and McKesson Technologies, Inc. as a defendant. Plaintiffs purport to represent all persons who were sent marketing faxes that did not contain proper opt-out notices and from whom McKesson Technologies, Inc. did not obtain prior express permission from June 2009 to the present. In July 2015, Plaintiffs filed a motion for class certification, however, on August 22, 2016, the United States District Court for the Northern District of California denied Plaintiffs’ motion which meant that Plaintiffs could only proceed on their individual claims and could not represent a class. Plaintiffs appealed that ruling to the United States Court of Appeals for the Ninth Circuit on September 6, 2016. The Court of Appeals has tentatively scheduled oral argument on the appeal to take place during the weeks of October 10, 2017 or October 17, 2017. The United States District Court for the Northern District of California administratively closed its docket for the underlying proceedings on February 1, 2017.

In August 2015, our parent, McKesson, and its subsidiaries and affiliates, including McKesson Technologies, Inc., were granted waivers from the opt-out requirement from the Federal Communications Commission (“FCC”). On March 31, 2017, the United States Court of Appeals for the District of Columbia Circuit held that the FCC did not have authority to require an opt-out notice on solicited faxes which mooted McKesson Technologies’ need for the FCC waiver for any solicited faxes that did not contain opt-out language. Plaintiffs plan to file a petition for certiorari appealing the Circuit Court’s ruling with the United States Supreme Court.

Government Subpoenas and Investigations

From time-to-time, Core MTS receives subpoenas or requests for information from various government agencies. Core MTS generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by Core MTS. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against Core MTS and other members of the health care industry, as well as to settlements.

Other Matters

Core MTS is involved in various other litigation, governmental proceedings and claims, not described above, that arise in the normal course of business. While it is not possible to determine the ultimate outcome or the duration of such litigation, governmental proceedings or claims, Core MTS believes, based on current knowledge and the advice of counsel, that such litigation, proceedings and claims will not have a material impact on Core MTS's financial position or results of operations.

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2015

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 1-34435

CHANGE HEALTHCARE HOLDINGS, INC.
(Exact Name of Registrant as Specified in its Charter)

Delaware	**20-5799664**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
3055 Lebanon Pike, Suite 1000 Nashville, TN	**37214**
(Address of Principal Executive Offices)	**(Zip Code)**

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act: None

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

As of December 31, 2015, there were issued and outstanding 100 shares of common stock, par value $.01 per share. The registrant is a wholly owned subsidiary of Change Healthcare Intermediate Holdings, Inc., which is a wholly owned subsidiary of Change Healthcare, Inc.

* The registrant is a voluntary filer of certain reports required to be filed by companies under Section 13 or 15(d) of the Securities and Exchange Act of 1934 and has filed all reports that would have been required to have been filed by the registrant during the preceding 12 months had it been subject to such filing requirements during the entirety of such period.

DOCUMENTS INCORPORATED BY REFERENCE

None.

12. Legal Proceedings

The Company finalized and paid $8,000 related to the settlement of a vendor fee dispute in 2014, with $3,000 and $5,000 of this amount recognized within sales, marketing, general and administrative expense during the years ended December 31, 2014 and 2013, respectively.

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2019

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 0-19291

CORVEL CORPORATION
(Exact Name of Registrant as Specified in its Charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
2010 Main Street, Suite 600	
Irvine, CA	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, Par Value $0.0001 Per Share	CRVL	NASDAQ Global Select Market

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☐	Accelerated filer	☑
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares outstanding of the registrant's Common Stock, $0.0001 par value per share, as of August 1, 2019, was 18,473,443.

Note 8 — Contingencies and Legal Proceedings

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

PART II - OTHER INFORMATION

Item 1 – Legal Proceedings

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

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

Form 10-K

(Mark One)

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

For the fiscal year ended March 31, 2018

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 0-19291

CorVel Corporation

(Exact name of Registrant as specified in its Charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
2010 Main Street, Suite 600	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant’s telephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act: Common Stock, Par Value $0.0001 Per Share; Common stock traded on the NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ‘ NO È

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ‘ NO È

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 È NO ‘

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). YES È NO ‘

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of Registrant’s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. È

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer,” “smaller reporting company,” and “emerging growth company” in Rule 12b-2 of the Exchange Act.

Large accelerated filer	‘	Accelerated filer	È
Non-accelerated filer	‘ (Do not check if a small reporting company)	Small reporting company	‘
Emerging growth company	‘		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ‘ NO È

As of September 30, 2017, the aggregate market value of the Registrant’s voting and non-voting common equity held by non-affiliates of the Registrant was approximately $513,053,000 based on the closing price per share of $54.40 for the Registrant’s common stock as reported on the Nasdaq Global Select Market on such date multiplied by 9,431,130 shares (total outstanding shares of 18,824,953 less 9,393,823 shares held by affiliates) of the Registrant’s common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of Registrant’s directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant’s outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of Registrant’s Common Stock outstanding as of June 5, 2018 was 18,945,318.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant’s definitive proxy statement for the Registrant’s 2018 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2018. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant’s definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note 9 — Contingencies and Legal Proceedings

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark O ne)

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

For the fiscal year ended March 31, 2018

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 0-19291

CorVel Corporation

(Exact name of Registrant as specified in its Charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
2010 Main Street, Suite 600	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act: Common Stock, Par Value $0.0001 Per Share; Common stock traded on the NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☐ NO ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☒

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

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). YES ☒ NO ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of " large accelerated filer," " accelerated filer," " smaller reporting company," and " emerging growth company" in Rule 12b-2 of the Exchange Act.

Fisher

Large accelerated filer	☐	Accelerated filer	☒
Non-accelerated filer	☐ (Do not check if a small reporting company)	Small reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☒

As of September 30, 2017, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $513,053,000 based on the closing price per share of $54.40 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 9,431,130 shares (total outstanding shares of 18,824,953 less 9,393,823 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of Registrant's Common Stock outstanding as of June 5, 2018 was 18,945,318.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2018 Annual Meeting of Stockholders, which will be filed with the Securities and

Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2018. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note 9 — Contingencies and Legal Proceedings

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark O ne)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THESECURITIES EXCHANGEACT OF 1934**

For the fiscal year ended March 31, 2017

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 0-19291

CorVel Corporation

(Exact name of Registrant as specified in its Charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
2010 Main Street, Suite 600	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act: Common Stock, Par Value $0.0001 Per Share; Common stock traded on the NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☐ NO ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☒

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

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). YES ☒ NO ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of " large accelerated filer," " accelerated filer," " smaller reporting company," and " emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☐	Accelerated filer	☒
Non-accelerated filer	☐ (Do not check if a small reporting company)	Small reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☒

As of September 30, 2016, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $392,673,000 based on the closing price per share of $38.40 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 10,225,855 shares (total outstanding shares of 19,552,218 less 9,326,363 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of Registrant's Common Stock outstanding as of June 6, 2017 was 18,754,764.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2017 Annual Meeting of Stockholders, which will be filed with the Securities and

Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2017. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note I — Contingencies and Legal Proceedings

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

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

For the fiscal year ended March 31, 2016

O R

☐ **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 0-19291

CorVel Corporation

(Exact name of registrant as specified in i ts charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
2010 Main Street, Suite 600,	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's te lephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock	**The NASDAQ Global Select Market, LLC**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of " large accelerated filer", " accelerated filer" and " smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently

completed second fiscal quarter:

As of September 30, 2015, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $330,421,000 based on the closing price per share of $32.30 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 10,229,765 shares (total outstanding shares of 19,787,279 less 9,557,514 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. T his determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 3, 2016, there were 19,574,261 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DO CUMENTS INCO RPO RATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2016 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2016. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note I — Contingencies and Legal Proceedings

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

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

For the fiscal year ended March 31, 2015 O R

☐ **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 0-19291

CorVel Corporation

(Exact name of registrant as specified in i ts charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
2010 Main Street, Suite 600,	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's te lephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock	**The NASDAQ Global Select Market, LLC**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of " large accelerated filer", " accelerated filer" and " smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2014, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $386,692,000 based on the closing price per share of $34.05 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 11,356,597 shares (total outstanding shares of 20,727,355 less 9,370,758 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. T his determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 5, 2015, there were 20,091,126 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DO CUMENTS INCO RPO RATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2015 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2015. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note I — Contingencies and Legal Proceedings

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

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

For the fiscal year ended March 31, 2015 O R

☐ **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 0-19291

CorVel Corporation

(Exact name of registrant as specified in i ts charter)

Delaware	**33-0282651**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
2010 Main Street, Suite 600,	
Irvine, California	**92614**
(Address of principal executive offices)	**(Zip Code)**

Registrant's te lephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock	**The NASDAQ Global Select Market, LLC**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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Large accelerated filer ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2014, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $386,692,000 based on the closing price per share of $34.05 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 11,356,597 shares (total outstanding shares of 20,727,355 less 9,370,758 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. T his determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 5, 2015, there were 20,091,126 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DO CUMENTS INCO RPO RATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2015 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2015. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note I — Contingencies and Legal Proceedings

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

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

For the fiscal year ended March 31, 2013

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 0-19291

CorVel Corporation

(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
2010 Main Street, Suite 600, **Irvine, California** *(Address of principal executive offices)*	***92614*** *(Zip Code)*

Registrant's telephone number, including area code: (949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	Name of each exchange on which registered:
Common Stock	The NASDAQ Global Select Market, LLC

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☑

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of " large accelerated filer", " accelerated filer" and " smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2012, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $273,360,000 based on the closing price per share of $44.75 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 6,108,593 shares (total outstanding shares of 11,238,777 less 5,130,184 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of May 28, 2013, there were 10,761,661 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2013 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2013. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

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

Note I — Contingencies and Legal Proceedings

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

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

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

☐ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended March 31, 2012

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 0-19291

CorVel Corporation

(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
2010 Main Street, Suite 600, Irvine, California	**92614**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:
(949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	Name of each exchange on which registered:
Common Stock	The NASDAQ Global Select Market, LLC

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☑

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of " large accelerated filer", " accelerated filer" and " smaller reporting company" in Rule 12b-2 of the Exchange Act.
Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2011, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $267,958,000 based on the closing price per share of $42.50 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 6,312,329 shares (total outstanding shares of 11,465,181 less 5,152,852 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 3, 2012, there were 11,257,348 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2012 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2012. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

On March 25, 2011, George Raymond Williams, MD. ("Williams"), as plaintiff, individually and on behalf of those similarly situated, filed a First Amended and Restated Petition for Damages and Class Certification in the 27th Judicial District Court, Parish of St. Landry, Louisiana, against CorVel Corporation ("CorVel") and its insurance carriers, Homeland Insurance Company of New York and Executive Risk Specialty Insurance Company and several other unrelated parties. Williams alleges that CorVel violated Louisiana's Any Willing Provider Act (the "AWPA"), which requires a payor accessing a preferred provider contract to give 30 days' advance written notice or point of service notice in the form of a benefit card before the payor accesses the discounted rates in the contract to pay the provider for services rendered to an insured under that payor's health benefit plan.

On March 31, 2011, CorVel entered into a Memorandum of Understanding with attorneys representing the plaintiffs and the class setting forth the terms of settlement of this class action lawsuit. The Memorandum of Understanding provides that subject to the execution of a mutually acceptable settlement agreement and final non-appealable approval of such settlement by the Louisiana state court, CorVel will pay $9 million to resolve claims for which CorVel recorded a $9 million pre-tax charge to earnings during the March 2011 quarter. In addition, CorVel will assign to the class certain rights it has to the proceeds of CorVel's insurance policies relating to the claims asserted by the class. The class action arbitration filed with the American Arbitration Association against CorVel in December 2006 by Southwest Louisiana Hospital Association dba Lake Charles
Memorial Hospital as previously disclosed by CorVel is encompassed within the settlement terms of the Memorandum of Understanding. Pursuant to the Memorandum of Understanding, the parties have also agreed to request that the appropriate courts stay all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association in which the parties are named, until the settlement agreement is prepared, executed and receives final court approval. The settlement does not constitute an admission of liability.

On June 23, 2011 CorVel and class counsel executed a definitive settlement agreement. The settlement agreement contains the same terms and conditions as were set forth in the Memorandum of Understanding. Accordingly, CorVel made a $9 million cash payment into escrow on July 6, 2011. As set forth in the settlement agreement, certain contingencies such as preliminary court approval, resolutions of objections filed by class members challenging the fairness of the settlement, class members excluded from the settlement not exceeding a materiality threshold, and final court approval, must be satisfied before the settlement can become final.

On June 23, 2011, the 27th Judicial District Court for the Parish of St. Landry, Louisiana granted preliminary approval of settlement and set a deadline of October 16, 2011 for parties to opt out of or object to the proposed settlement. Notice of the settlement was given to Class Members. The Court gave final approval of the settlement on November 4, 2011. No appeal has been filed since that time, so the judgment became final on January 17, 2012. CorVel has begun to move for dismissal of all claims covered by the settlement in state and federal court.

In exchange for the settlement payment by CorVel, class members will release CorVel and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the AWPA. Plaintiffs have also agreed to a notice procedure that CorVel may follow in the future to comply with the AWPA.

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case sought unspecified damages based on the Company's alleged failure to direct patients to medical providers who were members of the CorVel CorCare PPO network and also alleged that the Company used biased and arbitrary computer software to review medical providers' bills. The Company denies that its conduct was improper in any way and denied all liability. On October 29, 2010, the Company entered into a settlement agreement providing for the payment of $2.1 million to class members and up to an additional $700,000 for attorneys' fees and expenses, and as a result the Company accrued $2.8 million of estimated liability for this settlement agreement during the quarter ended September 30, 2010. In exchange for the settlement payment by the Company, class members consisting of Illinois medical providers (excluding hospitals) have released the Company and all of its affiliates for claims relating to any PPO or usual and customary reductions recommended by the Company on class members' medical bills. On January 21, 2011, the Circuit Court gave final approval to the settlement and awarded class counsel $700,000 in attorneys' fees and expenses. A modified final judgment approving the settlement and addressing certain class notice issues was approved on January 20, 2012; the modified judgment did not change the financial terms of the settlement or the release. Initial payments were sent to class members on July 18, 2011 and the remaining payments to class members should be completed by July 2012.

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

Note I — Contingencies and Legal Proceedings

On March 25, 2011, George Raymond Williams, MD. ("Williams"), as plaintiff, individually and on behalf of those similarly situated, filed a First Amended and Restated Petition for Damages and Class Certification in the 27th Judicial District Court, Parish of St. Landry, Louisiana, against CorVel Corporation ("CorVel") and its insurance carriers, Homeland Insurance Company of New York and Executive Risk Specialty Insurance Company and several other unrelated parties. Williams alleges that CorVel violated Louisiana's Any Willing Provider Act (the "AWPA"), which requires a payor accessing a preferred provider contract to give 30 days' advance written notice or point of service notice in the form of a benefit card before the payor accesses the discounted rates in the contract to pay the provider for services rendered to an insured under that payor's health benefit plan.

On March 31, 2011, CorVel entered into a Memorandum of Understanding with attorneys representing the plaintiffs and the class setting forth the terms of settlement of this class action lawsuit. The Memorandum of Understanding provides that subject to the execution of a mutually acceptable settlement agreement and final non-appealable approval of such settlement by the Louisiana state court, CorVel will pay $9 million to resolve claims for which CorVel recorded a $9 million pre-tax charge to earnings during the March 2011 quarter. In addition, CorVel will assign to the class certain rights it has to the proceeds of CorVel's insurance policies relating to the claims asserted by the class. The class action arbitration filed with the American Arbitration Association against CorVel in December 2006 by Southwest Louisiana Hospital Association dba Lake Charles Memorial Hospital as previously disclosed by CorVel is encompassed within the settlement terms of the Memorandum of Understanding. Pursuant to the Memorandum of Understanding, the parties have also agreed to request that the appropriate courts stay all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association in which the parties are named, until the settlement agreement is prepared, executed and receives final court approval. The settlement does not constitute an admission of liability.

On June 23, 2011 CorVel and class counsel executed a definitive settlement agreement. The settlement agreement contains the same terms and conditions as were set forth in the Memorandum of Understanding. Accordingly, CorVel made a $9 million cash payment into escrow on July 6, 2011. As set forth in the settlement agreement, certain contingencies such as preliminary court approval, resolutions of objections filed by class members challenging the fairness of the settlement, class members excluded from the settlement not exceeding a materiality threshold, and final court approval, must be satisfied before the settlement can become final.

On June 23, 2011, the 27th Judicial District Court for the Parish of St. Landry, Louisiana granted preliminary approval of settlement and set a deadline of October 16, 2011 for parties to opt out of or object to the proposed settlement. Notice of the settlement was given to Class Members. The Court gave final approval of the settlement on November 4, 2011. No appeal has been filed since that time, so the judgment became final on January 17, 2012. CorVel has begun to move for dismissal of all claims covered by the settlement in state and federal court.

In exchange for the settlement payment by CorVel, class members will release CorVel and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the AWPA. Plaintiffs have also agreed to a notice procedure that CorVel may follow in the future to comply with the AWPA.

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case sought unspecified damages based on the Company's alleged failure to direct patients to medical providers who were members of the CorVel CorCare PPO network and also alleged that the Company used biased and arbitrary computer software to review medical providers' bills. The Company denies that its conduct was improper in any way and denied all liability. On October 29, 2010, the Company entered into a settlement agreement providing for the payment of $2.1 million to class members and up to an additional $700,000 for attorneys' fees and expenses, and as a result the Company accrued $2.8 million of estimated liability for this settlement agreement during the quarter ended September 30, 2010. In exchange for the settlement payment by the Company, class members consisting of Illinois medical providers (excluding hospitals) have released the Company and all of its affiliates for claims relating to any PPO or usual and customary reductions recommended by the Company on class members' medical bills. On January 21, 2011, the Circuit Court gave final approval to the settlement and awarded class counsel $700,000 in attorneys' fees and expenses. A modified final judgment approving the settlement and addressing certain class notice issues was approved on January 20, 2012; the modified judgment did not change the financial terms of the settlement or the release. Initial payments were sent to class members on July 18, 2011 and the remaining payments to class members should be completed by July 2012.

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

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

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)**
OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended March 31, 2011

OR

o **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 0-19291

CorVel Corporation

(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
2010 Main Street, Suite 600, Irvine, California	**92614**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:
(949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock	The NASDAQ Global Select Market, LLC

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☑

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☑	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2010, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $276,324,000 based on the closing price per share of $42.45 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 6,509,406 shares (total outstanding shares of 11,834,279 less 5,324,873 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 8, 2011, there were 11,602,078 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2011 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2011. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

On March 25, 2011, George Raymond Williams, MD. ("Williams"), as plaintiff, individually and on behalf of those similarly situated, filed a First Amended and Restated Petition for Damages and Class Certification in the 27th Judicial District Court, Parish of St. Landry, Louisiana, against CorVel Corporation ("CorVel") and its insurance carriers, Homeland Insurance Company of New York and Executive Risk Specialty Insurance Company and several other unrelated parties. Williams alleges that CorVel violated Louisiana's Any Willing Provider Act (the "AWPA"), which requires a payor accessing a preferred provider contract to give 30 days' advance written notice or point of service notice in the form of a benefit card before the payor accesses the discounted rates in the contract to pay the provider for services rendered to an insured under that payor's health benefit plan.

On March 31, 2011, CorVel entered into a Memorandum of Understanding with attorneys representing the plaintiffs and the class setting forth the terms of settlement of this class action lawsuit. The Memorandum of Understanding provides that subject to the execution of a mutually acceptable settlement agreement and final non-appealable approval of such settlement by the Louisiana state court, CorVel will pay $9 million to resolve claims for which CorVel recorded a $9 million pre-tax charge to earnings during the March 2011 quarter. In addition, CorVel will assign to the class certain rights it has to the proceeds of CorVel's insurance policies relating to the claims asserted by the class. The class action arbitration filed with the American Arbitration Association against CorVel in December 2006 by Southwest Louisiana Hospital Association dba Lake Charles Memorial Hospital as previously disclosed by CorVel is encompassed within the settlement terms of the Memorandum of Understanding. Pursuant to the Memorandum of Understanding, the parties have also agreed to request that the appropriate courts stay all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association in which the parties are named, until the settlement agreement is prepared, executed and receives final court approval. The settlement does not constitute an admission of liability.

In exchange for the settlement payment by CorVel, class members will release CorVel and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the AWPA. Plaintiffs have also agreed to a notice procedure that CorVel may follow in the future to comply with the AWPA. As noted, the Memorandum of Understanding is contingent upon the execution of a mutually acceptable definitive settlement agreement. Under Louisiana law, once the parties have executed such a settlement agreement, they must apply to the court for approval of the settlement following a court-supervised process of notice to the class and an opportunity for the class to be heard about the fairness of the settlement or to be excluded from the settlement. CorVel expects to be able to arrive at such a definitive settlement agreement by the end of June 2011, but there can be no assurance that the parties will be able to reach a definitive settlement agreement within that timeframe or at all, that the court will approve the settlement or that a large number of class members will not opt out of the settlement. If a definitive settlement agreement is not reached or is not approved by the court, all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association that have been stayed pending settlement will resume.

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case sought unspecified damages based on the Company's alleged failure to direct patients to medical providers who were members of the CorVel CorCare PPO network and also alleged that the Company used biased and arbitrary computer software to review medical providers' bills. On October 29, 2010, the Company entered into a settlement agreement providing for the payment of $2.1 million to class members and up to an additional $700,000 for attorneys' fees and expenses, and as a result the Company accrued $2.8 million of estimated liability for this settlement agreement during the quarter ended September 30, 2010. None of these amounts have been paid to the class members through March 31, 2011. The Company denies that its conduct was improper in any way and has denied all liability. In exchange for the settlement payment by the Company, class members consisting of Illinois medical providers (excluding hospitals) have released the Company and all of its affiliates for claims relating to any PPO or usual and customary reductions recommended by the Company on class members' medical bills. On January 21, 2011, the Circuit Court gave final approval to the settlement and awarded class counsel $700,000 in attorneys' fees and expenses and a $5,000 incentive award to Kathleen Roche, the class representative.

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

Note I — Contingencies and Legal Proceedings

On March 25, 2011, George Raymond Williams, MD. ("Williams"), as plaintiff, individually and on behalf of those similarly situated, filed a First Amended and Restated Petition for Damages and Class Certification in the 27th Judicial District Court, Parish of St. Landry, Louisiana, against CorVel Corporation ("CorVel") and its insurance carriers, Homeland Insurance Company of New York and Executive Risk Specialty Insurance Company and several other unrelated parties. Williams alleges that CorVel violated Louisiana's Any Willing Provider Act (the "AWPA"), which requires a payor accessing a preferred provider contract to give 30 days' advance written notice or point of service notice in the form of a benefit card before the payor accesses the discounted rates in the contract to pay the provider for services rendered to an insured under that payor's health benefit plan.

On March 31, 2011, CorVel entered into a Memorandum of Understanding with attorneys representing the plaintiffs and the class setting forth the terms of settlement of this class action lawsuit. The Memorandum of Understanding provides that subject to the execution of a mutually acceptable settlement agreement and final non-appealable approval of such settlement by the Louisiana state court, CorVel will pay $9 million to resolve claims for which CorVel recorded a $9 million pre-tax charge to earnings (included in general and administrative costs) during the March 2011 quarter. In addition, CorVel will assign to the class certain rights it has to the proceeds of CorVel's insurance policies relating to the claims asserted by the class. The class action arbitration filed with the American Arbitration Association against CorVel in December 2006 by Southwest Louisiana Hospital Association dba Lake Charles Memorial Hospital as previously disclosed by CorVel is encompassed within the settlement terms of the Memorandum of Understanding. Pursuant to the Memorandum of Understanding, the parties have also agreed to request that the appropriate courts stay all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association in which the parties are named, until the settlement agreement is prepared, executed and receives final court approval. The settlement does not constitute an admission of liability.

In exchange for the settlement payment by CorVel, class members will release CorVel and all of its affiliates and clients for any claims relating in any way to re-pricing, payment for, or reimbursement of a workers' compensation bill, including but not limited to claims under the AWPA. Plaintiffs have also agreed to a notice procedure that CorVel may follow in the future to comply with the AWPA. As noted, the Memorandum of Understanding is contingent upon the execution of a mutually acceptable definitive settlement agreement. Under Louisiana law, once the parties have executed such a settlement agreement, they must apply to the court for approval of the settlement following a court-supervised process of notice to the class and an opportunity for the class to be heard about the fairness of the settlement or to be excluded from the settlement. CorVel expects to be able to arrive at such a definitive settlement agreement by the end of June 2011, but there can be no assurance that the parties will be able to reach a definitive settlement agreement within that timeframe or at all, that the court will approve the settlement or that a large number of class members will not opt out of the settlement. If a definitive settlement agreement is not reached or is not approved by the court, all related proceedings in State and Federal Court, as well as the Louisiana Office of Workers Compensation and the arbitration proceeding before the American Arbitration Association that have been stayed pending settlement will resume.

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case sought unspecified damages based on the Company's alleged failure to direct patients to medical providers who were members of the CorVel CorCare PPO network and also alleged that the Company used biased and arbitrary computer software to review medical providers' bills. On October 29, 2010, the Company entered into a settlement agreement providing for the payment of $2.1 million to class members and up to an additional $700,000 for attorneys' fees and expenses, and as a result the Company accrued $2.8 million of estimated liability for this settlement agreement during the quarter ended September 30, 2010. None of these amounts have been paid to the claimants through March 31, 2011, pending the administrative process. The amounts due to the attorneys was paid prior to March 31, 2011. The Company denies that its conduct was improper in any way and has denied all liability. In exchange for the settlement payment by the Company, class members consisting of Illinois medical providers (excluding hospitals) have released the Company and all of its affiliates for claims relating to any PPO or usual and customary reductions recommended by the Company on class members' medical bills. On January 21, 2011, the Circuit Court gave final approval to the settlement and awarded class counsel $700,000 in attorneys' fees and expenses and a $5,000 incentive award to Kathleen Roche, the class representative.

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

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

Form 10-K

FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)**
OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended March 31, 2010

OR

o **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 0-19291

CorVel Corporation

(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
2010 Main Street, Suite 600, Irvine, California	**92614**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:
(949) 851-1473

Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock	The NASDAQ Global Select Market, LLC

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act Yes ☐ No ☑

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

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

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2009, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately $201,000,000 based on the closing price per share of $28.40 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 7,092,588 shares (total outstanding shares of 12,405,630 less 5,313,042 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of June 1, 2010, there were 11,921,632 shares of the Registrant's common stock, par value $0.0001 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2010 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2010. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

Item 3. ***Legal Proceedings.***

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case seeks unspecified damages based on the Company's alleged failure to direct patients to medical providers who are members of the CorVel CorCare PPO network and also alleges that the Company used biased and arbitrary computer software to review medical providers' bills. In December 2007, the trial court certified a class in this case of all Illinois health care providers with CorVel PPO agreements, excluding hospitals. In January 2008, CorVel filed with the Illinois Appellate Court a petition for interlocutory appeal of the trial court's class certification order which was denied in April 2008. In May 2008, the Company appealed the appellate court's denial of its petition for interlocutory appeal which appeal was also denied by the Illinois Supreme Court in September 2008. The Company intends to pursue all available legal remedies including vigorously defending this case. The Company is not able to estimate the amount of possible loss, if any, at this time.

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

Note H— Commitments, Contingencies and Legal Proceedings

The Company leases office facilities under non-cancelable operating leases. Some of these leases contain escalation clauses. Future minimum rental commitments under operating leases at March 31, 2010 are $14,202,000 in fiscal 2011, $11,163,000 in fiscal 2012, $8,434,000 in fiscal 2013, $6,066,000 in fiscal 2014, $4,397,000 in fiscal 2015, $4,526,000 thereafter, and $48,788,000 in the aggregate. Total rental expense of $14,338,000, $15,094,000, and $15,114,000 was charged to operations for the years ended March 31, 2008, 2009, and 2010, respectively.

In February 2005, Kathleen Roche, D.C., as plaintiff, filed a putative class action in Circuit Court for the 20th Judicial District, St. Clair County, Illinois, against the Company. The case seeks unspecified damages based on the Company's alleged failure to direct patients to medical providers who are members of the CorVel CorCare PPO network and also alleges that the Company used biased and arbitrary computer software to review medical providers' bills. In December 2007, the trial court certified a class in this case of all Illinois health care providers with CorVel PPO agreements, excluding hospitals. In January 2008, CorVel filed with the Illinois Appellate Court a petition for interlocutory appeal of the trial court's class certification order which was denied in April 2008. In May 2008, the Company appealed the appellate court's denial of its petition for interlocutory appeal which appeal was also denied by the Illinois Supreme Court in September 2008. The Company intends to pursue all available legal remedies including vigorously defending this case. The Company is not able to estimate the amount of possible loss, if any, at this time.

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

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

FORM 10-Q

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

For the quarterly period ended September 30, 2019

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: 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	11-3656261
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive Irving, TX	75038
(Address of principal executive offices)	(Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

Not applicable
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock $0.01 par value	HMSY	The Nasdaq Stock Market LLC

Nasdaq Global Select Market

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒
As of October 31, 2019, there were approximately 88,097,605 shares of the registrant's common stock outstanding.

12. Commitments and Contingencies

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On March 14, 2018, the Court held a hearing on the Company's post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. On June 27, 2018, prior to the Court issuing a decision on the motion, the Company entered into a Settlement Agreement (the "Settlement Agreement") with the Plaintiffs, John Alfred Lewis and Christopher Brandon Lewis. Pursuant to the terms of the Settlement Agreement, the Company paid $20 million to resolve all matters in controversy pertaining to the lawsuit. On July 5, 2018, the Court entered an order to discontinue the lawsuit pursuant to the Stipulation of Discontinuance with Prejudice filed by the parties.

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. In March 2018, the Company provided certain documents and information in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company moved to dismiss the complaint and the Court heard oral arguments on May 2, 2019. A decision on the motion has not yet been issued by the Court. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.
From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

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

FORM 10-Q

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

For the quarterly period ended June 30, 2019

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: 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware			11-3656261
(State or other jurisdiction of incorporation or organization)			(I.R.S. Employer Identification No.)
5615 High Point Drive	Irving	TX	75038
(Address of principal executive offices)			(Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

Not applicable
(Former name, former address and former fiscal year, if changed since last report)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock $0.01 par value	HMSY	The Nasdaq Stock Market LLC Nasdaq Global Select Market

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90

days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of July 31, 2019, there were approximately 87,353,476 shares of the registrant's common stock outstanding.

12. Commitments and Contingencies

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On March 14, 2018, the Court held a hearing on the Company's post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. On June 27, 2018, prior to the Court issuing a decision on the motion, the Company entered into a Settlement Agreement (the "Settlement Agreement") with the Plaintiffs, John Alfred Lewis and Christopher Brandon Lewis. Pursuant to the terms of the Settlement Agreement, the Company paid $20 million to resolve all matters in controversy pertaining to the lawsuit. On July 5, 2018, the Court entered an order to discontinue the lawsuit pursuant to the Stipulation of Discontinuance with Prejudice filed by the parties.

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. In March 2018, the Company provided certain documents and information in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company has moved to dismiss the complaint. On May 2, 2019, the Court held a hearing on the Company's motion to dismiss. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

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

FORM 10-Q

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

For the quarterly period ended March 31, 2019

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: 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	75038
(Address of principal executive offices)	(Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

Not applicable
(Former name, former address and former fiscal year, if changed since last report)

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).
Yes ☐ No ☒

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock $0.01 par value	HMSY	The Nasdaq Stock Market LLC (Nasdaq Global Select Market)

As of May 2, 2019, there were approximately 87,095,920 shares of the registrant's common stock outstanding.

12. Commitments and Contingencies

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. In March 2018, the Company provided certain documents and information in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company has moved to dismiss the complaint. On May 2, 2019, the Court held a hearing on the Company's motion to dismiss. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.

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HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

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

Form 10-K

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

For the fiscal year ended December 31, 2018

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 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	75038
(Address of principal executive offices)	(Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	The Nasdaq Stock Market LLC (Nasdaq Global Select Market)

Securities registered pursuant to section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 29, 2018 the last business day of the registrant's most recently completed second quarter was approximately $1.8 billion based on the last reported sale price of the registrant's common stock on the Nasdaq Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers, directors and persons who hold 10% or more of the outstanding shares of common stock of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination is not necessarily a conclusive determination for any other purposes.

There were 85,271,867 shares of common stock outstanding as of February 15, 2019.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the registrant's 2019 definitive proxy statement, to the extent stated herein. Such proxy statement or amendment will be filed with the Securities and Exchange Commission within 120 days of the registrant's fiscal year ended December 31, 2018.

15. Commitments and Contingencies

(b) Litigation

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On March 14, 2018, the Court held a hearing on the Company's post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. On June 27, 2018, prior to the Court issuing a decision on the motion, the Company entered into a Settlement Agreement (the "Settlement Agreement") with the Plaintiffs, John Alfred Lewis and Christopher Brandon Lewis. Pursuant to the terms of the Settlement Agreement, the Company paid $20 million to resolve all matters in controversy pertaining to the lawsuit. On July 5, 2018, the Court entered an order to discontinue the lawsuit pursuant to the Stipulation of Discontinuance with Prejudice filed by the parties.

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. The Company provided certain documents and information in March 2018 in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company has moved to dismiss the complaint and the motion is currently under consideration by the Court. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

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

Form 10-K

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

For the fiscal year ended December 31, 2017

Or

o **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 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	75038
(Address of principal executive offices)	(Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	**The Nasdaq Stock Market LLC (Nasdaq Global Select Market)**

Securities registered pursuant to section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2017, the last business day of the registrant's most recently completed second quarter was $1.5 billion based on the last reported sale price of the registrant's common stock on the Nasdaq Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers, directors and persons who hold 10% or more of the outstanding shares of common stock of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination is not necessarily a conclusive determination for any other purposes.

There were 82,891,340 shares of common stock outstanding as of February 16, 2018.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the registrant's 2018 proxy statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the registrant's fiscal year ended December 31, 2017.

13. Commitments and Contingencies

(b) Litigation

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in *Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis* (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On November 20, 2017, the Company filed a post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. A hearing on the motion is set for March 2018. The Company continues to believe that strong grounds exist to overturn or greatly reduce the damages awarded by the jury. In light of the Company's belief that the jury award was unsupportable as a matter of law, the Company has not recorded a reserve for this pending litigation. HMS will continue to monitor developments in assessing the probability and measurability of any related loss contingency.

In February 2018, the Company received a Civil Investigative Demand from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. HMS intends to cooperate with the investigation.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

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

Form 10-K

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

For the fiscal year ended December 31, 2016

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 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX (Address of principal executive offices)	75038 (Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	**The NASDAQ Stock Market LLC (NASDAQ Global Select Market)**

Securities registered pursuant to section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒	Accelerated Filer ☐	Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2016, the last business day of the registrant's most recently completed second quarter was $1.5 billion based on the last reported sale price of the registrant's common stock on the NASDAQ Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers, directors and persons who hold 10% or more of the outstanding shares of common stock of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination is not necessarily a conclusive determination for any other purposes.

There were 83,909,845 shares of common stock outstanding as of May 31, 2017.

Documents Incorporated by Reference

None.

12. Commitments and Contingencies

(b) Litigation

Dennis Demetre and Lori Lewis: In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in *Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis* (the "California Action"), which are recoverable under the SPA. Mediation took place in September 2014 but the matter was not resolved. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action.

In January 2016, HMS moved for summary judgment on its counterclaim for breach of contract and for summary judgment on the Plaintiffs' breach of contract causes of action against HMS (HMS did not move for summary judgment on Plaintiffs' breach of implied covenant of good faith and fair dealing claim). The motions were argued on June 22, 2016. A decision on the motions has not yet been issued by the Court and a trial date has not been set. HMS continues to believe that the Plaintiffs' claims are without merit and will continue to vigorously defend against them.

Shareholder Proceedings: On March 3, 2017, a putative securities class action was filed in the Federal District Court for the District of New Jersey, entitled *Danahar v. HMS Holdings Corp., et al*. The complaint names the Company, its Chief Executive Officer, and its Chief Financial Officer as defendants and arises out of the Company's disclosure on March 2, 2017 that the filing of its 2016 Form 10-K would be delayed in order to permit the Company to complete the Company's previously disclosed review of its estimated liability for appeals and related internal control over financial reporting, and that the Company's auditor had informed the Company that it had identified what it believed was a material weakness in the Company's internal control over financial reporting related to the CMS reserves. The complaint alleges that the Company's Form 10-K for the period ended December 31, 2015 and its quarterly reports on Form 10-Q for the period January 1, 2016 to September 30, 2016 were false and misleading for failing to disclose the matters set forth above. On May 19, 2017, the New Jersey District Court granted the defendants' motion to transfer the action to the United States District Court for the Northern District of Texas. The action is at its early stages, and the Company has not yet responded to the complaint.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

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

Form 10-K

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

For the fiscal year ended December 31, 2015

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 000-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

Delaware	**11-3656261**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	**75038**
(Address of principal executive offices)	(Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock $0.01 par value	**NASDAQ Global Select Market**

Securities registered pursuant to section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒	Accelerated Filer ☐	Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2015, the last business day of the registrant's most recently completed second quarter was $1.5 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers and directors of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination of executive officers and directors as affiliates is not necessarily a conclusive determination for any other purposes.

There were 84,005,986 shares of common stock outstanding as of February 25, 2016.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the registrant's 2016 proxy statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the registrant's fiscal year ended December 31, 2015.

13. Commitments and Contingencies

(b) Litigation

Kern Health Systems: In August 2011, in the Superior Court of the State of California, County of Los Angeles, Kern Health Systems ("KHS") sought to recover in excess of $7.0 million exclusive of interest, attorneys' fees and costs, against HMS's wholly owned subsidiary Allied Management Group Special Investigation Unit, Inc. ("AMG") and two of AMG's former owners Dennis Demetre and Lori Lewis (collectively, the "Defendants"), jointly and severally, on causes of action for breach of contract, professional negligence, intentional misrepresentation, negligent misrepresentation and unfair business practices under the California Business and Professions Code. In June 2014, the jury issued its verdict in favor of all the Defendants, and against KHS, on all causes of action except negligent misrepresentation. On that cause of action, the jury issued a verdict against all the Defendants, jointly and severally, in the sum of $1.38 million. The negligent misrepresentation verdict was based on representations to KHS allegedly made by AMG and Demetre in the spring of 2008, prior to the Company's acquisition of AMG. HMS believes that the jury erroneously awarded damages based on an error inasmuch as the jury unanimously found that the Defendants (through Demetre) made the negligent misrepresentation to KHS while having reasonable grounds for believing the representation to be true. Based on the jury's verdict, HMS believes AMG is properly characterized as the prevailing party on the breach of contract claim. AMG has filed an appeal of the verdict and is seeking to recover its attorneys' fees and costs in the sum of approximately $2.3 million. HMS has not recorded an obligation at this time, as the Company continues to believe that it is probable that AMG will prevail on the appeal of this matter, although there are risks and uncertainties related to any litigation, including appeals, and neither the Company nor its counsel can assure litigation results. Pending the appeal process, HMS was required to obtain a surety bond in the amount of 150% of the final judgment amount, or approximately $2.2 million, which was collateralized by a cash deposit and is reflected in other current assets on the Company's Consolidated Balance Sheet as of December 31, 2015.

Dennis Demetre and Lori Lewis: In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price of AMG under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. Although the Plaintiffs also alleged an action based on fraud, the court dismissed that claim and further denied their subsequent appeal to resurrect the dismissed claim. HMS filed a counterclaim for breach of contract arising out of the Plaintiffs' failure to indemnify the Company for costs, including attorneys' fees arising out of the Company's defense of the *Kern Health Systems* matter described above and for fraud and negligent misrepresentation arising out of the Plaintiffs' misrepresentations concerning capabilities of their software platform. In July 2015, the court granted in part and denied in part the Plaintiffs' motion to dismiss HMS's counterclaims, allowing its counterclaim for breach of contract to proceed but dismissing the counterclaims for fraud and negligent misrepresentation. On January 4, 2016, HMS moved for summary judgment on (i) its remaining counterclaim for breach of contract against the Plaintiffs and (ii) the Plaintiffs' breach of contract causes of action against HMS. A pretrial conference has been set for April 2016 but no trial date has been set. HMS believes it has a meritorious defense and will continue to defend this matter vigorously, although there are risks and uncertainties related to any litigation. As such, HMS has not accrued for any loss contingencies related to this matter because no assessment can been made as to the likely outcome of this lawsuit or whether the outcome will be material to the Company.

Restrictive Covenants, Trade Secret, Contract and other Causes of Action in Texas and New York: HMS is the plaintiff in lawsuits filed in August 2014, entitled *HMS Holdings Corp., et al. v. Public Consulting Group, Inc., James Gambino and Jason Ramos* , in the District Court of Dallas County, Texas (the "Texas Action"), and *HMS Holdings Corp., et al. v. Matthew Arendt, Sean Curtin and Danielle Lange* , in the New York State Supreme Court, Albany County (the "New York Action"). In July 2015, HMS filed a third related lawsuit, entitled *HMS Holdings Corp., et al. v. Elena Moiseenko and Joseph Flora* , in the New York State Supreme Court, Albany County (the "Second New York Action"). These suits allege that, in violation of their respective contractual, statutory and common law obligations to the Company, defendants PCG, Joseph Flora and former HMS employees Gambino, Ramos, Arendt, Curtin, Lange and Moiseenko unlawfully misappropriated HMS's confidential, proprietary and trade secret information and committed other wrong doing. The lawsuits seek damages and injunctive relief and assert causes of action including breach of contract, breach of fiduciary duty and misappropriation of trade secrets. HMS has sought injunctions in all three Actions.

In July 2015, the court in the Texas Action found that HMS had proved the existence of unlawful conduct and had demonstrated a probable right to recovery at trial regarding its claims against PCG, Gambino and Ramos and that an injunction was necessary to avoid imminent and irreparable harm to the Company. As such, the Texas court issued an order that granted a temporary injunction against those defendants that was ordered to remain in place through the time of trial in the Texas Action (the "Texas Injunction"). As a condition to obtaining the Texas Injunction, HMS was required to post a surety bond in the amount of $0.5 million. In August 2015, HMS filed an appeal of the Texas Injunction to, among other things, expand upon the relief the trial court had awarded in order to enjoin PCG from providing TPL services to State Medicaid agencies through the time of trial, which PCG, Gambino and Ramos cross-appealed. Oral argument in this matter is set for March 2016. Additionally, in August 2015, PCG filed a counterclaim against the Company in the Texas Action claiming damages for alleged business disparagement and for tortious interference with an existing contract and prospective business relations, which HMS denied. In October 2015, PCG moved for partial summary judgment on HMS's claims requesting that the court enter a judgment in favor of PCG on the issue of damages suffered in connection with certain PCG TPL proposals. On December 4, 2015, the Texas court denied PCG's motion for partial summary judgment. On December 14, 2015, PCG filed an application for temporary injunction that would prohibit HMS from referring to certain conclusions made by the court in the Texas Injunction, which relate to the conduct of PCG or PCG's employees, as "factual findings" in the Company's future discussions with state authorities charged with awarding TPL contracts. If granted, PCG's temporary injunction would last through the time of trial in the Texas Action, which is set for April 25, 2016.

In May 2015, the court in the New York action issued an order granting HMS's motion for spoliation against Curtin and Lange finding that these defendants had engaged in egregious misconduct regarding the wrongful destruction of evidence. The court ordered Curtin and Lange to repay the Company's associated attorneys' fees and costs. Pursuant to the court's order, HMS is seeking reimbursement of approximately $0.45 million from these defendants. In July 2015, following the Texas court's ruling on the Texas Injunction, the court in the New York Action issued its decision and order on HMS's motion for a preliminary injunction against Curtin, Lange and Arendt. The New York court found that HMS had successfully established a likelihood of prevailing on its non-solicitation claims against all three defendants and on its trade secret misappropriation claims against Curtin and Lange; however, the court held that injunctive relief in the New York Action was not necessary due to the Texas Injunction. The court's order also preserved the Company's right to again seek injunctive relief in the New York Action in the event of a change of status regarding the Texas Injunction. Trial in the New York Action is tentatively set for June 6, 2016.

In August 2015, the court in the Second New York Action entered a temporary restraining order against defendants Moiseenko and Flora pending the court's final determination of HMS's application for a preliminary injunction in this matter. Flora generally denied HMS's motion, and Moiseenko opposed it on its merits and filed a cross-motion to dismiss the complaint on the grounds of improper forum. On November 13, 2015, the court in the Second New York Action issued an order granting a preliminary injunction against Flora after concluding that HMS had demonstrated a probable right to recovery at trial on its claim that Flora had misappropriated and misused the Company's trade secrets. The court's order also granted Moiseenko's motion to dismiss without prejudice to refiling in a proper forum.

As HMS has disclosed in previous filings with the SEC, in July 2015, HMS received notice that reprocurement of its TPL contract with the New Jersey Department of Human Services had been awarded to PCG. On February 12, 2016, HMS filed a protest with the State of New Jersey Division of Purchase and Property challenging the award. After multiple contract extensions, HMS's current TPL contract with the New Jersey Department of Human Services expires on March 31, 2016. In addition, in August 2015, the New York State Office of Medicaid General Inspector ("OMIG") awarded HMS the new Medicaid Third Party Liability Match and Recovery Services contract. PCG filed a protest of the award with the New York Office of the State Comptroller, which HMS and OMIG opposed. On January 8, 2016, HMS entered into an amendment to extend its existing TPL contract with OMIG through April 6, 2016. No decision has been rendered regarding the outcome of either protest.

While HMS believes its legal claims are meritorious, there are inherent uncertainties in any litigation, and there can be no assurances that HMS will ultimately prevail at trial or in legal proceedings related to the lawsuits, such as protests, or that the rulings in these proceedings are or will be adequate to protect the Company's confidential or trade secret information or that the rulings or outcomes in these matters would not have an adverse effect on the Company's business, financial condition or operating results.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes and employment-related matters. The Company's contractual relationships, including those with federal and state government entities, subject HMS operations, billing and business practices to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. Every so often, HMS may have contractual disputes with the Company's customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability . As of December 31, 2015, HMS accrued $2.6 million for litigation or other legal proceedings asserted or pending against the Company that could have, in the aggregate, a material adverse effect on its financial condition, results of operations or cash flows, and believe that adequate provision for any probable and estimable losses has been made in its consolidated financial statements. Although HMS believes that none of the Company's accruals for outstanding legal matters are material to the Company's financial position, the ultimate result of any current or future litigation or other legal proceedings, audits or disputes is inherently unpredictable and could result in liabilities that are higher than currently predicted.

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒

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

For the fiscal year ended December 31, 2014

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

Delaware	**11-3656261**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	**75038**
(Address of principal executive offices)	(Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	NASDAQ Global Select Market

Securities registered pursuant to section 12(g) of the Act:**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒	Accelerated Filer ☐	Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2014, the last business day of the registrant's most recently completed second quarter was $1.8 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 88,356,591 shares of common stock outstanding as of February 25, 2015.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the Registrant's 2015 Proxy Statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the Registrant's fiscal year ended December 31, 2014.

14. Commitments and Contingencies

(b) Litigation

From time to time, we may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of our business, including but not limited to regulatory audits, billing and contractual disputes and employment-related matters. We record accruals for outstanding legal matters when we believe it is probable that a loss will be incurred and the amount can be reasonably estimated. We evaluate, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, we do not establish an accrued liability. None of our accruals for outstanding legal matters are material in the aggregate to our financial position.

Our contractual relationships, including those with federal and state government entities, subject our operations, billing and business practices to scrutiny and audit, including by multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of our contractual performance. From time to time, we may have contractual disputes with our customers arising from differing interpretations of contractual provisions that define our rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that we accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect our business, financial condition, results of operations and cash flows.

Kern Health Systems: In August 2011, in the Superior Court of the State of California, County of Los Angeles, Kern Health Systems ("KHS" or "Plaintiff") sought to recover in excess of $7.0 million exclusive of interest, attorney fees and costs, against Allied Management Group Special Investigation Unit, Inc. ("AMG"), Dennis Demetre, and Lori Lewis (collectively, "Defendants"), jointly and severally, on causes of action for breach of contract, professional negligence, intentional misrepresentation, negligent misrepresentation and unfair business practices under the California Business and Professions Code. On

June 9, 2014, the jury issued its verdict in favor of all Defendants, and against KHS, on all causes of action except negligent misrepresentation. On that cause of action, the jury issued a verdict against all Defendants, jointly and severally, in the sum of $1.38 million. The negligent misrepresentation verdict was based on representations to KHS allegedly made by AMG and former owner Dennis Demetre in the spring of 2008, prior to our acquisition of AMG. We believe that the jury erroneously awarded damages based on an error inasmuch as the jury unanimously found that Defendants (through Demetre) made the negligent misrepresentation to KHS while having reasonable grounds for believing the representation to be true. Based on the jury's verdict, we believe we are properly characterized as the prevailing party on the breach of contract claim. AMG has filed an appeal of the verdict and is seeking to recover its attorney fees and costs in the sum of approximately $2.3 million. We have not recorded an obligation on this matter at this time, as we have appealed this decision and believe it is probable that we will prevail on the appeal of this matter, although there are risks and uncertainties related to any litigation, including appeals, and neither we nor our counsel can assure litigation results. Pending the appeal process, we were required to obtain a surety bond in the amount of 150% of the final judgment amount, or approximately $2.2 million, which was collateralized by a cash deposit and is reflected in Other current assets on our audited Consolidated Balance Sheet at December 31, 2014.

Dennis Demetre and Lori Lewis: In July 2012, two of AMG's former owners, Dennis Demetre and Lori Lewis filed an action in the Supreme Court of the State of New York, claiming an undetermined amount of damages alleging that various actions unlawfully deprived Demetre and Lewis of the acquisition earn-out portion of the purchase price of AMG under the applicable Stock Purchase Agreement (the "SPA") and that we had breached certain contractual provisions under the SPA. Demetre and Lewis filed a second amended complaint with two causes of action for breach of contract. We filed a counter claim for breach of contract arising out of Demetre's and Lewis's failure to indemnify us for costs, including attorney fees arising out of our defense of the KHS action described above and for fraud arising out of Demetre's and Lewis's misrepresentations concerning capabilities of their software platform. We believe we have a meritorious defense and will continue to defend this matter vigorously, although there are risks and uncertainties related to any litigation.

Restrictive Covenants and Trade Secret Actions in Texas and New York: We are the plaintiff in lawsuits filed in August 2014, entitled HMS Holdings Corp., et al. v. Public Consulting Group, Inc., James Gambino, and Jason Ramos, in the District Court of Dallas County, Texas, Cause No. DC-14-09047 (the "Texas Action"), and HMS Holdings Corp., et al. v. Matthew Arendt, Sean Curtin, and Danielle Lange, in New York State Supreme Court, Albany County, Index No. A00754/2014 (the "New York Action"). These suits allege that, in violation of their respective contractual, statutory and common law obligations to us, defendant Public Consulting Group, Inc. and defendant former HMS employees Gambino, Ramos, Arendt, Curtin, and Lange, unlawfully misappropriated our confidential, proprietary and trade secret information, as well as our employee and customer relationships. The lawsuits seek damages and injunctive relief and assert causes of action including breach of contract, breach of fiduciary duty and misappropriation of trade secrets. At the Texas Court's direction, an agreed temporary restraining order was entered, under which, inter alia, the defendants are prohibited from using our confidential information, and must return any of our information. Both the Texas and New York matters are currently in the discovery phase.

As of December 31, 2014, we accrued $0.9 million for litigation or other legal proceedings asserted or pending against us that could have, in the aggregate, a material adverse effect on our financial condition, results of operations or cash flows, and believe that adequate provision for any probable and estimable losses has been made in our consolidated financial statements. However, the ultimate result of any current or future litigation or other legal proceedings, audits or disputes is inherently unpredictable and could result in liabilities that are higher than currently predicted.

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒

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

For the fiscal year ended December 31, 2013

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

Delaware	**11-3656261**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX	**75038**
(Address of principal executive offices)	(Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	NASDAQ Global Select Market

Securities registered pursuant to section 12(g) of the Act:**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒ Accelerated Filer ☐ Non-Accelerated Filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2013, the last business day of the registrant's most recently completed second quarter was $2.0 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 87,485,097 shares of common stock outstanding as of February 25, 2014.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the Registrant's 2014 Proxy Statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the Registrant's fiscal year ended December 31, 2013.

13. Commitments and Contingencies

From time to time, we may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of our business, including but not limited to regulatory audits, billing and contractual disputes and employment-related matters. We record accruals for outstanding legal matters when we believe it is probable that a loss will be incurred and the amount can be reasonably estimated. We evaluate, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, we do not establish an accrued liability. None of our accruals for outstanding legal matters are material in the aggregate to our financial position.

Our contractual relationships, including those with federal and state government entities, subject to our operations, billing, and business practices to scrutiny and audit, including by multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of our contractual performance. From time to time, we may have contractual disputes with our clients arising from differing interpretations of contractual provisions that define our rights, obligations, scope of work, or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that we accept some amount of loss or liability in order to avoid client abrasion, negative marketplace perceptions and other disadvantageous results that could impact our business, results of operations and financial condition.

As of December 31, 2013, we accrued $2.2 million for litigation or other legal proceedings asserted or pending against us that could have, in the aggregate, a material adverse effect on our financial position, results of operations or cash flows, and believe that adequate provision for any probable and estimable losses has been made in our consolidated financial statements. However, the ultimate result of any current or future litigation or other legal proceedings, audits or disputes is inherently unpredictable and could result in liabilities that are higher than currently predicted.

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

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

For the fiscal year ended December 31, 2012

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York (State or other jurisdiction of incorporation or organization)	**11-3656261** (I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX (Address of principal executive offices)	**75038** (Zip Code)

(Registrant's telephone number, including area code)
(214) 453-3000

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	**NASDAQ Global Select Market**

Securities registered pursuant to section 12(g) of the Act:**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒	Accelerated Filer ☐	Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2012, the last business day of the registrant's most recently completed second quarter was $2.8 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 87,046,260 shares of common stock outstanding as of February 25, 2013.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the Registrant's 2013 Proxy Statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the Registrant's fiscal year ended December 31, 2012.

12. Commitments and Contingencies

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒

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

For the fiscal year ended December 31, 2011

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York	**11-3656261**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
401 Park Avenue South, New York, NY	**10016**
(Address of principal executive offices)	(Zip Code)

(Registrant's telephone number, including area code)
(212) 725-7965

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	**NASDAQ Global Select Market**

Securities registered pursuant to section 12(g) of the Act:**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒	Accelerated Filer ☐	Non-Accelerated Filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2011, the last business day of the registrant's most recently completed second quarter was $6.5 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 85,987,493 shares of common stock outstanding as of February 24, 2012.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the Registrant's 2012 Proxy Statement, to the extent stated herein. Such proxy statement or amendment will be filed with the SEC within 120 days of the Registrant's fiscal year ended December 31, 2011.

12. Commitments and Contingencies

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

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2010

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
401 Park Avenue South, New York, NY	**10016**
(Address of principal executive offices)	*(Zip Code)*

(212) 725-7965
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock $0.01 par value	NASDAQ Global Select Market

Securities registered pursuant to section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☑

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2010, the last business day of the registrant's most recently completed second quarter was $1.4 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 27,875,869 shares of common stock outstanding as of February 18, 2011.

Documents Incorporated by Reference

None.

12. Commitments and Contingencies

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

Form 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2009

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 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

New York	KRS 61.878(1)(a)
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
401 Park Avenue South, New York, NY	**10016**
(Address of principal executive offices)	*(Zip Code)*

(212) 725-7965
Registrant's telephone number, including area code

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock $0.01 par value	NASDAQ Global Select Market

Securities registered pursuant to section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Securities Act. Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☑

The aggregate market value of the registrant's common stock held by non-affiliates as of June 30, 2009, the last business day of

the registrant's most recently completed second quarter was $1.04 billion based on the last reported sale price of the registrant's Common Stock on the NASDAQ Global Select Market on that date.

There were 27,039,565 shares of common stock outstanding as of February 25, 2010.

Documents Incorporated by Reference

The information required by Part III of this Report, to the extent not set forth herein, is incorporated herein by reference from the registrant's definitive proxy statement relating to the Annual Meeting of Shareholders to be held in June 2010, which definitive proxy statement shall be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this Report relates.

13. Commitments and Contingencies

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-Q

(Mark One)

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

For the Quarterly Period Ended September 30, 2019

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

One Federal Street, Boston, Massachusetts 02110
(Address of Principal Executive Offices, Including Zip Code)

(617) 535-4766
(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 ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer Non-accelerated filer Smaller reporting company Emerging growth company

If emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Securities registered pursuant to Section 12(b) of the Exchange Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	IRM	NYSE

As of October 25, 2019, the registrant had 287,143,406 outstanding shares of common stock, $.01 par value.

IRON MOUNTAIN INCORPORATED

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(In Thousands, Except Share and Per Share Data)

(Unaudited)

(8) Commitments and Contingencies

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably able to be estimated. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. There have been no material updates or changes to the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report. We believe that the resolution of the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report will not have a material impact on our consolidated financial condition, results of operations or cash flows.

We have estimated a reasonably possible range for all loss contingencies, including those disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report and the item below, and believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $17,000 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

In June 2019, we received a notification of assessment from tax and customs authorities in the Netherlands related to a VAT liability of approximately 16,800 Euros. The notification of assessment is related to our customs clearing and logistics business in the Netherlands, which we acquired through the acquisition of Bonded Services of America, Inc. and Bonded Services Acquisition, Ltd. (collectively, “Bonded”) in September 2017. As part of the import and declaration services we provide in the Netherlands, we file import declaration forms to the customs authorities for all goods imported in a particular month and calculate the amount of VAT that is due on the goods being imported. In certain instances, we remit import VAT to the Dutch tax authorities and subsequently are reimbursed by the entity the goods are being imported on behalf of. In other instances, however, the payment of VAT may be deferred and paid upon the sale of the goods to the ultimate end customer in cases where the entity receiving the goods holds a valid license allowing for the deferment of VAT (referred to as an Article 23 license). In the notification of assessment, the Dutch tax authorities have asserted that (i) we inappropriately deferred VAT for goods imported under Article 23 for certain of our customers between March 2017 and August 2018 and (ii) we are liable for the amount of VAT related to those goods for which VAT was inappropriately deferred. We have responded to the notification of assessment and have requested additional information regarding the matter from the Dutch tax authorities.

We believe that the assessed amount will be subject to interest and potential penalties. We have established a reserve for this matter based upon our estimate of the amount of loss that is both probable and estimable. We are in the process of exploring potential recoveries (including insurance recoveries and/or claims against other third parties) against any losses we incur associated with this matter.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-Q

(Mark One)

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

For the Quarterly Period Ended June 30, 2019

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 1-13045

IRON MOUNTAIN INC ORPORATED

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

One Federal Street , Boston , Massachusetts 02110
(Address of Principal Executive Offices, Including Zip Code)

(617) 535-4766
(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 ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer Non-accelerated filer Smaller reporting company Emerging growth company

If emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Securities registered pursuant to Section 12(b) of the Exchange Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	IRM	NYSE

As of July 26, 2019 , the registrant had 287,106,811 outstanding shares of common stock, $.01 par value.

IRON MOUNTAIN INCORPORATED

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(In Thousands, Except Share and Per Share Data)

(Unaudited)

(7) Commitments and Contingencies

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably able to be estimated. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. There have been no material updates or changes to the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report. We believe that the resolution of the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report will not have a material impact on our consolidated financial condition, results of operations or cash flows.

We have estimated a reasonably possible range for all loss contingencies, including those disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report and the item below, and believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $17,000 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

In June 2019, we received a notification of assessment from tax and customs authorities in the Netherlands related to a VAT liability of approximately 16,800 Euros. The notification of assessment is related to our customs clearing and logistics business in the Netherlands, which we acquired through the acquisition of Bonded Services of America, Inc. and Bonded Services Acquisition, Ltd. (collectively, “Bonded”) in September 2017. As part of the import and declaration services we provide in the Netherlands, we file import declaration forms to the customs authorities for all goods imported in a particular month and calculate the amount of VAT that is due on the goods being imported. In certain instances, we remit import VAT to the Dutch tax authorities and subsequently are reimbursed by the entity the goods are being imported on behalf of. In other instances, however, the payment of VAT may be deferred and paid upon the sale of the goods to the ultimate end customer in cases where the entity receiving the goods holds a valid license allowing for the deferment of VAT (referred to as an Article 23 license). In the notification of assessment, the Dutch tax authorities have asserted that (i) we inappropriately deferred VAT for goods imported under Article 23 for certain of our customers between March 2017 and August 2018 and (ii) we are liable for the amount of VAT related to those goods for which VAT was inappropriately deferred. We have responded to the notification of assessment and have requested additional information regarding the matter from the Dutch tax authorities.

We believe that the amount, if assessed, would be subject to interest and potential penalties. We have established a reserve for this matter based upon our estimate of the amount of loss that is both probable and estimable. We are in the process of exploring potential recoveries (including insurance recoveries and/or claims against other third parties) against any losses we incur associated with this matter.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-Q

(Mark One)

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

For the Quarterly Period Ended March 31, 2019

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

One Federal Street, Boston, Massachusetts 02110
(Address of Principal Executive Offices, Including Zip Code)

(617) 535-4766
(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 ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐	Non-accelerated filer ☐	Smaller reporting company ☐	Emerging growth company ☐

If emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Number of shares of the registrant's Common Stock outstanding at April 19, 2019 : 286,880,641

IRON MOUNTAIN INCORPORATED

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(In Thousands, Except Share and Per Share Data)

(Unaudited)

(7) Commitments and Contingencies

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably able to be estimated. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. There have been no material updates or changes to the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report, nor have there been any new material loss contingencies since December 31, 2018. We believe that the resolution of the matters disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report will not have a material impact on our consolidated financial condition, results of operations or cash flows. We have estimated a reasonably possible range for all loss contingencies, including those disclosed in Note 10 to Notes to Consolidated Financial Statements included in our Annual Report, and believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $17,500 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2018

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically, every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Emerging growth company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2018 , the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $9.9 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 8, 2019 : 286,365,695

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2019 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2018 .

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2018
(In thousands, except share and per share data)

10. Commitments and Contingencies

c. Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $16,800 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d. Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We have been sued by six customers. Four of those lawsuits have been settled and two remain pending, including a claim asserted by Azienda per i Transporti Autoferrotranviari del Comune di Roma, S.p.A, seeking 42,600 Euros for the loss of its current and historical archives. We have also received correspondence from other affected customers, including certain customers demanding payment under various theories of liability. Although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows. We sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with this fire. As a result of the sale of the Italian operations, any future statement of operations and cash flow impacts related to the fire will be reflected as discontinued operations.

e. Argentina Fire

On February 5, 2014, we experienced a fire at a facility we own in Buenos Aires, Argentina. As a result of the quick response by local fire authorities, the fire was contained before the entire facility was destroyed and all employees were safely evacuated; however, a number of first responders lost their lives, or in some cases, were severely injured. The cause of the fire is currently being investigated. We believe we carry adequate insurance and do not expect that this event will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations at this facility represent less than 0.5% of our consolidated revenues. In December 2018, we received insurance proceeds of approximately $13,700 related to the involuntary conversion of assets included in the facility and, as a result, we recorded a gain on disposal/write-down of property, plant and equipment (excluding real estate), net of $8,814 during the fourth quarter of 2018.

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IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2018
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

f. Brooklyn Fire (Recall)

On January 31, 2015, a former Recall leased facility located in Brooklyn, New York was completely destroyed by a fire. Approximately 900,000 cartons of customer records were lost impacting approximately 1,200 customers. No one was injured as a result of the fire. We believe we carry adequate insurance to cover any losses resulting from the fire. There is one pending customer-related lawsuit stemming from the fire, which is being defended by our warehouse legal liability insurer. We have also received correspondence from other customers, under various theories of liability. We deny any liability with respect to the fire and we have referred these claims to our insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

g. Roye Fire (Recall)

On January 28, 2002, a former leased Recall records management facility located in Roye, France was destroyed by a fire. Local French authorities conducted an investigation relating to the fire and issued a charge of criminal negligence for non-compliance with security regulations against the Recall entity that leased the facility. We intend to defend this matter vigorously. We are currently corresponding with various customers impacted by the fire who are seeking payment under various theories of liability. There is also pending civil litigation with the owner of the destroyed facility, who is demanding payment for lost rental income and other items. Based on known and expected claims and our expectation of the ultimate outcome of those claims, we believe we carry adequate insurance coverage. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

h. Puerto Rico Facility Damage

In September 2017, two of our four facilities in Puerto Rico, one owned and one leased, sustained damage as a result of Hurricane Maria. The leased facility experienced structural damage to a portion of the roof and wall, while the owned facility sustained non-structural damage to a portion of the roof. Both buildings sustained water damage that impacted certain customer records. We believe we carry adequate insurance coverage for this event and do not believe it will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations in Puerto Rico represent less than 0.5% of our consolidated revenues.

Our policy related to business interruption insurance recoveries is to record gains within Other expense (income), net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment (excluding real estate), net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2017

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
Emerging growth company ☐	

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2017 , the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $9.0 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 9, 2018 : 285,311,549

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2018 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2017 .

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2017
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c. Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $21,500 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d. Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We have been sued by six customers. Four of those lawsuits have been settled and two remain pending, including a claim asserted by Azienda per i Transporti Autoferrotranviari del Comune di Roma, S.p.A, seeking 42,600 Euros for the loss of its current and historical archives. We have also received correspondence from other affected customers, including certain customers demanding payment under various theories of liability. Although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows. We sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with this fire. As a result of the sale of the Italian operations, any future statement of operations and cash flow impacts related to the fire will be reflected as discontinued operations.

e. Argentina Fire

On February 5, 2014, we experienced a fire at a facility we own in Buenos Aires, Argentina. As a result of the quick response by local fire authorities, the fire was contained before the entire facility was destroyed and all employees were safely evacuated; however, a number of first responders lost their lives, or in some cases, were severely injured. The cause of the fire is currently being investigated. We believe we carry adequate insurance and do not expect that this event will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations at this facility represent less than 0.5% of our consolidated revenues.

f. Brooklyn Fire (Recall)

On January 31, 2015, a former Recall leased facility located in Brooklyn, New York was completely destroyed by a fire. Approximately 900,000 cartons of customer records were lost impacting approximately 1,200 customers. No one was injured as a result of the fire. We believe we carry adequate insurance to cover any losses resulting from the fire. There are three pending customer-related lawsuits stemming from the fire, which are being defended by our warehouse legal liability insurer. We have also received correspondence from other customers, under various theories of liability. We deny any liability with respect to the fire and we have referred these claims to our insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

g. Roye Fire (Recall)

On January 28, 2002, a former leased Recall records management facility located in Roye, France was destroyed by a fire. Local French authorities conducted an investigation relating to the fire and issued a charge of criminal negligence for non-compliance with security regulations against the Recall entity that leased the facility. We intend to defend this matter vigorously. We are currently corresponding with various customers impacted by the fire who are seeking payment under various theories of liability. There is also pending civil litigation with the owner of the destroyed facility, who is demanding payment for lost rental income and other items. Based on known and expected claims and our expectation of the ultimate outcome of those claims, we believe we carry adequate insurance coverage. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

h. Puerto Rico Facility Damage

In September 2017, two of our four facilities in Puerto Rico, one owned and one leased, sustained damage as a result of Hurricane Maria. The leased facility experienced structural damage to a portion of the roof and wall, while the owned facility sustained non-structural damage to a portion of the roof. Both buildings sustained water damage that impacted certain customer records and we are in the process of fully assessing the extent of the damage to our customers' records at these facilities. We believe we carry adequate insurance coverage for this event and do not believe it will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations in Puerto Rico represent less than 0.5% of our consolidated revenues.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment (excluding real estate), net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2016

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 1-13045

IRON MOUNTAIN INCORPORATED
(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2016 , the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $10.4 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 17, 2017 : 263,724,213

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2016 .

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2016
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c. Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $20,000 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d. Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We have been sued by five customers. Four of those lawsuits have been settled and one , a claim asserted by Azienda per i Transporti Autoferrotranviari del Comune di Roma, S.p.A, seeking 42,600 Euro for the loss of its current and historical archives, remains pending. We have also received correspondence from other affected customers, including certain customers demanding payment under various theories of liability. Although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows. We sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with this fire. As a result of the sale of the Italian operations, any future statement of operations and cash flow impacts related to the fire will be reflected as discontinued operations.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment (excluding real estate), net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment.

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2016
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

e. Argentina Fire

On February 5, 2014, we experienced a fire at a facility we own in Buenos Aires, Argentina. As a result of the quick response by local fire authorities, the fire was contained before the entire facility was destroyed and all employees were safely evacuated; however, a number of first responders lost their lives, or in some cases, were severely injured. The cause of the fire is currently being investigated. We believe we carry adequate insurance and do not expect that this event will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations at this facility represent less than 0.5% of our consolidated revenues.

f. Brooklyn Fire (Recall)

On January 31, 2015, a former Recall leased facility located in Brooklyn, New York was completely destroyed by a fire. Approximately 900,000 cartons of customer records were lost impacting approximately 1,200 customers. No one was injured as a result of the fire. We believe we carry adequate insurance to cover any losses resulting from the fire. There are three pending customer-related lawsuits stemming from the fire, which are being defended by our warehouse legal liability insurer. We have also received correspondence from other customers, under various theories of liability. We deny any liability with respect to the fire and we have referred these claims to our insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

g. Roye Fire (Recall)

On January 28, 2002, a former leased Recall records management facility located in Roye, France was destroyed by a fire. Local French authorities conducted an investigation relating to the fire and issued a charge of criminal negligence for non-compliance with security regulations against the Recall entity that leased the facility. We intend to defend this matter vigorously. We are currently corresponding with various customers impacted by the fire who are seeking payment under various theories of liability. There is also pending civil litigation with the owner of the destroyed facility, who is demanding payment for lost rental income and other items. Based on known and expected claims and our expectation of the ultimate outcome of those claims, we believe we carry adequate insurance coverage. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2015

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	
(Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2015 , the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $6.5 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 19, 2016 : 211,508,202

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2015 .

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2015
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c. Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $6,000 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d. Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We have been sued by five customers. Three of those lawsuits have been settled and two remain pending, including a claim asserted by Azienda per i Transporti Autoferrotranviari del Comune di Roma, S.p.A, seeking 42,600 Euro for the loss of its current and historical archives. We have also received correspondence from other affected customers, including certain customers demanding payment under various theories of liability. Although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows. As discussed in Note 14, we sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with the fire.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment (excluding real estate), net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment. As a result of the sale of the Italian operations, statements of operations and cash flows related to the fire are reflected as discontinued operations.

e. Argentina Fire

On February 5, 2014, we experienced a fire at a facility we own in Buenos Aires, Argentina. As a result of the quick response by local fire authorities, the fire was contained before the entire facility was destroyed and all employees were safely evacuated; however, a number of first responders lost their lives, or in some cases, were severely injured. The cause of the fire is currently being investigated. We believe we carry adequate insurance and do not expect that this event will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations at this facility represent less than 0.5% of our consolidated revenues.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2014

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2014, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $6.2 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 20, 2015: 210,071,985

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2014.

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2014
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $4,500 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d.

Government Contract Billing Matter

Since October 2001, we have provided services to the United States Government under several General Services Administration ("GSA") multiple award schedule contracts (the "Schedules"). The Schedules contain a price reductions clause ("Price Reductions Clause") that requires us to offer to reduce the prices billed under the Schedules to correspond to the prices billed to certain benchmark commercial customers. In 2011, we initiated an internal review covering the contract period commencing in October 2006, and we discovered potential non-compliance with the Price Reductions Clause. We voluntarily disclosed the potential non-compliance for that period to the GSA and its Office of Inspector General ("OIG") in June 2011.

In April 2012, the United States Government sent us a subpoena seeking information that substantially overlapped with the subjects that were covered by the voluntary disclosure process that we initiated with the GSA and OIG in June 2011, except that the subpoena sought information dating back to 2000, and sought information about non-GSA federal and state and local customers. In June 2014, we learned that the government subpoena and investigation were the result of a pending, sealed *qui tam* lawsuit brought against us on behalf of the United States and the State of California. In December 2014, we settled the lawsuit. As a result of the settlement, we paid the United States Government and the State of California $44,500 and $1,250, respectively, in the fourth quarter of 2014. There was no material impact to our consolidated statement of operations in 2014 as a result of the settlement as we had previously accrued and maintained a deferred revenue liability related to this matter.

e.

Commonwealth of Massachusetts Assessment

During the third quarter of 2012, we applied for an abatement of assessments from the Commonwealth of Massachusetts. The assessments, issued in the second quarter of 2012, related to a corporate excise audit of the 2004 through 2006 tax years in the aggregate amount of $8,191, including tax, interest and penalties through the assessment date. The applications for abatement were denied during the third quarter of 2012. On October 19, 2012 we filed petitions with the Massachusetts Appellate Tax Board challenging the assessments. In addition, during the second quarter of 2013, Massachusetts assessed tax for the 2007 and 2008 tax years in the aggregate amount of $4,120, including tax, interest and penalties through the assessment date. The assessment is for issues consistent with those assessed in the earlier years. In the third quarter of 2013, we filed an application for abatement for the 2007 and 2008 tax years, which Massachusetts denied on October 15, 2013. On December 13, 2013, we filed a petition with the Massachusetts Appellate Tax Board to challenge the assessment for the 2007 and 2008 tax years. In February 2015, we reached a settlement agreement with the Commonwealth of Massachusetts, under which we paid $6,000 to settle the assessments related to the 2004 through 2008 tax years. Additionally, following a corporate excise audit for the 2009 through 2011 tax years, Massachusetts has issued Notices of Intention to Assess dated December 27, 2014 which set forth proposed corporate excise assessments in the aggregate amount of $1,503, including tax, interest and penalties. We intend to defend this matter vigorously at the Massachusetts Appellate Tax Board.

f.

Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. Although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We have been sued by four customers, of which three of those matters have been settled. We have also received correspondence from other customers, under various theories of liabilities. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations or cash flows. As discussed in Note 14, we sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with the fire.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment (excluding real estate), net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment. As a result of the sale of the Italian operations, statements of operations and cash flows related to the fire are reflected as discontinued operations.

g.

Argentina Fire

On February 5, 2014, we experienced a fire at a facility we own in Buenos Aires, Argentina. As a result of the quick response by local fire authorities, the fire was contained before the entire facility was destroyed and all employees were safely evacuated; however, a number of first responders lost their lives, or in some cases, were severely injured. The cause of the fire is currently being investigated. We believe we carry adequate insurance and do not expect that this event will have a material impact to our consolidated financial condition, results of operations or cash flows. Revenues from our operations at this facility represent less than 0.5% of our consolidated revenues.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2013

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
One Federal Street, Boston, Massachusetts	**02110**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered

Common Stock, $.01 par value per share	New York Stock Exchange
Rights to Purchase Series A Junior Participating Preferred Stock	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 28, 2013, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $4.6 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 7, 2014: 191,504,318

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K (the "Annual Report") is incorporated by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Stockholders (our "Proxy Statement") to be filed with the Securities and Exchange Commission (the "SEC") within 120 days after the close of the fiscal year ended December 31, 2013.

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2013
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $46,500 over the next several years, of which certain amounts would be covered by insurance or indemnity arrangements.

d. Government Contract Billing Matter

Since October 2001, we have provided services to the U.S. Government under several General Services Administration ("GSA") multiple award schedule contracts (the "Schedules"). From October 1, 2001 through December 31, 2013, we billed approximately $73,100 under the Schedules. The earliest of the Schedules was renewed in October 2006 with certain modifications to its terms. The Schedules contain a price reductions clause ("Price Reductions Clause") that requires us to offer to reduce the prices billed under the Schedules to correspond to the prices billed to certain benchmark commercial customers. In 2011, we initiated an internal review covering the contract period commencing in October 2006, and we discovered potential non-compliance with the Price Reductions Clause. We voluntarily disclosed the potential non-compliance for that period to the GSA and its Office of Inspector General ("OIG") in June 2011.

In April 2012, the U.S. Government sent us a subpoena seeking information that substantially overlaps with the subjects that are covered by the voluntary disclosure process that we initiated with the GSA and OIG in June 2011, except that the subpoena seeks information dating back to 2000, including the initial GSA schedule period of 2001 to 2006, and seeks information about non-GSA federal and state and local customers. Despite the substantial overlap, we understand that the subpoena relates to a separate inquiry, under the civil False Claims Act, that has been initiated independent of the GSA and OIG voluntary disclosure matter.

We continue to review this matter and provide the U.S. Government with information, including pricing practices and the proposed pricing adjustment amount to be refunded. The U.S. Government, however, may not agree with our determination of the refund amount and may request additional pricing adjustments, refunds, civil penalties, up to treble damages and/or interest.

Given the above, it is reasonably possible that an adjustment to our estimates may be required in the future as a result of updated facts and circumstances. To the extent that an adjustment to our estimates is necessary in a future period, we will assess, at that time, whether the adjustment is a result of a change in estimate or the correction of an error. A change in estimate would be reflected as an adjustment through the then-current period statement of operations. A correction of an error would require a quantitative and qualitative analysis to determine the approach to correcting the error. A correction of an error could be reflected in the then-current period statement of operations or as a restatement of prior period financial information, depending upon the underlying facts and circumstances and our quantitative and qualitative analysis.

e.

State of Massachusetts Assessment

During the third quarter of 2012, we applied for an abatement of assessments from the state of Massachusetts. The assessments, issued in the second quarter of 2012, related to a corporate excise audit of the 2004 through 2006 tax years in the aggregate amount of $8,191, including tax, interest and penalties through the assessment date. The applications for abatement were denied during the third quarter of 2012. On October 19, 2012 we filed petitions with the Massachusetts Appellate Tax Board challenging the assessments. We intend to defend this matter vigorously at the Massachusetts Appellate Tax Board. In addition, during the second quarter of 2013, Massachusetts assessed tax for the 2007 and 2008 tax years in the aggregate amount of $4,120, including tax, interest and penalties through the assessment date. The assessment is for issues consistent with those assessed in the earlier years. In the third quarter of 2013, we filed an application for abatement for the 2007 and 2008 tax years, which Massachusetts denied on October 15, 2013. On December 13, 2013, we filed a petition with the Massachusetts Appellate Tax Board to challenge the assessment for the 2007 and 2008 tax years and will vigorously defend the matter. Additionally, the state is auditing us for the 2009-2011 tax years.

f.

Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We continue to assess the impact of the fire, and, although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We have been sued by three customers, and all three of those matters have been settled. We have also received correspondence from other customers, under various theories of liabilities. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations and cash flows. As discussed in Note 14, we sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with the fire.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our Consolidated Statements of Operations and proceeds received within cash flows from operating activities in our Consolidated Statements of Cash Flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment, net within operating income in our Consolidated Statements of Operations and proceeds received within cash flows from investing activities within our Consolidated Statements of Cash Flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment. As a result of the sale of the Italian operations, statements of operation and cash flow impacts related to the fire will be reflected as discontinued operations.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2012

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
745 Atlantic Avenue, Boston, Massachusetts	**02111**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 29, 2012, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was approximately $4.8 billion based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 8, 2013: 190,140,008

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2012
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation—General

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably

possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $37,000 over the next several years.

d.

Patent Infringement Lawsuit

In August 2010, we were named as a defendant in a patent infringement suit filed in the U.S. District Court for the Eastern District of Texas by Oasis Research, LLC. The plaintiff alleged that the technology found in our Connected and LiveVault products infringed certain U.S. patents owned by the plaintiff. As part of the sale of our Digital Business, discussed in Note 14, our Connected and LiveVault products were sold to Autonomy, and Autonomy assumed this obligation and the defense of this litigation and agreed to indemnify us against any losses. In November 2012, the claim was settled and Autonomy paid the entire settlement amount.

e.

Government Contract Billing Matter

Since October 2001, we have provided services to the U.S. Government under several General Services Administration ("GSA") multiple award schedule contracts (the "Schedules"). The earliest of the Schedules was renewed in October 2006 with certain modifications to its terms. The Schedules contain a price reductions clause ("Price Reductions Clause") that requires us to offer to reduce the prices billed to the Government under the Schedules to correspond to the prices billed to certain benchmark commercial customers. Through December 31, 2012, we billed approximately $54,000 under the Schedules. In 2011, we initiated an internal review covering the contract period commencing in October 2006, and we discovered potential non-compliance with the Price Reductions Clause. We voluntarily disclosed the potential non-compliance to the GSA and its Office of Inspector General ("OIG") in June 2011.

We continue to review this matter and provide the GSA and OIG with information regarding our pricing practices and the proposed pricing adjustment amount to be refunded. The GSA and OIG, however, may not agree with our determination of the refund amount and may request additional pricing adjustments, refunds, civil penalties, up to treble damages and/or interest related to our Schedules.

In April 2012, the U.S. Government sent us a subpoena seeking information that substantially overlaps with the subjects that are covered by the voluntary disclosure process that we initiated with the GSA and OIG in June 2011, except that the subpoena seeks information dating back to 2000 and seeks information about non-GSA federal and state and local customers. Despite the substantial overlap, we understand that the subpoena relates to a separate inquiry, under the civil False Claims Act, that has been initiated independent of the GSA and OIG voluntary disclosure matter. We cannot determine at this time whether this separate inquiry will result in liability in addition to the amount that may be paid in connection with the voluntary disclosure to the OIG and GSA described above.

Given the above, it is reasonably possible that an adjustment to our estimates may be required in the future as a result of updated facts and circumstances. To the extent that an adjustment to our estimates is necessary in a future period, we will assess, at that time, whether the adjustment is a result of a change in estimate or the correction of an error. A change in estimate would be reflected as an adjustment through the then-current period statement of operations. A correction of an error would

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2012
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

require a quantitative and qualitative analysis to determine the approach to correcting the error. A correction of an error could be reflected in the then-current period statement of operations or as a restatement of prior period financial information, depending upon the underlying facts and circumstances and our quantitative and qualitative analysis.

f.

State of Massachusetts Assessment

During the third quarter of 2012, we applied for abatement of assessments from the state of Massachusetts. The assessments related to a corporate excise audit of the 2004 through 2006 tax years in the aggregate amount of $8,191, including tax, interest and penalties through the assessment date. The applications for abatement were denied during the third quarter of 2012. On October 19, 2012 we filed petitions with the Massachusetts Appellate Tax Board challenging the assessments. The final outcome of this matter may require payment of additional corporate excise tax, which consists of two measures, an income tax, which is a component of the provision for income taxes, and a net worth tax, which is an operating charge. We intend to defend this matter vigorously at the Massachusetts Appellate Tax Board. In addition, we are currently under a corporate excise audit by the state of Massachusetts for the 2007 and 2008 tax years. The adjustments being proposed are for issues consistent with those assessed in the earlier years. The state has also informed us that an audit of the 2009-2011 years will begin shortly.

g.

Italy Fire

On November 4, 2011, we experienced a fire at a facility we leased in Aprilia, Italy. The facility primarily stored archival and inactive business records for local area businesses. Despite quick response by local fire authorities, damage to the building was extensive, and the building and its contents were a total loss. We continue to assess the impact of the fire, and, although our warehouse legal liability insurer has reserved its rights to contest coverage related to certain types of potential claims, we believe we carry adequate insurance. We have been sued by two customers, and have received correspondence from other customers, under various theories of liabilities. We deny any liability with respect to the fire and we have referred these claims to our warehouse legal liability insurer for an appropriate response. We do not expect that this event will have a material impact on our consolidated financial condition, results of operations and cash flows. As discussed in Note 14, we sold our Italian operations on April 27, 2012, and we indemnified the buyers related to certain obligations and contingencies associated with the fire.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our consolidated statement of operations and proceeds received within cash flows from operating activities in our consolidated statement of cash flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment, net within operating income in our consolidated statement of operations and proceeds received within cash flows from investing activities within our consolidated statement of cash flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment. As a result of the sale of the Italian operations, statements of operation and cash flow impacts related to the fire will be reflected as discontinued operations.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2011

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
745 Atlantic Avenue, Boston, Massachusetts	**02111**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2011, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was $6,038,510,230.13 based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 10, 2012: 171,087,289

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2011
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation

We are involved in litigation from time to time in the ordinary course of business. A portion of the defense and/or settlement costs associated with such litigation is covered by various commercial liability insurance policies purchased by us and, in limited cases, indemnification from third parties. Our policy is to establish reserves for loss contingencies when the losses are both probable and reasonably estimable. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred. The matters described below represent our significant loss contingencies. We have evaluated each matter and, if both probable and estimable, accrued an amount that represents our estimate of any probable loss associated with such matter. In addition, we have estimated a reasonably possible range for all loss contingencies including those described below. We believe it is reasonably possible that we could incur aggregate losses in addition to amounts currently accrued for all matters up to an additional $51,300 over the next several years.

d.

London Fire

In July 2006, we experienced a significant fire in a leased records and information management facility in London, England, that resulted in the complete destruction of the facility and its contents. The London Fire Brigade ("LFB") issued a report in which it concluded that the fire resulted either from human agency, i.e., arson, or an unidentified ignition device or source, and its report to the Home Office concluded that the fire resulted from a deliberate act. The LFB also concluded that the installed sprinkler system failed to control the fire because the primary electric fire pump was disabled prior to the fire and the standby diesel fire pump was disabled in the early stages of the fire by third-party contractors. We have received notices of claims from customers or their subrogated insurance carriers under various theories of liability arising out of lost data and/or records as a result of the fire. Certain of those claims have resulted in litigation in courts in the United Kingdom. We deny any liability in respect of the London fire, and we have referred these claims to our excess warehouse legal liability insurer, which has been defending them to date under a reservation of rights. Certain of the claims have been settled for nominal amounts, typically one to two British pounds sterling per carton, as specified in the contracts, which amounts have been or will be reimbursed to us from our primary property insurer. We believe we carry adequate property and liability insurance related to this incident.

e.

Chile Earthquake

As a result of the February 27, 2010 earthquake in Chile, we experienced damage to certain of our 13 owned and leased records management facilities in that region. None of our facilities were destroyed by fire or significantly impacted by water damage. However, the structural integrity of five buildings was compromised, and some of the racking included in certain buildings was damaged or destroyed. Some customer materials were impacted by this event. Revenues from Chile represent less than 1% of our consolidated enterprise revenues. We believe we carry adequate property and liability insurance and do not expect that this event will have a material impact on our consolidated results of operations or financial condition. We received cumulative payments of $33,800 from our insurance carriers of which $27,000 was received in 2010 and $6,800 was received in 2011. Such amount represents final settlements of claims filed with our insurance carriers. Cash from our insurance settlements was used to fund capital expenditures and for general working capital needs. Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our consolidated statement of operations and proceeds received within cash flows from operating activities in our consolidated statement of cash flows. Such amounts are recorded in the period the cash is received. We recorded approximately $100 within other income (expense), net in our consolidated statement of operations associated with business interruption insurance recoveries in the year ended December 31, 2011. We have recorded gains on the disposal/write-down of property, plant and equipment, net in our statement of operations of approximately $10,200 for the year ended December 31, 2010. We have reflected approximately $14,800 of the cash proceeds received from our insurers in the year ended December 31, 2010 as proceeds from sales of property and equipment, net in our statement of cash flows. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment, net within operating income in our consolidated statement of operations and proceeds received within cash flows from investing activities within our consolidated statement of cash flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment.

f.

Brazilian Litigation

In September 2010, Iron Mountain do Brasil Ltda., our Brazilian operating subsidiary ("IMB"), was sued in Curitiba, Brazil in the 11th Lower Labor Claim Court. The plaintiff in the six related lawsuits, Sindicato dos Trabalhadores em Empresas de Serviços Contábeis, Assessoramento, Perícias, Informações, Pesquisas, e em Empresas Prestadoras de Serviços do Estado do Paraná (Union of Workers in Business Services Accounting, Advice, Expertise, Information, Research and Services Companies in the State of Parana), a labor union in Brazil, purported to represent 2,008 individuals who provided services for IMB. The complaint alleged that these individuals were incorrectly classified as non-employees by IMB and requested unspecified monetary damages, including attorneys' fees, unpaid wages, unpaid benefits and certain penalties. In August 2011, the court approved a settlement between the parties pursuant to which we will pay $2 for each of 531 individuals, subject to each individual's acceptance thereof. If all 531 individuals accept the settlement, it would result in payment by the Company of approximately $1,100. The claims of the remaining 1,477 individuals in the lawsuits not receiving proceeds in the settlement were dismissed by the court.

g.

Patent Infringement Lawsuit

In August 2010, we were named as a defendant in a patent infringement suit filed in the U.S. District Court for the Eastern District of Texas by Oasis Research, LLC. The plaintiff alleges that the technology found in our Connected and LiveVault products infringed certain U.S. patents owned by the plaintiff and seeks an unspecified amount of damages. A final pre-trial conference has been scheduled for October 12, 2012. We expect the court to establish a trial date during the pre-trial conference. As part of the sale of our Digital Business discussed at Note 14, our Connected and LiveVault products were sold to Autonomy and Autonomy has assumed this obligation and the defense of this litigation and has agreed to indemnify us against any losses.

h.

Government Contract Billing Matter

Since October, 2001, we have provided services to the U.S. Government under several General Services Administration ("GSA") multiple award schedule contracts (the "Schedules"). The earliest of the Schedules was renewed with certain modifications to its terms in October 2006. The Schedules contain a price reductions clause ("Price Reductions Clause") that requires us to offer to reduce the prices billed to the Government under the Schedules to correspond to the prices billed to certain benchmark commercial customers. Over the five years and three months ended December 31, 2011 we billed approximately $42,000 under the Schedules. In 2011, we initiated an internal review covering the contract period commencing in October 2006 and we discovered potential non-compliance with the Price Reductions Clause. We voluntarily disclosed the potential non-compliance to the GSA and its Office of Inspector General ("OIG") in June 2011. See Note 2.y.

We continue to review this matter and will provide the GSA and OIG with information regarding our pricing practices and proposed pricing adjustment amount to be refunded. The GSA and OIG, however, may not agree with our determination of the refund amount and may request additional pricing adjustments, refunds, civil penalties, up to treble damages and/or interest related to our Schedules.

i.

State of Massachusetts Notices of Intention to Assess

We are currently under audit by the state of Massachusetts for the 2004 through 2008 tax years. We have not received any final assessments to date. However, we have received notices of intention to assess for the 2004 to 2006 tax years in the amount of $7,867, including tax and penalties (but excluding interest). Currently this audit is on appeal with the Massachusetts Department of Revenue. The final outcome of this audit may result in an assessment of income tax, which is a component of the income tax provision, or an assessment of net worth tax, which is an operating charge. We intend to defend this matter vigorously.

j.

Italy Fire

We experienced a fire at a facility we lease in Aprilla, Italy on November 4, 2011. All employees were evacuated safely and the cause of the fire is currently being investigated. The facility primarily stored archival and inactive business records for local area businesses.

The leased facility, constructed in 2004, is one of approximately 1,000 facilities in our global portfolio and one of 10 facilities located in Italy. Despite quick response by local fire authorities, damage to the building was extensive and the building appears to be a total loss. We believe we carry adequate insurance and are in the process of assessing the impact of the fire but do not expect that this event will have a material impact to our consolidated financial condition, results of operations and cash flows.

Our policy related to business interruption insurance recoveries is to record gains within other (income) expense, net in our consolidated statement of operations and proceeds received within cash flows from operating activities in our consolidated statement of cash flows. Such amounts are recorded in the period the cash is received. Our policy with respect to involuntary conversion of property, plant and equipment is to record any gain or loss within (gain) loss on disposal/write-down of property, plant and equipment, net within operating income in our consolidated statement of operations and proceeds received within cash flows from investing activities within our consolidated statement of cash flows. Losses are recorded when incurred and gains are recorded in the period when the cash received exceeds the carrying value of the related property, plant and equipment.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2010

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
745 Atlantic Avenue, Boston, Massachusetts	**02111**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2010, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was $3,942,455.18 based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 10, 2011: 200,194,653

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2010
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation

We are involved in litigation from time to time in the ordinary course of business with a portion of the defense and/or settlement costs being covered by various commercial liability insurance policies purchased by us. In the opinion of management, no material legal proceedings are pending to which we, or any of our properties, are subject, except as discussed below. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred.

d.

London Fire

In July 2006, we experienced a significant fire in a leased records and information management facility in London, England, that resulted in the complete destruction of the facility and its contents. The London Fire Brigade ("LFB") issued a report in which it was concluded that the fire resulted either from human agency, i.e., arson, or an unidentified ignition device or source, and its report to the Home Office concluded that the fire resulted from a deliberate act. The LFB also concluded that the installed sprinkler system failed to control the fire due to the primary electric fire pump being disabled prior to the fire and the standby diesel fire pump being disabled in the early stages of the fire by third-party contractors. We have received notices of claims from customers or their subrogated insurance carriers under various theories of liability arising out of lost data and/or records as a result of the fire. Certain of those claims have resulted in litigation in courts in the United Kingdom. We deny any liability in respect of the London fire and we have referred these claims to our excess warehouse legal liability insurer, which has been defending them to date under a reservation of rights. Certain of the claims have been settled for nominal amounts, typically one to two British pounds sterling per carton, as specified in the contracts, which amounts have been or will be reimbursed to us from our primary property insurer. We believe we carry adequate property and liability insurance. We do not expect that legal proceedings related to this event will have a material impact to our consolidated results of operations or financial condition.

e.

Chile Earthquake

As a result of the February 27, 2010 earthquake in Chile, we experienced damage to certain of our 13 owned and leased records management facilities in that region. None of our facilities were destroyed by fire or significantly impacted by water damage. However, the structural integrity of five buildings was compromised, and some of the racking included in certain buildings was damaged or destroyed. Some customer materials were impacted by this event. Revenues from this country represent less than 1% of our consolidated enterprise revenues. We believe we carry adequate property and liability insurance and do not expect that this event will have a material impact on our consolidated results of operations or financial condition. We have received cumulative year-to-date payments from our insurance carriers of approximately $27,000. Such amount represents a portion of our business personal property, business interruption, and expense claims filed with our insurance carriers. We expect to utilize cash from our insurance settlements to fund capital expenditures and for general working capital needs. We have recorded gains on the disposal/writedown of property, plant and equipment, net in our statement of operations of approximately $10,200 for the year ended December 31, 2010. Proceeds from our business personal property claims are reflected in our statement of cash flows under proceeds from sales of property and equipment and other, net included in the investing activities section when received. We have reflected approximately $14,800 of the cash proceeds received to date as proceeds from sales of property and equipment, net in our statement of cash flows for the year ended December 31, 2010 as a result of the settlement of a portion of the property component of our claim.

f.

New Zealand Earthquake

As a result of the September 2010 earthquake in New Zealand, we experienced damage to one of our leased records management facilities in that region. The facility was not destroyed by fire or significantly impacted by water damage. However, some of the racking included in the building was damaged or destroyed. Some customer materials were impacted by this event. Revenues from this country represent less than 1% of our consolidated enterprise revenues. We believe we carry adequate property and liability insurance and do not expect that this event will have a material impact on our consolidated results of operations or financial condition. We expect to utilize cash from our insurance settlements to fund capital expenditures and for general working capital needs. We expect to receive proceeds from our property claims that exceed the carrying value of the related assets. We, therefore, expect to recognize gains on the disposal/writedown of property, plant and equipment, net in our statement of operations in future periods when the cash received to date exceeds the carrying value of the related property, plant and equipment, net. Proceeds from our business personal property claims are reflected in our statement of cash flows under proceeds from sales of property, plant and equipment and other, net included in the investing activities section when received.

g.

Brazilian Litigation

In September 2010, Iron Mountain do Brasil Ltda., our Brazilian operating subsidiary ("IMB"), was sued in Curitiba, Brazil in the 11th Lower Labor Claim Court. The plaintiff in the six related lawsuits, Sindicato dos Trabalhadores em Empresas de Serviços Contábeis, Assessoramento, Perícias, Informações, Pesquisas, e em Empresas Prestadoras de Serviços do Estado do Paraná (Union of Workers in Business Services Accounting, Advice, Expertise, Information, Research and Services Companies in the State of Parana), a labor union in Brazil, purports to represent approximately 2,000 individuals who provided services for IMB. The complaint alleges that these individuals were incorrectly classified as non-employees by IMB and seeks unspecified monetary damages, including attorneys' fees, unpaid wages, unpaid benefits and certain penalties. The parties participated in a preliminary hearing in December 2010 and an additional hearing is scheduled to take place in May 2011, in which oral arguments will be presented. We intend to defend this case vigorously. While we are unable to predict the final outcome of this matter at this time, we do not expect this lawsuit will have a material impact on our consolidated results of operations or financial condition.

h.

Patent Infringement Lawsuit

In August 2010, we were named as a defendant in a patent infringement suit filed in the US District Court for the Eastern District of Texas by Oasis Research, LLC. The plaintiff alleges that our Connected backup technology infringes certain U.S. patents owned by the plaintiff and seeks damages equal to 10% of our Connected revenue from 2005 through 2010, or approximately $26,000, and future royalties. In November 2010, we filed a motion to dismiss for misjoinder, or in the alternative, to sever and transfer claims to the US District Court for the District of Massachusetts. In December 2010, Oasis Research LLC filed a response opposing our motions. The court has not ruled on any outstanding motions. A scheduling conference has been set for April 18, 2011. Although we are unable to predict the final outcome of this matter at this time, we believe we have meritorious defenses and intend to defend this case vigorously. We do not expect this lawsuit will have a material impact on our consolidated results of operations or financial condition.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

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

For the Fiscal Year Ended December 31, 2010

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 1-13045

IRON MOUNTAIN INCORPORATED

(Exact name of Registrant as Specified in Its Charter)

Delaware	**23-2588479**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
745 Atlantic Avenue, Boston, Massachusetts	**02111**
(Address of principal executive offices)	(Zip Code)

617-535-4766

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $.01 par value per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a small reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2010, the aggregate market value of the Common Stock of the registrant held by non-affiliates of the registrant was $3,942,455.18 based on the closing price on the New York Stock Exchange on such date.

Number of shares of the registrant's Common Stock at February 10, 2011: 200,194,653

IRON MOUNTAIN INCORPORATED

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

DECEMBER 31, 2010
(In thousands, except share and per share data)

10. Commitments and Contingencies (Continued)

c.

Litigation

We are involved in litigation from time to time in the ordinary course of business with a portion of the defense and/or settlement costs being covered by various commercial liability insurance policies purchased by us. In the opinion of management, no material legal proceedings are pending to which we, or any of our properties, are subject, except as discussed below. We record legal costs associated with loss contingencies as expenses in the period in which they are incurred.

d.

London Fire

In July 2006, we experienced a significant fire in a leased records and information management facility in London, England, that resulted in the complete destruction of the facility and its contents. The London Fire Brigade ("LFB") issued a report in which it was concluded that the fire resulted either from human agency, i.e., arson, or an unidentified ignition device or source, and its report to the Home Office concluded that the fire resulted from a deliberate act. The LFB also concluded that the installed sprinkler system failed to control the fire due to the primary electric fire pump being disabled prior to the fire and the standby diesel fire pump being disabled in the early stages of the fire by third-party contractors. We have received notices of claims from customers or their subrogated insurance carriers under various theories of liability arising out of lost data and/or records as a result of the fire. Certain of those claims have resulted in litigation in courts in the United Kingdom. We deny any liability in respect of the London fire and we have referred these claims to our excess warehouse legal liability insurer, which has been defending them to date under a reservation of rights. Certain of the claims have been settled for nominal amounts, typically one to two British pounds sterling per carton, as specified in the contracts, which amounts have been or will be reimbursed to us from our primary property insurer. We believe we carry adequate property and liability insurance. We do not expect that legal proceedings related to this event will have a material impact to our consolidated results of operations or financial condition.

e.

Chile Earthquake

As a result of the February 27, 2010 earthquake in Chile, we experienced damage to certain of our 13 owned and leased records management facilities in that region. None of our facilities were destroyed by fire or significantly impacted by water damage. However, the structural integrity of five buildings was compromised, and some of the racking included in certain buildings was damaged or destroyed. Some customer materials were impacted by this event. Revenues from this country represent less than 1% of our consolidated enterprise revenues. We believe we carry adequate property and liability insurance and do not expect that this event will have a material impact on our consolidated results of operations or financial condition. We have received cumulative year-to-date payments from our insurance carriers of approximately $27,000. Such amount represents a portion of our business personal property, business interruption, and expense claims filed with our insurance carriers. We expect to utilize cash from our insurance settlements to fund capital expenditures and for general working capital needs. We have recorded gains on the disposal/writedown of property, plant and equipment, net in our statement of operations of approximately $10,200 for the year ended December 31, 2010. Proceeds from our business personal property claims are reflected in our statement of cash flows under proceeds from sales of property and equipment and other, net included in the investing activities section when received. We have reflected approximately $14,800 of the cash proceeds received to date as proceeds from sales of property and equipment, net in our statement of cash flows for the year ended December 31, 2010 as a result of the settlement of a portion of the property component of our claim.

f.

New Zealand Earthquake

As a result of the September 2010 earthquake in New Zealand, we experienced damage to one of our leased records management facilities in that region. The facility was not destroyed by fire or significantly impacted by water damage. However, some of the racking included in the building was damaged or destroyed. Some customer materials were impacted by this event. Revenues from this country represent less than 1% of our consolidated enterprise revenues. We believe we carry adequate property and liability insurance and do not expect that this event will have a material impact on our consolidated results of operations or financial condition. We expect to utilize cash from our insurance settlements to fund capital expenditures and for general working capital needs. We expect to receive proceeds from our property claims that exceed the carrying value of the related assets. We, therefore, expect to recognize gains on the disposal/writedown of property, plant and equipment, net in our statement of operations in future periods when the cash received to date exceeds the carrying value of the related property, plant and equipment, net. Proceeds from our business personal property claims are reflected in our statement of cash flows under proceeds from sales of property, plant and equipment and other, net included in the investing activities section when received.

g.

Brazilian Litigation

In September 2010, Iron Mountain do Brasil Ltda., our Brazilian operating subsidiary ("IMB"), was sued in Curitiba, Brazil in the 11th Lower Labor Claim Court. The plaintiff in the six related lawsuits, Sindicato dos Trabalhadores em Empresas de Serviços Contábeis, Assessoramento, Perícias, Informações, Pesquisas, e em Empresas Prestadoras de Serviços do Estado do Paraná (Union of Workers in Business Services Accounting, Advice, Expertise, Information, Research and Services Companies in the State of Parana), a labor union in Brazil, purports to represent approximately 2,000 individuals who provided services for IMB. The complaint alleges that these individuals were incorrectly classified as non-employees by IMB and seeks unspecified monetary damages, including attorneys' fees, unpaid wages, unpaid benefits and certain penalties. The parties participated in a preliminary hearing in December 2010 and an additional hearing is scheduled to take place in May 2011, in which oral arguments will be presented. We intend to defend this case vigorously. While we are unable to predict the final outcome of this matter at this time, we do not expect this lawsuit will have a material impact on our consolidated results of operations or financial condition.

h.

Patent Infringement Lawsuit

In August 2010, we were named as a defendant in a patent infringement suit filed in the US District Court for the Eastern District of Texas by Oasis Research, LLC. The plaintiff alleges that our Connected backup technology infringes certain U.S. patents owned by the plaintiff and seeks damages equal to 10% of our Connected revenue from 2005 through 2010, or approximately $26,000, and future royalties. In November 2010, we filed a motion to dismiss for misjoinder, or in the alternative, to sever and transfer claims to the US District Court for the District of Massachusetts. In December 2010, Oasis Research LLC filed a response opposing our motions. The court has not ruled on any outstanding motions. A scheduling conference has been set for April 18, 2011. Although we are unable to predict the final outcome of this matter at this time, we believe we have meritorious defenses and intend to defend this case vigorously. We do not expect this lawsuit will have a material impact on our consolidated results of operations or financial condition.

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

Form 10-Q

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

FOR THE QUARTERLY PERIOD ENDED SEPTEMBER 30, 2019

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**NYSE**

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐
Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of October 31, 2019, there were 947,414,929 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

UNITEDHEALTH GROUP

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PART I

ITEM 1. FINANCIAL STATEMENTS

UnitedHealth Group
Condensed Consolidated Balance Sheets
(Unaudited)

(in millions, except per share data)	September 30, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 12,363	$ 10,866
Short-term investments	3,455	3,458
Accounts receivable, net	10,964	11,388
Other current receivables, net	10,152	6,862
Assets under management	3,051	3,032
Prepaid expenses and other current assets	3,556	3,086
Total current assets	43,541	38,692
Long-term investments	36,840	32,510
Property, equipment and capitalized software, net	8,501	8,458
Goodwill	65,205	58,910
Other intangible assets, net	10,521	9,325
Other assets	9,101	4,326
Total assets	$173,709	$152,221
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 20,939	$ 19,891
Accounts payable and accrued liabilities	18,570	16,705
Commercial paper and current maturities of long-term debt	6,387	1,973
Unearned revenues	2,500	2,396
Other current liabilities	14,245	12,244
Total current liabilities	62,641	53,209
Long-term debt, less current maturities	38,507	34,581
Deferred income taxes	2,902	2,474
Other liabilities	9,912	5,730
Total liabilities	113,962	95,994
Commitments and contingencies (Note 7)		
Redeemable noncontrolling interests	1,991	1,908
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 947 and 960 issued and outstanding	9	10
Retained earnings	58,696	55,846
Accumulated other comprehensive loss	(3,709)	(4,160)
Nonredeemable noncontrolling interests	2,760	2,623
Total equity	57,756	54,319
Total liabilities, redeemable noncontrolling interests and equity	$173,709	$152,221

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Operations
(Unaudited)

(in millions, except per share data)	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018
Revenues:				
Premiums	$47,397	$44,613	$142,074	$133,155
Products	7,546	7,344	23,971	21,050
Services	4,942	4,217	13,756	12,590
Investment and other income	466	382	1,453	1,035
Total revenues	60,351	56,556	181,254	167,830
Operating costs:				
Medical costs	39,041	36,158	117,164	108,448
Operating costs	8,960	8,479	25,892	25,371
Cost of products sold	6,627	6,718	21,606	19,373
Depreciation and amortization	709	611	2,002	1,791
Total operating costs	55,337	51,966	166,664	154,983
Earnings from operations	5,014	4,590	14,590	12,847
Interest expense	(449)	(353)	(1,267)	(1,026)
Earnings before income taxes	4,565	4,237	13,323	11,821
Provision for income taxes	(936)	(953)	(2,752)	(2,603)
Net earnings	3,629	3,284	10,571	9,218
Earnings attributable to noncontrolling interests	(91)	(96)	(273)	(272)
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,538	$ 3,188	$ 10,298	$ 8,946
Earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	$ 3.73	$ 3.31	$ 10.82	$ 9.29
Diluted	$ 3.67	$ 3.24	$ 10.65	$ 9.09
Basic weighted-average number of common shares outstanding	949	962	952	963
Dilutive effect of common share equivalents	14	21	15	21
Diluted weighted-average number of common shares outstanding	963	983	967	984
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	12	7	10	7

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

(in millions)	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018
Net earnings	$3,629	$3,284	$10,571	$ 9,218
Other comprehensive (loss) income:				
Gross unrealized gains (losses) on investment securities during the period	230	(91)	1,243	(512)
Income tax effect	(53)	21	(285)	117
Total unrealized gains (losses), net of tax	177	(70)	958	(395)
Gross reclassification adjustment for net realized gains included in net earnings	(69)	(3)	(70)	(58)
Income tax effect	16	—	16	13
Total reclassification adjustment, net of tax	(53)	(3)	(54)	(45)
Total foreign currency translation losses	(560)	(233)	(453)	(1,303)
Other comprehensive (loss) income	(436)	(306)	451	(1,743)
Comprehensive income	3,193	2,978	11,022	7,475
Comprehensive income attributable to noncontrolling interests	(91)	(96)	(273)	(272)
Comprehensive income attributable to UnitedHealth Group common shareholders	$3,102	$2,882	$10,749	$ 7,203

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Equity
(Unaudited)

Three months ended September 30, (in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at June 30, 2019	948	$ 9	$ —	$ 56,367	$ 516	$ (3,789)	$ 2,751	$55,854
Net earnings				3,538			82	3,620
Other comprehensive income (loss)					124	(560)		(436)
Issuances of common stock, and related tax effects	2	—	277					277
Share-based compensation			130					130
Common share repurchases	(3)	—	(415)	(185)				(600)
Cash dividends paid on common shares ($1.08 per share)				(1,024)				(1,024)
Redeemable noncontrolling interests fair value and other adjustments			8					8
Acquisition and other adjustments of nonredeemable noncontrolling interests							(7)	(7)
Distribution to nonredeemable noncontrolling interests							(66)	(66)
Balance at September 30, 2019	947	$ 9	$ —	$ 58,696	$ 640	$ (4,349)	$ 2,760	$57,756
Balance at June 30, 2018	962	$ 10	$ —	$ 52,363	$ (356)	$ (3,724)	$ 2,490	$50,783
Net earnings				3,188			71	3,259
Other comprehensive loss					(73)	(233)		(306)
Issuances of common stock, and related tax effects	2	—	239					239
Share-based compensation			146					146
Common share repurchases	(2)	—	(201)	(299)				(500)
Cash dividends paid on common shares ($0.90 per share)				(866)				(866)
Redeemable noncontrolling interests fair value and other adjustments			(184)					(184)
Acquisition and other adjustments of nonredeemable noncontrolling interests							102	102
Distribution to nonredeemable noncontrolling interests							(77)	(77)
Balance at September 30, 2018	962	$ 10	$ —	$ 54,386	$ (429)	$ (3,957)	$ 2,586	$52,596

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Equity
(Unaudited)

Nine months ended September 30, (in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2019	960	$ 10	$ —	$ 55,846	$ (264)	$ (3,896)	$ 2,623	$54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				10,298			196	10,494
Other comprehensive income (loss)					904	(453)		451
Issuances of common stock, and related tax effects	8	—	438					438
Share-based compensation			521					521
Common share repurchases	(21)	(1)	(573)	(4,527)				(5,101)
Cash dividends paid on common shares ($3.06 per share)				(2,908)				(2,908)
Redeemable noncontrolling interests fair value and other adjustments			(277)					(277)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				157	48
Distribution to nonredeemable noncontrolling interests							(211)	(211)
Balance at September 30, 2019	947	$ 9	$ —	$ 58,696	$ 640	$ (4,349)	$ 2,760	$57,756
Balance at January 1, 2018	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				8,946			183	9,129
Other comprehensive loss					(440)	(1,303)		(1,743)
Issuances of common stock, and related tax effects	9	—	761					761
Share-based compensation			493					493
Common share repurchases	(16)	—	(2,838)	(812)				(3,650)
Cash dividends paid on common shares ($2.55 per share)				(2,454)				(2,454)
Redeemable noncontrolling interests fair value and other adjustments			(119)					(119)
Acquisition and other adjustments of nonredeemable noncontrolling interests							518	518
Distribution to nonredeemable noncontrolling interests							(172)	(172)
Balance at September 30, 2018	962	$ 10	$ —	$ 54,386	$ (429)	$ (3,957)	$ 2,586	$52,596

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Cash Flows
(Unaudited)

(in millions)	Nine Months Ended September 30, 2019	2018
Operating activities		
Net earnings	$ 10,571	$ 9,218
Noncash items:		
Depreciation and amortization	2,002	1,791
Deferred income taxes	177	9
Share-based compensation	525	512
Other, net	(181)	(136)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	957	(984)
Other assets	(2,181)	(1,641)
Medical costs payable	223	1,745
Accounts payable and other liabilities	105	2,783
Unearned revenues	60	20
Cash flows from operating activities	12,258	13,317
Investing activities		
Purchases of investments	(13,386)	(11,316)
Sales of investments	6,198	2,872
Maturities of investments	5,160	4,715
Cash paid for acquisitions, net of cash assumed	(8,200)	(5,824)
Purchases of property, equipment and capitalized software	(1,421)	(1,505)
Other, net	338	(187)
Cash flows used for investing activities	(11,311)	(11,245)
Financing activities		
Common share repurchases	(5,101)	(3,650)
Cash dividends paid	(2,908)	(2,454)
Proceeds from common stock issuances	740	745
Repayments of long-term debt	(1,250)	(2,600)
Proceeds from (repayments of) commercial paper, net	3,998	(164)
Proceeds from issuance of long-term debt	5,444	3,964
Customer funds administered	420	1,552
Other, net	(756)	(1,086)
Cash flows from (used for) financing activities	587	(3,693)
Effect of exchange rate changes on cash and cash equivalents	(37)	(97)
Increase (decrease) in cash and cash equivalents	1,497	(1,718)
Cash and cash equivalents, beginning of period	10,866	11,981
Cash and cash equivalents, end of period	$ 12,363	$ 10,263

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Notes to the Condensed Consolidated Financial Statements
(Unaudited)

1. Basis of Presentation

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and the "Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

The Company has prepared the Condensed Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The year-end condensed consolidated balance sheet was derived from audited financial statements, but does not include all disclosures required by GAAP. In accordance with the rules and regulations of the U.S. Securities and Exchange Commission (SEC), the Company has omitted certain footnote disclosures that would substantially duplicate the disclosures contained in its annual audited Consolidated Financial Statements. Therefore, these Condensed Consolidated Financial Statements should be read together with the Consolidated Financial Statements and the Notes included in Part II, Item 8, "Financial Statements and Supplementary Data" in the Company's Annual Report on Form 10-K for the year ended December 31, 2018 as filed with the SEC (2018 10-K). The accompanying Condensed Consolidated Financial Statements include all normal recurring adjustments necessary to present the interim financial statements fairly.

Use of Estimates

These Condensed Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates include medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Recently Adopted Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11, 2018-20 and 2019-01 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. The Company adopted ASU 2016-02 using a cumulative-effect upon adoption approach as of January 1, 2019. Upon adoption, the Company recognized $3.3 billion of lease right-of-use (ROU) assets and liabilities for operating leases on its Condensed Consolidated Balance Sheet, of which, $668 million were classified as current liabilities. The adoption of ASU 2016-02 was immaterial to the Company's consolidated results of operations, equity and cash flows. The Company has included the disclosures required by ASU 2016-02 below and in Note 7, "Commitments and Contingencies."

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. At the lease commencement date, lease ROU assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period that closely matches the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Condensed Consolidated Balance Sheet.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Condensed Consolidated Financial Statements.

2. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
September 30, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,591	$ 83	$ (2)	$ 3,672
State and municipal obligations	5,657	256	(3)	5,910
Corporate obligations	17,824	352	(9)	18,167
U.S. agency mortgage-backed securities	6,361	113	(6)	6,468
Non-U.S. agency mortgage-backed securities	1,685	48	(1)	1,732
Total debt securities — available-for-sale	35,118	852	(21)	35,949
Debt securities — held-to-maturity:				
U.S. government and agency obligations	272	2	—	274
State and municipal obligations	32	1	—	33
Corporate obligations	547	—	—	547
Total debt securities — held-to-maturity	851	3	—	854
Total debt securities	$ 35,969	$ 855	$ (21)	$ 36,803
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518

The Company held $2.0 billion of equity securities as of both September 30, 2019 and December 31, 2018. The Company's investments in equity securities primarily consist of employee savings plan related investments, shares of Brazilian real denominated fixed-income funds and dividend paying stocks with readily determinable fair values. Additionally, the Company's investments included $1.4 billion and $1.5 billion of equity method investments in operating businesses in the health care sector as of September 30, 2019 and December 31, 2018, respectively.

The amortized cost and fair value of debt securities as of September 30, 2019, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,571	$ 3,577	$ 313	$ 313
Due after one year through five years	11,904	12,084	258	259
Due after five years through ten years	8,303	8,669	141	141
Due after ten years	3,294	3,419	139	141
U.S. agency mortgage-backed securities	6,361	6,468	—	—
Non-U.S. agency mortgage-backed securities	1,685	1,732	—	—
Total debt securities	$ 35,118	$ 35,949	$ 851	$ 854

The fair value of available-for-sale debt securities with gross unrealized losses by security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
September 30, 2019						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 286	$ (1)	$ 228	$ (1)	$ 514	$ (2)
State and municipal obligations	296	(2)	83	(1)	379	(3)
Corporate obligations	1,360	(5)	1,022	(4)	2,382	(9)
U.S. agency mortgage-backed securities	570	(2)	518	(4)	1,088	(6)
Non-U.S. agency mortgage-backed securities	217	(1)	—	—	217	(1)
Total debt securities — available-for-sale	$ 2,729	$ (11)	$ 1,851	$ (10)	$ 4,580	$ (21)
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$ 12,355	$ (156)	$ 11,002	$ (287)	$ 23,357	$ (443)

The Company's unrealized losses from debt securities as of September 30, 2019 were generated from 4,000 positions out of a total of 32,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of September 30, 2019, the Company did not

have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

3. Fair Value

Certain assets and liabilities are measured at fair value in the Condensed Consolidated Financial Statements or have fair values disclosed in the Notes to the Condensed Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP.

For a description of the methods and assumptions that are used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument, see Note 4 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
September 30, 2019				
Cash and cash equivalents	$ 12,210	$ 153	$ —	$ 12,363
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,421	251	—	3,672
State and municipal obligations	—	5,910	—	5,910
Corporate obligations	71	17,879	217	18,167
U.S. agency mortgage-backed securities	—	6,468	—	6,468
Non-U.S. agency mortgage-backed securities	—	1,732	—	1,732
Total debt securities — available-for-sale	3,492	32,240	217	35,949
Equity securities	1,839	21	—	1,860
Assets under management	1,116	1,907	28	3,051
Total assets at fair value	$ 18,657	$ 34,321	$ 245	$ 53,223
Percentage of total assets at fair value	35%	65%	—%	100%
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$ 10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$ 47,641
Percentage of total assets at fair value	35%	65%	—%	100%

There were no transfers in or out of Level 3 financial assets or liabilities during the nine months ended September 30, 2019 or 2018.

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
September 30, 2019					
Debt securities — held-to-maturity	$ 410	$ 176	$ 268	$ 854	$ 851
Long-term debt and other financing obligations	$ —	$ 45,342	$ —	$ 45,342	$ 40,814
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during either the nine months ended September 30, 2019 or 2018.

4. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the nine months ended September 30:

(in millions)	2019	2018
Medical costs payable, beginning of period	$ 19,891	$ 17,871
Acquisitions	868	333
Reported medical costs:		
Current year	117,624	108,658
Prior years	(460)	(210)
Total reported medical costs	117,164	108,448
Medical payments:		
Payments for current year	(99,487)	(90,348)
Payments for prior years	(17,497)	(16,454)
Total medical payments	(116,984)	(106,802)
Medical costs payable, end of period	$ 20,939	$ 19,850

For the nine months ended September 30, 2019 and 2018, the medical cost reserve development included no individual factors that were significant. Medical costs payable included reserves for claims incurred by insured customers but not yet reported to the Company of $14.2 billion and $13.2 billion at September 30, 2019 and December 31, 2018, respectively.

5. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	September 30, 2019 Par Value	September 30, 2019 Carrying Value	September 30, 2019 Fair Value	December 31, 2018 Par Value	December 31, 2018 Carrying Value	December 31, 2018 Fair Value
Commercial paper	$ 4,082	$ 4,080	$ 4,080	$ —	$ —	$ —
1.700% notes due February 2019	—	—	—	750	750	749
1.625% notes due March 2019	—	—	—	500	500	499
2.300% notes due December 2019	500	499	500	500	494	497
2.700% notes due July 2020	1,500	1,499	1,508	1,500	1,498	1,494
Floating rate notes due October 2020	300	300	300	300	299	298
3.875% notes due October 2020	450	450	457	450	443	456
1.950% notes due October 2020	900	898	900	900	897	884
4.700% notes due February 2021	400	404	412	400	398	412
2.125% notes due March 2021	750	748	752	750	747	734
Floating rate notes due June 2021	350	349	349	350	349	347
3.150% notes due June 2021	400	399	408	400	399	400
3.375% notes due November 2021	500	502	512	500	489	503
2.875% notes due December 2021	750	755	764	750	735	748
2.875% notes due March 2022	1,100	1,088	1,120	1,100	1,051	1,091
3.350% notes due July 2022	1,000	997	1,036	1,000	997	1,005
2.375% notes due October 2022	900	895	909	900	894	872
0.000% notes due November 2022	15	13	13	15	12	13
2.750% notes due February 2023	625	627	637	625	602	611
2.875% notes due March 2023	750	776	769	750	750	739
3.500% notes due June 2023	750	747	786	750	746	756
3.500% notes due February 2024	750	745	790	750	745	755
2.375% notes due August 2024	750	746	756	—	—	—
3.750% notes due July 2025	2,000	1,990	2,150	2,000	1,989	2,025
3.700% notes due December 2025	300	298	323	300	298	303
3.100% notes due March 2026	1,000	996	1,045	1,000	995	965
3.450% notes due January 2027	750	746	798	750	746	742
3.375% notes due April 2027	625	619	663	625	619	611
2.950% notes due October 2027	950	939	982	950	938	898
3.850% notes due June 2028	1,150	1,142	1,259	1,150	1,142	1,163
3.875% notes due December 2028	850	843	936	850	842	861
2.875% notes due August 2029	1,000	1,022	1,021	—	—	—
4.625% notes due July 2035	1,000	992	1,208	1,000	992	1,060
5.800% notes due March 2036	850	838	1,134	850	838	1,003
6.500% notes due June 2037	500	492	711	500	492	638
6.625% notes due November 2037	650	641	940	650	641	841
6.875% notes due February 2038	1,100	1,076	1,625	1,100	1,076	1,437
3.500% notes due August 2039	1,250	1,241	1,301	—	—	—
5.700% notes due October 2040	300	296	397	300	296	355
5.950% notes due February 2041	350	345	476	350	345	426
4.625% notes due November 2041	600	589	710	600	588	627
4.375% notes due March 2042	502	484	572	502	484	503
3.950% notes due October 2042	625	607	676	625	607	596
4.250% notes due March 2043	750	735	844	750	734	744
4.750% notes due July 2045	2,000	1,973	2,431	2,000	1,973	2,116
4.200% notes due January 2047	750	738	852	750	738	745
4.250% notes due April 2047	725	717	823	725	717	719
3.750% notes due October 2047	950	933	1,005	950	933	869
4.250% notes due June 2048	1,350	1,329	1,550	1,350	1,329	1,349
4.450% notes due December 2048	1,100	1,086	1,301	1,100	1,087	1,132
3.700% notes due August 2049	1,250	1,235	1,323	—	—	—
3.875% notes due August 2059	1,250	1,231	1,327	—	—	—
Total commercial paper and long-term debt	$ 43,999	$ 43,690	$ 48,141	$ 35,667	$ 35,234	$ 36,591

The Company's long-term debt obligations included $1.2 billion and $1.3 billion of other financing obligations, of which $309 million and $229 million were classified as current as of September 30, 2019 and December 31, 2018, respectively.

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of September 30, 2019, the Company's outstanding commercial paper had a weighted average annual interest rate of 2.2%.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. The Company additionally has a $2.5 billion 364-day revolving bank credit facility with 6 banks that matures in May 2020. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of September 30, 2019, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of September 30, 2019, annual interest rates would have ranged from 2.7% to 2.8%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including covenants requiring the Company to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of September 30, 2019.

6. Dividends

In June 2019, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to $4.32 compared to $3.60 per share, which the Company had paid since June 2018. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2019 dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
March 19	$ 0.90	$ 860
June 25	1.08	1,024
September 24	1.08	1,024

7. Commitments and Contingencies

Leases

Operating lease costs were $275 million and $760 million for the three and nine months ended September 30, 2019, respectively, and included immaterial variable and short-term lease costs. Cash payments made on the Company's operating lease liabilities were $552 million for the nine months ended September 30, 2019, which were classified within operating activities in the Condensed Consolidated Statements of Cash Flows. As of September 30, 2019, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.6 years and 3.9%, respectively.

As of September 30, 2019, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Operating Lease Payments
2019	$ 198
2020	782
2021	693
2022	580
2023	477
Thereafter	1,978
Total future minimum lease payments	4,708
Less imputed interest	(758)
Total	$ 3,950

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare and Medicaid Services (CMS), state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The

whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

8. Business Combinations

During the nine months ended September 30, 2019, the Company completed several business combinations for total cash consideration of $9.7 billion.

The total consideration exceeded the estimated fair value of the net tangible assets acquired by $8.6 billion, of which $2.0 billion has been allocated to finite-lived intangible assets and $6.6 billion to goodwill. The goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 1,537
Accounts receivable and other current assets	1,775
Property, equipment and other long-term assets	1,941
Medical costs payable	(868)
Accounts payable and other current liabilities	(1,669)
Other long-term liabilities	(1,283)
Total net tangible assets	$ 1,433

The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized.

The acquisition date fair values and weighted-average useful lives assigned to acquired finite-lived intangible assets were:

(in millions, except years)	Fair Value	Weighted-Average Useful Life
Customer-related	$ 1,670	14
Trademarks and technology	117	4
Other	164	10
Total acquired finite-lived intangible assets	$ 1,951	13

The results of operations and financial condition of acquired entities have been included in the Company's consolidated results and the results of the corresponding operating segment as of date of acquisition. Through September 30, 2019, acquired entities' impact on revenues and net earnings was not material.

Unaudited pro forma revenues for the nine months ended September 30, 2019 and 2018 as if the acquisitions had occurred on January 1, 2018 were immaterial for both periods. The pro forma effects of the acquisitions on net earnings were immaterial for both years.

9. Segment Financial Information

The Company's four reportable segments are UnitedHealthcare, OptumHealth, OptumInsight and OptumRx. For more information on the Company's segments see Part I, Item I, "Business" and Note 13 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K. Total assets at OptumHealth increased to $40.1 billion as of September 30, 2019 compared to $29.8 billion as of December 31, 2018, primarily due to goodwill and other intangibles assets from a second quarter 2019 acquisition and the recognition of ROU assets from ASU 2016-02. Total assets at OptumInsight increased to $15.1 billion as of September 30, 2019 compared to $11.0 billion as of December 31, 2018, primarily due to goodwill and other intangibles assets from a third quarter 2019 acquisition.

The following tables present reportable segment financial information:

		Optum						
(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum	Corporate and Eliminations	Consolidated
Three Months Ended September 30, 2019								
Revenues — unaffiliated customers:								
Premiums	$ 45,557	$ 1,840	$ —	$ —	$ —	$ 1,840	$ —	$ 47,397
Products	—	6	29	7,511	—	7,546	—	7,546
Services	2,274	1,487	988	193	—	2,668	—	4,942
Total revenues — unaffiliated customers	47,831	3,333	1,017	7,704	—	12,054	—	59,885
Total revenues — affiliated customers	—	4,630	1,594	10,734	(441)	16,517	(16,517)	—
Investment and other income	274	170	6	16	—	192	—	466
Total revenues	$ 48,105	$ 8,133	$ 2,617	$ 18,454	$ (441)	$ 28,763	$ (16,517)	$ 60,351
Earnings from operations	$ 2,655	$ 748	$ 632	$ 979	$ —	$ 2,359	$ —	$ 5,014
Interest expense	—	—	—	—	—	—	(449)	(449)
Earnings before income taxes	$ 2,655	$ 748	$ 632	$ 979	$ —	$ 2,359	$ (449)	$ 4,565
Three Months Ended September 30, 2018								
Revenues — unaffiliated customers:								
Premiums	$ 43,628	$ 985	$ —	$ —	$ —	$ 985	$ —	$ 44,613
Products	—	13	29	7,302	—	7,344	—	7,344
Services	2,067	1,196	790	164	—	2,150	—	4,217
Total revenues — unaffiliated customers	45,695	2,194	819	7,466	—	10,479	—	56,174
Total revenues — affiliated customers	—	3,733	1,431	9,960	(352)	14,772	(14,772)	—
Investment and other income	242	125	4	11	—	140	—	382
Total revenues	$ 45,937	$ 6,052	$ 2,254	$ 17,437	$ (352)	$ 25,391	$ (14,772)	$ 56,556
Earnings from operations	$ 2,559	$ 622	$ 534	$ 875	$ —	$ 2,031	$ —	$ 4,590
Interest expense	—	—	—	—	—	—	(353)	(353)
Earnings before income taxes	$ 2,559	$ 622	$ 534	$ 875	$ —	$ 2,031	$ (353)	$ 4,237

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
Nine Months Ended September 30, 2019								
Revenues — unaffiliated customers:								
Premiums	$ 138,088	$ 3,986	$ —	$ —	$ —	$ 3,986	$ —	$ 142,074
Products	—	23	74	23,874	—	23,971	—	23,971
Services	6,603	4,131	2,532	490	—	7,153	—	13,756
Total revenues — unaffiliated customers	144,691	8,140	2,606	24,364	—	35,110	—	179,801
Total revenues — affiliated customers	—	13,366	4,522	30,786	(1,181)	47,493	(47,493)	—
Investment and other income	904	488	17	44	—	549	—	1,453
Total revenues	$ 145,595	$ 21,994	$ 7,145	$ 55,194	$ (1,181)	$ 83,152	$ (47,493)	$ 181,254
Earnings from operations	$ 8,251	$ 2,062	$ 1,589	$ 2,688	$ —	$ 6,339	$ —	$ 14,590
Interest expense	—	—	—	—	—	—	(1,267)	(1,267)
Earnings before income taxes	$ 8,251	$ 2,062	$ 1,589	$ 2,688	$ —	$ 6,339	$ (1,267)	$ 13,323
Nine Months Ended September 30, 2018								
Revenues — unaffiliated customers:								
Premiums	$ 130,361	$ 2,794	$ —	$ —	$ —	$ 2,794	$ —	$ 133,155
Products	—	37	72	20,941	—	21,050	—	21,050
Services	6,248	3,587	2,306	449	—	6,342	—	12,590
Total revenues — unaffiliated customers	136,609	6,418	2,378	21,390	—	30,186	—	166,795
Total revenues — affiliated customers	—	10,979	4,115	29,062	(1,026)	43,130	(43,130)	—
Investment and other income	633	355	15	32	—	402	—	1,035
Total revenues	$ 137,242	$ 17,752	$ 6,508	$ 50,484	$ (1,026)	$ 73,718	$ (43,130)	$ 167,830
Earnings from operations	$ 7,316	$ 1,680	$ 1,382	$ 2,469	$ —	$ 5,531	$ —	$ 12,847
Interest expense	—	—	—	—	—	—	(1,026)	(1,026)
Earnings before income taxes	$ 7,316	$ 1,680	$ 1,382	$ 2,469	$ —	$ 5,531	$ (1,026)	$ 11,821

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Condensed Consolidated Financial Statements and Notes and with our 2018 10-K, including the Consolidated Financial Statements and Notes in Part II, Item 8, "Financial Statements and Supplementary Data" in that report. Unless the context indicates otherwise, references to the terms "UnitedHealth Group," "we," "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations refer to UnitedHealth Group Incorporated and its consolidated subsidiaries.

Readers are cautioned that the statements, estimates, projections or outlook contained in this Management's Discussion and Analysis of Financial Condition and Results of Operations, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 2, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed or implied in the forward-looking statements. A description of some of the risks and uncertainties is set forth in Part I, Item 1A, "Risk Factors" in our 2018 10-K and in the discussion below.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

Further information on our business is presented in Part I, Item 1, "Business" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K and additional information on our segments can be found in this Item 2 and in Note 9 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Business Trends

Our businesses participate in the United States, South American and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. Overall spending on health care is impacted by inflation; medical technology and pharmaceutical advancement; regulatory requirements; demographic trends in the population and national interest in health and well-being, mitigated by our continued efforts to control health care costs. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which could impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any impact from the Health Insurance Industry Tax. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum medical loss ratio (MLR) thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform

changes. Pricing for contracts that cover some portion of calendar year 2020 reflects the return of the Health Insurance Industry Tax after a moratorium in 2019.

Government programs in the public and senior sector tend to receive lower rates of increase than the commercial market due to governmental budget pressures and lower cost trends.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high quality, affordable care.

Regulatory Trends and Uncertainties

Following is a summary of management's view of regulatory trends and uncertainties. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business — Government Regulation," Part 1, Item 1A, "Risk Factors" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K.

Medicare Advantage Rates. Final 2020 Medicare Advantage rates resulted in an increase in industry base rates of approximately 2.5%, short of the industry forward medical cost trend, including the return of the non-reimbursable Health Insurance Industry Tax, creating continued pressure in the Medicare Advantage program.

Health Insurance Industry Tax. There is a one year moratorium on the Health Insurance Industry Tax in 2019. This moratorium impacts year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following summarizes select third quarter 2019 year-over-year operating comparisons to third quarter 2018.

- Consolidated revenues grew 7%, UnitedHealthcare revenues grew 5% and Optum revenues grew 13%.
- UnitedHealthcare served 415,000 additional people primarily as a result of acquisitions and growth in services to self-funded employers and seniors.
- Consolidated earnings from operations increased 9%, including increases of 4% at UnitedHealthcare and 16% at Optum.
- Diluted earnings per common share increased 13%.
- Cash flows from operations for the nine months ended September 30, 2019 were $12.3 billion.
- Return on equity was 26.2%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Increase/ (Decrease) 2019 vs. 2018		Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues:								
Premiums	$47,397	$44,613	$2,784	6%	$142,074	$133,155	$ 8,919	7%
Products	7,546	7,344	202	3	23,971	21,050	2,921	14
Services	4,942	4,217	725	17	13,756	12,590	1,166	9
Investment and other income	466	382	84	22	1,453	1,035	418	40
Total revenues	60,351	56,556	3,795	7	181,254	167,830	13,424	8
Operating costs:								
Medical costs	39,041	36,158	2,883	8	117,164	108,448	8,716	8
Operating costs	8,960	8,479	481	6	25,892	25,371	521	2
Cost of products sold	6,627	6,718	(91)	(1)	21,606	19,373	2,233	12
Depreciation and amortization	709	611	98	16	2,002	1,791	211	12
Total operating costs	55,337	51,966	3,371	6	166,664	154,983	11,681	8
Earnings from operations	5,014	4,590	424	9	14,590	12,847	1,743	14
Interest expense	(449)	(353)	(96)	27	(1,267)	(1,026)	(241)	23
Earnings before income taxes	4,565	4,237	328	8	13,323	11,821	1,502	13
Provision for income taxes	(936)	(953)	17	(2)	(2,752)	(2,603)	(149)	6
Net earnings	3,629	3,284	345	11	10,571	9,218	1,353	15
Earnings attributable to noncontrolling interests	(91)	(96)	5	(5)	(273)	(272)	(1)	—
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,538	$ 3,188	$ 350	11%	$ 10,298	$ 8,946	$ 1,352	15%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 3.67	$ 3.24	$ 0.43	13%	$ 10.65	$ 9.09	$ 1.56	17%
Medical care ratio (a)	82.4%	81.0%	1.4%		82.5%	81.4%	1.1%	
Operating cost ratio	14.8	15.0	(0.2)		14.3	15.1	(0.8)	
Operating margin	8.3	8.1	0.2		8.0	7.7	0.3	
Tax rate	20.5	22.5	(2.0)		20.7	22.0	(1.3)	
Net earnings margin (b)	5.9	5.6	0.3		5.7	5.3	0.4	
Return on equity (c)	26.2%	25.9%	0.3%		26.0%	24.6%	1.4%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as annualized net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the quarters in the year presented.

2019 RESULTS OF OPERATIONS COMPARED TO 2018 RESULTS OF OPERATIONS

Consolidated Financial Results

Revenue

The increases in revenue were primarily driven by the increase in the number of individuals served through Medicare Advantage; pricing trends; and acquisition and organic growth across the Optum business, primarily due to expansion in pharmacy care services and care delivery; partially offset by the moratorium of the Health Insurance Industry Tax in 2019.

Medical Costs and MCR

Medical costs increased due to growth in people served through Medicare Advantage and medical cost trends, partially offset by increased prior year favorable medical cost development. The MCR increased primarily due to the revenue effects of the Health Insurance Industry Tax moratorium.

Operating Cost Ratio

The operating cost ratio decreased due to the impact of the Health Insurance Industry Tax moratorium and effective operating cost management.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of the moratorium of the nondeductible Health Insurance Industry Tax.

Reportable Segments

See Note 9 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	Three Months Ended September 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018		Nine Months Ended September 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues								
UnitedHealthcare	$ 48,105	$ 45,937	$ 2,168	5%	$ 145,595	$ 137,242	$ 8,353	6%
OptumHealth	8,133	6,052	2,081	34	21,994	17,752	4,242	24
OptumInsight	2,617	2,254	363	16	7,145	6,508	637	10
OptumRx	18,454	17,437	1,017	6	55,194	50,484	4,710	9
Optum eliminations	(441)	(352)	(89)	25	(1,181)	(1,026)	(155)	15
Optum	28,763	25,391	3,372	13	83,152	73,718	9,434	13
Eliminations	(16,517)	(14,772)	(1,745)	12	(47,493)	(43,130)	(4,363)	10
Consolidated revenues	$ 60,351	$ 56,556	$ 3,795	7%	$ 181,254	$ 167,830	$ 13,424	8%
Earnings from operations								
UnitedHealthcare	$ 2,655	$ 2,559	$ 96	4%	$ 8,251	$ 7,316	$ 935	13%
OptumHealth	748	622	126	20	2,062	1,680	382	23
OptumInsight	632	534	98	18	1,589	1,382	207	15
OptumRx	979	875	104	12	2,688	2,469	219	9
Optum	2,359	2,031	328	16	6,339	5,531	808	15
Consolidated earnings from operations	$ 5,014	$ 4,590	$ 424	9%	$ 14,590	$ 12,847	$ 1,743	14%
Operating margin								
UnitedHealthcare	5.5%	5.6%	(0.1)%		5.7%	5.3%	0.4%	
OptumHealth	9.2	10.3	(1.1)		9.4	9.5	(0.1)	
OptumInsight	24.1	23.7	0.4		22.2	21.2	1.0	
OptumRx	5.3	5.0	0.3		4.9	4.9	—	
Optum	8.2	8.0	0.2		7.6	7.5	0.1	
Consolidated operating margin	8.3%	8.1%	0.2%		8.0%	7.7%	0.3%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	Three Months Ended September 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018		Nine Months Ended September 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018	
UnitedHealthcare Employer & Individual	$ 14,291	$ 13,734	$ 557	4%	$ 42,407	$ 40,856	$ 1,551	4%
UnitedHealthcare Medicare & Retirement	20,698	18,789	1,909	10	62,649	56,573	6,076	11
UnitedHealthcare Community & State	10,670	11,054	(384)	(3)	33,038	32,471	567	2
UnitedHealthcare Global	2,446	2,360	86	4	7,501	7,342	159	2
Total UnitedHealthcare revenues	$ 48,105	$ 45,937	$ 2,168	5%	$ 145,595	$ 137,242	$ 8,353	6%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	September 30, 2019	September 30, 2018	Increase/ (Decrease) 2019 vs. 2018	
Commercial:				
Risk-based	8,605	8,450	155	2%
Fee-based	19,230	18,365	865	5
Total commercial	27,835	26,815	1,020	4
Medicare Advantage	5,230	4,915	315	6
Medicaid	5,965	6,630	(665)	(10)
Medicare Supplement (Standardized)	4,510	4,540	(30)	(1)
Total public and senior	15,705	16,085	(380)	(2)
Total UnitedHealthcare — domestic medical	43,540	42,900	640	1
International	5,845	6,070	(225)	(4)
Total UnitedHealthcare — medical	49,385	48,970	415	1%
Supplemental Data:				
Medicare Part D stand-alone	4,415	4,725	(310)	(7)%

Fee-based commercial group business increased primarily due to an acquisition. Medicare Advantage increased due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by proactive withdrawal from the Iowa market as well as by states adding new carriers to existing programs and managing eligibility, partially offset by increases in Dual Special Needs Plans.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served through Commercial and Medicare Advantage, including a greater mix of people with higher acuity needs. Revenue increases were partially offset by the moratorium on the Health Insurance Industry Tax in 2019. Earnings from operations were also favorably impacted by operating cost management.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of productivity and overall cost management initiatives in addition to the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth primarily due to organic growth and acquisitions in care delivery, increased care services and organic growth in behavioral health. Increased operating earnings were primarily due to care delivery and care services. OptumHealth served approximately 95 million people as of September 30, 2019 compared to 92 million people as of September 30, 2018.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to organic and acquisition growth in managed services.

OptumRx

Revenue at OptumRx increased primarily due to acquisitions and organic growth in specialty pharmacy, partially offset by an expected large client transition. Earnings from operations increased primarily due to the factors that increased revenue as well as improved supply chain management. OptumRx fulfilled 325 million and 331 million adjusted scripts in the third quarter of 2019 and 2018, respectively. The decrease was due to the large client transition.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018	Increase/(Decrease) 2019 vs. 2018
Sources of cash:			
Cash provided by operating activities	$ 12,258	$ 13,317	$ (1,059)
Issuances of commercial paper and long-term debt, net of repayments	8,192	1,200	6,992
Proceeds from common stock issuances	740	745	(5)
Customer funds administered	420	1,552	(1,132)
Other	338	—	338
Total sources of cash	21,948	16,814	
Uses of cash:			
Common stock repurchases	(5,101)	(3,650)	(1,451)
Cash paid for acquisitions, net of cash assumed	(8,200)	(5,824)	(2,376)
Purchases of investments, net of sales and maturities	(2,028)	(3,729)	1,701
Purchases of property, equipment and capitalized software	(1,421)	(1,505)	84
Cash dividends paid	(2,908)	(2,454)	(454)
Other	(756)	(1,273)	517
Total uses of cash	(20,414)	(18,435)	
Effect of exchange rate changes on cash and cash equivalents	(37)	(97)	60
Net increase (decrease) in cash and cash equivalents	$ 1,497	$ (1,718)	$ 3,215

2019 Cash Flows Compared to 2018 Cash Flows

Decreased cash flows provided by operating activities were primarily driven by changes in working capital accounts, partially offset by higher net earnings. Other significant changes in sources or uses of cash year-over-year included increased issuances of commercial paper and decreased net purchases of investments partially offset by increases in cash paid for acquisitions and common stock repurchases.

Financial Condition

As of September 30, 2019, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $50.4 billion included approximately $12.4 billion of cash and cash equivalents (of which $1.5 billion was available for general corporate use), $35.9 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash and cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of “Double A” as of September 30, 2019. When multiple credit ratings

are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of September 30, 2019, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was approximately 41%.

Long-Term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, such as to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our long-term debt, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Credit Ratings. Our credit ratings as of September 30, 2019 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. During the nine months ended September 30, 2019, we repurchased 21 million shares at an average price of $245.18 per share. As of September 30, 2019, we had Board authorization to purchase up to 74 million shares of our common stock.

Dividends. In June 2019, our Board increased our quarterly cash dividend to shareholders to an annual dividend rate of $4.32 per share. For more information on our dividend, see Note 6 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

For additional liquidity discussion, see Note 10 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 in our 2018 10-K.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018 was disclosed in our 2018 10-K. During the nine months ended September 30, 2019, there were no material changes to this previously disclosed information outside the ordinary course of business. However, we

continually evaluate opportunities to expand our operations, including through internal development of new products, programs and technology applications and acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 1 of Notes to the Condensed Consolidated Financial Statements in Part I, Item 1 of this report for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and disclosure of our contingent liabilities. We base our assumptions and estimates primarily on historical experience and consider known and projected trends. On an ongoing basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may materially differ from our calculated estimates, and this difference would be reported in our current operations.

Our critical accounting estimates include medical costs payable and goodwill. For a detailed description of our critical accounting estimates, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in Part II, Item 7 in our 2018 10-K. For a detailed discussion of our significant accounting policies, see Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8, “Financial Statements and Supplementary Data” in our 2018 10-K.

FORWARD-LOOKING STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this document include “forward-looking” statements which are intended to take advantage of the “safe harbor” provisions of the federal securities law. The words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” and similar expressions identify forward-looking statements. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties.

Actual results could differ materially from those that management expects, depending on the outcome of certain factors including: our ability to effectively estimate, price for and manage medical costs; new or changes in existing health care laws or regulations, or their enforcement or application; the DOJ’s legal action relating to the risk adjustment submission matter; our ability to maintain and achieve improvement in quality scores impacting revenue; reductions in revenue or delays to cash flows received under government programs; changes in Medicare, the CMS star ratings program or the application of risk adjustment data validation audits; cyber-attacks, other privacy/data security incidents, or our failure to comply with related regulations; risks and uncertainties associated with the pharmacy benefits management industry; competitive pressures; changes in or challenges to our public sector contract awards; our ability to contract on competitive terms with physicians, hospitals and other service providers; failure to achieve targeted operating cost productivity improvements; increases in costs and other liabilities associated with litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete or receive anticipated benefits of strategic transactions; fluctuations in foreign currency exchange rates; downgrades in our credit ratings; our investment portfolio performance; impairment of our goodwill and intangible assets; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; and our ability to obtain sufficient funds from our regulated subsidiaries or from external financings to fund our obligations, maintain our debt to total capital ratio at targeted levels, maintain our quarterly dividend payment cycle, or continue repurchasing shares of our common stock.

This above list is not exhaustive. We discuss these matters, and certain risks that may affect our business operations, financial condition and results of operations more fully in our filings with the SEC, including our reports on Forms 10-K, 10-Q and 8-K. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by law.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of September 30, 2019 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	September 30, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 310	$ 268	$ (2,607)	$ (6,824)
1	155	134	(1,293)	(3,709)
(1)	(155)	(134)	1,227	4,440
(2)	(310)	(268)	1,954	9,440

ITEM 4. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this quarterly report on Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of September 30, 2019. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of September 30, 2019.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended September 30, 2019 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

A description of our legal proceedings is included in and incorporated by reference to Note 7 of Notes to the Condensed Consolidated Financial Statements contained in Part I, Item 1 of this report.

ITEM 1A. RISK FACTORS

In addition to the other information set forth in this report, you should carefully consider the factors discussed in Part I, Item 1A, "Risk Factors" of our 2018 10-K, which could materially affect our business, financial condition or future results. The risks described in our 2018 10-K are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition or future results.

There have been no material changes to the risk factors disclosed in our 2018 10-K.

ITEM 2. UNREGISTERED SALE OF EQUITY SECURITIES AND USE OF PROCEEDS

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the third quarter 2019, we repurchased approximately 3 million shares at an average price of $233.38 per share. As of September 30, 2019, we had Board authorization to purchase up to 74 million shares of our common stock.

ITEM 6. EXHIBITS*

The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form 8-A/A filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1998, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
10.1	Separation and Release Agreement, effective as of September 30, 2019, between Steven H. Nelson and United HealthCare Services, Inc.
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document — the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

* Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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/ DAVID S. WICHMANN **David S. Wichmann**	Chief Executive Officer (principal executive officer)	Dated: November 6, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	Dated: November 6, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	Dated: November 6, 2019

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

Form 10-Q

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

FOR THE QUARTERLY PERIOD ENDED JUNE 30, 2019

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(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 ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act

Large Accelerated Filer	☒	Accelerated filer	☐	Non-accelerated filer	☐
Smaller reporting company	☐			Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**NYSE**

As of July 31, 2019, there were 947,680,609 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

UNITEDHEALTH GROUP

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PART I

ITEM 1. FINANCIAL STATEMENTS

UnitedHealth Group
Condensed Consolidated Balance Sheets
(Unaudited)

(in millions, except per share data)	June 30, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 13,745	$ 10,866
Short-term investments	3,524	3,458
Accounts receivable, net	9,741	11,388
Other current receivables, net	8,434	6,862
Assets under management	2,943	3,032
Prepaid expenses and other current assets	3,651	3,086
Total current assets	42,038	38,692
Long-term investments	35,696	32,510
Property, equipment and capitalized software, net	8,681	8,458
Goodwill	62,000	58,910
Other intangible assets, net	9,999	9,325
Other assets	8,786	4,326
Total assets	$167,200	$152,221
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 20,907	$ 19,891
Accounts payable and accrued liabilities	17,128	16,705
Commercial paper and current maturities of long-term debt	7,800	1,973
Unearned revenues	2,019	2,396
Other current liabilities	14,474	12,244
Total current liabilities	62,328	53,209
Long-term debt, less current maturities	34,473	34,581
Deferred income taxes	2,908	2,474
Other liabilities	9,435	5,730
Total liabilities	109,144	95,994
Commitments and contingencies (Note 7)		
Redeemable noncontrolling interests	2,202	1,908
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 948 and 960 issued and outstanding	9	10
Retained earnings	56,367	55,846
Accumulated other comprehensive loss	(3,273)	(4,160)
Nonredeemable noncontrolling interests	2,751	2,623
Total equity	55,854	54,319
Total liabilities, redeemable noncontrolling interests and equity	$167,200	$152,221

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Operations
(Unaudited)

(in millions, except per share data)	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018	Six Months Ended June 30, 2019	Six Months Ended June 30, 2018
Revenues:				
Premiums	$47,164	$44,458	$ 94,677	$ 88,542
Products	8,353	7,004	16,425	13,706
Services	4,496	4,269	8,814	8,373
Investment and other income	582	355	987	653
Total revenues	60,595	56,086	120,903	111,274
Operating costs:				
Medical costs	39,184	36,427	78,123	72,290
Operating costs	8,415	8,386	16,932	16,892
Cost of products sold	7,598	6,471	14,979	12,655
Depreciation and amortization	654	598	1,293	1,180
Total operating costs	55,851	51,882	111,327	103,017
Earnings from operations	4,744	4,204	9,576	8,257
Interest expense	(418)	(344)	(818)	(673)
Earnings before income taxes	4,326	3,860	8,758	7,584
Provision for income taxes	(941)	(850)	(1,816)	(1,650)
Net earnings	3,385	3,010	6,942	5,934
Earnings attributable to noncontrolling interests	(92)	(88)	(182)	(176)
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,293	$ 2,922	$ 6,760	$ 5,758
Earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	$ 3.47	$ 3.04	$ 7.09	$ 5.98
Diluted	$ 3.42	$ 2.98	$ 6.97	$ 5.85
Basic weighted-average number of common shares outstanding	950	961	954	963
Dilutive effect of common share equivalents	14	21	16	21
Diluted weighted-average number of common shares outstanding	964	982	970	984
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	11	6	9	7

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

(in millions)	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018	Six Months Ended June 30, 2019	Six Months Ended June 30, 2018
Net earnings	$3,385	$ 3,010	$6,942	$ 5,934
Other comprehensive income (loss):				
Gross unrealized gains (losses) on investment securities during the period	493	(43)	1,013	(421)
Income tax effect	(113)	10	(232)	96
Total unrealized gains (losses), net of tax	380	(33)	781	(325)
Gross reclassification adjustment for net realized gains included in net earnings	(5)	(36)	(1)	(55)
Income tax effect	1	9	—	13
Total reclassification adjustment, net of tax	(4)	(27)	(1)	(42)
Total foreign currency translation gains (losses)	109	(1,069)	107	(1,070)
Other comprehensive income (loss)	485	(1,129)	887	(1,437)
Comprehensive income	3,870	1,881	7,829	4,497
Comprehensive income attributable to noncontrolling interests	(92)	(88)	(182)	(176)
Comprehensive income attributable to UnitedHealth Group common shareholders	$3,778	$ 1,793	$7,647	$ 4,321

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Equity
(Unaudited)

Three months ended June 30, (in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at March 31, 2019	953	$ 10	$ —	$ 55,472	$ 140	$ (3,898)	$ 2,727	$54,451
Net earnings				3,293			54	3,347
Other comprehensive income					376	109		485
Issuances of common stock, and related tax effects	1	—	105					105
Share-based compensation			152					152
Common share repurchases	(6)	(1)	(124)	(1,374)				(1,499)
Cash dividends paid on common shares ($1.08 per share)				(1,024)				(1,024)
Redeemable noncontrolling interests fair value and other adjustments			(133)					(133)
Acquisition and other adjustments of nonredeemable noncontrolling interests							32	32
Distribution to nonredeemable noncontrolling interests							(62)	(62)
Balance at June 30, 2019	948	$ 9	$ —	$ 56,367	$ 516	$ (3,789)	$ 2,751	$55,854
Balance at March 31, 2018	962	$ 10	$ —	$ 50,494	$ (296)	$ (2,655)	$ 2,483	$50,036
Net earnings				2,922			59	2,981
Other comprehensive loss					(60)	(1,069)		(1,129)
Issuances of common stock, and related tax effects	2	—	107					107
Share-based compensation			141					141
Common share repurchases	(2)	—	(313)	(187)				(500)
Cash dividends paid on common shares ($0.90 per share)				(866)				(866)
Redeemable noncontrolling interests fair value and other adjustments			65					65
Acquisition and other adjustments of nonredeemable noncontrolling interests							(7)	(7)
Distribution to nonredeemable noncontrolling interests							(45)	(45)
Balance at June 30, 2018	962	$ 10	$ —	$ 52,363	$ (356)	$ (3,724)	$ 2,490	$50,783

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Equity
(Unaudited)

Six months ended June 30, (in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2019	960	$ 10	$ —	$ 55,846	$ (264)	$ (3,896)	$ 2,623	$54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				6,760			114	6,874
Other comprehensive income					780	107		887
Issuances of common stock, and related tax effects	6	—	161					161
Share-based compensation			391					391
Common share repurchases	(18)	(1)	(158)	(4,342)				(4,501)
Cash dividends paid on common shares ($1.98 per share)				(1,884)				(1,884)
Redeemable noncontrolling interests fair value and other adjustments			(285)					(285)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				164	55
Distribution to nonredeemable noncontrolling interests							(145)	(145)
Balance at June 30, 2019	948	$ 9	$ —	$ 56,367	$ 516	$ (3,789)	$ 2,751	$55,854
Balance at January 1, 2018	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				5,758			112	5,870
Other comprehensive loss					(367)	(1,070)		(1,437)
Issuances of common stock, and related tax effects	7	—	522					522
Share-based compensation			347					347
Common share repurchases	(14)	—	(2,637)	(513)				(3,150)
Cash dividends paid on common shares ($1.65 per share)				(1,588)				(1,588)
Redeemable noncontrolling interests fair value and other adjustments			65					65
Acquisition and other adjustments of nonredeemable noncontrolling interests							416	416
Distribution to nonredeemable noncontrolling interests							(95)	(95)
Balance at June 30, 2018	962	$ 10	$ —	$ 52,363	$ (356)	$ (3,724)	$ 2,490	$50,783

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Cash Flows
(Unaudited)

(in millions)	Six Months Ended June 30, 2019	2018
Operating activities		
Net earnings	$ 6,942	$ 5,934
Noncash items:		
Depreciation and amortization	1,293	1,180
Deferred income taxes	195	(158)
Share-based compensation	398	358
Other, net	(127)	10
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	2,196	(1,021)
Other assets	(1,774)	(2,369)
Medical costs payable	447	1,263
Accounts payable and other liabilities	(33)	2,233
Unearned revenues	(429)	4,946
Cash flows from operating activities	9,108	12,376
Investing activities		
Purchases of investments	(7,649)	(8,182)
Sales of investments	2,680	2,003
Maturities of investments	3,315	3,211
Cash paid for acquisitions, net of cash assumed	(4,751)	(2,636)
Purchases of property, equipment and capitalized software	(977)	(960)
Other, net	504	(134)
Cash flows used for investing activities	(6,878)	(6,698)
Financing activities		
Common share repurchases	(4,501)	(3,150)
Cash dividends paid	(1,884)	(1,588)
Proceeds from common stock issuances	448	478
Repayments of long-term debt	(1,250)	(1,100)
Proceeds from (repayments of) commercial paper, net	6,924	(181)
Proceeds from issuance of long-term debt	—	3,964
Customer funds administered	1,435	3,082
Other, net	(529)	(718)
Cash flows from financing activities	643	787
Effect of exchange rate changes on cash and cash equivalents	6	(78)
Increase in cash and cash equivalents	2,879	6,387
Cash and cash equivalents, beginning of period	10,866	11,981
Cash and cash equivalents, end of period	$13,745	$18,368

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Notes to the Condensed Consolidated Financial Statements
(Unaudited)

1. Basis of Presentation

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and the "Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

The Company has prepared the Condensed Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The year-end condensed consolidated balance sheet was derived from audited financial statements, but does not include all disclosures required by GAAP. In accordance with the rules and regulations of the U.S. Securities and Exchange Commission (SEC), the Company has omitted certain footnote disclosures that would substantially duplicate the disclosures contained in its annual audited Consolidated Financial Statements. Therefore, these Condensed Consolidated Financial Statements should be read together with the Consolidated Financial Statements and the Notes included in Part II, Item 8, "Financial Statements and Supplementary Data" in the Company's Annual Report on Form 10-K for the year ended December 31, 2018 as filed with the SEC (2018 10-K). The accompanying Condensed Consolidated Financial Statements include all normal recurring adjustments necessary to present the interim financial statements fairly.

Use of Estimates

These Condensed Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates include medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Recently Adopted Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11, 2018-20 and 2019-01 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. The Company adopted ASU 2016-02 using a cumulative-effect upon adoption approach as of January 1, 2019. Upon adoption, the Company recognized $3.3 billion of lease right-of-use (ROU) assets and liabilities for operating leases on its Condensed Consolidated Balance Sheet, of which, $668 million were classified as current liabilities. The adoption of ASU 2016-02 was immaterial to the Company's consolidated results of operations, equity and cash flows. The Company has included the disclosures required by ASU 2016-02 below and in Note 7, "Commitments and Contingencies."

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. At the lease commencement date, lease ROU assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period that closely matches the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Condensed Consolidated Balance Sheet.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Condensed Consolidated Financial Statements.

2. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
June 30, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,684	$ 80	$ (5)	$ 3,759
State and municipal obligations	6,532	237	(1)	6,768
Corporate obligations	16,597	265	(12)	16,850
U.S. agency mortgage-backed securities	5,662	83	(15)	5,730
Non-U.S. agency mortgage-backed securities	1,593	39	(1)	1,631
Total debt securities — available-for-sale	34,068	704	(34)	34,738
Debt securities — held-to-maturity:				
U.S. government and agency obligations	275	2	—	277
State and municipal obligations	31	1	—	32
Corporate obligations	435	1	—	436
Total debt securities — held-to-maturity	741	4	—	745
Total debt securities	$ 34,809	$ 708	$ (34)	$ 35,483
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518

The Company held $2.2 billion and $2.0 billion of equity securities as of June 30, 2019 and December 31, 2018, respectively. The Company's investments in equity securities primarily consist of employee savings plan related investments, shares of Brazilian real denominated fixed-income funds and dividend paying stocks with readily determinable fair values. Additionally, the Company's investments included $1.5 billion of equity method investments in operating businesses in the health care sector as of both June 30, 2019 and December 31, 2018.

The amortized cost and fair value of debt securities as of June 30, 2019, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,647	$ 3,652	$ 182	$ 182
Due after one year through five years	12,150	12,298	283	285
Due after five years through ten years	8,084	8,394	136	136
Due after ten years	2,932	3,033	140	142
U.S. agency mortgage-backed securities	5,662	5,730	—	—
Non-U.S. agency mortgage-backed securities	1,593	1,631	—	—
Total debt securities	$ 34,068	$ 34,738	$ 741	$ 745

The fair value of available-for-sale debt securities with gross unrealized losses by security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
June 30, 2019						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ —	$ —	$ 655	$ (5)	$ 655	$ (5)
State and municipal obligations	—	—	366	(1)	366	(1)
Corporate obligations	703	(3)	2,352	(9)	3,055	(12)
U.S. agency mortgage-backed securities	—	—	1,562	(15)	1,562	(15)
Non-U.S. agency mortgage-backed securities	—	—	128	(1)	128	(1)
Total debt securities — available-for-sale	$ 703	$ (3)	$ 5,063	$ (31)	$ 5,766	$ (34)
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$ 12,355	$ (156)	$ 11,002	$ (287)	$ 23,357	$ (443)

The Company's unrealized losses from debt securities as of June 30, 2019 were generated from 5,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of June 30, 2019, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

3. Fair Value

Certain assets and liabilities are measured at fair value in the Condensed Consolidated Financial Statements or have fair values disclosed in the Notes to the Condensed Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP.

For a description of the methods and assumptions that are used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument, see Note 4 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
June 30, 2019				
Cash and cash equivalents	$ 13,562	$ 183	$ —	$ 13,745
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,474	285	—	3,759
State and municipal obligations	—	6,768	—	6,768
Corporate obligations	65	16,583	202	16,850
U.S. agency mortgage-backed securities	—	5,730	—	5,730
Non-U.S. agency mortgage-backed securities	—	1,631	—	1,631
Total debt securities — available-for-sale	3,539	30,997	202	34,738
Equity securities	2,035	15	—	2,050
Assets under management	1,011	1,911	21	2,943
Total assets at fair value	$ 20,147	$ 33,106	$ 223	$ 53,476
Percentage of total assets at fair value	38%	62%	—%	100%
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$ 10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$ 47,641
Percentage of total assets at fair value	35%	65%	—%	100%

There were no transfers in or out of Level 3 financial assets or liabilities during the six months ended June 30, 2019 or 2018.

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
June 30, 2019					
Debt securities — held-to-maturity	$ 293	$ 177	$ 275	$ 745	$ 741
Long-term debt and other financing obligations	$ —	$ 38,927	$ —	$ 38,927	$ 35,300
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during either the six months ended June 30, 2019 or 2018.

4. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the six months ended June 30:

(in millions)	2019	2018
Medical costs payable, beginning of period	$ 19,891	$ 17,871
Acquisitions	522	261
Reported medical costs:		
Current year	78,523	72,570
Prior years	(400)	(280)
Total reported medical costs	78,123	72,290
Medical payments:		
Payments for current year	(60,707)	(55,738)
Payments for prior years	(16,922)	(15,345)
Total medical payments	(77,629)	(71,083)
Medical costs payable, end of period	$ 20,907	$ 19,339

For the six months ended June 30, 2019 and 2018, the medical cost reserve development included no individual factors that were significant. Medical costs payable included reserves for claims incurred by insured customers but not yet reported to the Company of $14.5 billion and $13.2 billion at June 30, 2019 and December 31, 2018, respectively.

5. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	June 30, 2019			December 31, 2018		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 6,984	$ 6,973	$ 6,973	$ —	$ —	$ —
1.700% notes due February 2019	—	—	—	750	750	749
1.625% notes due March 2019	—	—	—	500	500	499
2.300% notes due December 2019	500	498	500	500	494	497
2.700% notes due July 2020	1,500	1,498	1,506	1,500	1,498	1,494
Floating rate notes due October 2020	300	299	300	300	299	298
3.875% notes due October 2020	450	449	457	450	443	456
1.950% notes due October 2020	900	898	896	900	897	884
4.700% notes due February 2021	400	404	413	400	398	412
2.125% notes due March 2021	750	748	749	750	747	734
Floating rate notes due June 2021	350	349	350	350	349	347
3.150% notes due June 2021	400	399	407	400	399	400
3.375% notes due November 2021	500	500	512	500	489	503
2.875% notes due December 2021	750	752	761	750	735	748
2.875% notes due March 2022	1,100	1,082	1,117	1,100	1,051	1,091
3.350% notes due July 2022	1,000	997	1,034	1,000	997	1,005
2.375% notes due October 2022	900	895	903	900	894	872
0.000% notes due November 2022	15	13	13	15	12	13
2.750% notes due February 2023	625	622	633	625	602	611
2.875% notes due March 2023	750	772	764	750	750	739
3.500% notes due June 2023	750	747	782	750	746	756
3.500% notes due February 2024	750	745	786	750	745	755
3.750% notes due July 2025	2,000	1,990	2,136	2,000	1,989	2,025
3.700% notes due December 2025	300	298	320	300	298	303
3.100% notes due March 2026	1,000	996	1,030	1,000	995	965
3.450% notes due January 2027	750	746	789	750	746	742
3.375% notes due April 2027	625	619	653	625	619	611
2.950% notes due October 2027	950	939	966	950	938	898
3.850% notes due June 2028	1,150	1,142	1,246	1,150	1,142	1,163
3.875% notes due December 2028	850	843	927	850	842	861
4.625% notes due July 2035	1,000	992	1,149	1,000	992	1,060
5.800% notes due March 2036	850	838	1,090	850	838	1,003
6.500% notes due June 2037	500	492	693	500	492	638
6.625% notes due November 2037	650	641	915	650	641	841
6.875% notes due February 2038	1,100	1,076	1,591	1,100	1,076	1,437
5.700% notes due October 2040	300	296	385	300	296	355
5.950% notes due February 2041	350	345	462	350	345	426
4.625% notes due November 2041	600	588	684	600	588	627
4.375% notes due March 2042	502	484	556	502	484	503
3.950% notes due October 2042	625	607	655	625	607	596
4.250% notes due March 2043	750	735	820	750	734	744
4.750% notes due July 2045	2,000	1,973	2,369	2,000	1,973	2,116
4.200% notes due January 2047	750	738	820	750	738	745
4.250% notes due April 2047	725	717	797	725	717	719
3.750% notes due October 2047	950	933	974	950	933	869
4.250% notes due June 2048	1,350	1,329	1,500	1,350	1,329	1,349
4.450% notes due December 2048	1,100	1,088	1,267	1,100	1,087	1,132
Total commercial paper and long-term debt	$ 41,401	$ 41,085	$ 44,650	$ 35,667	$ 35,234	$ 36,591

The Company's long-term debt obligations included $1.2 billion and $1.3 billion of other financing obligations, of which $329 million and $229 million were classified as current as of June 30, 2019 and December 31, 2018, respectively.

Long-term Debt

In July 2019, the Company issued $5.5 billion of senior unsecured notes consisting of the following:

(in millions, except percentages)	Par Value
2.375% notes due August 2024	$ 750
2.875% notes due August 2029	1,000
3.500% notes due August 2039	1,250
3.700% notes due August 2049	1,250
3.875% notes due August 2059	1,250

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of June 30, 2019, the Company's outstanding commercial paper had a weighted average annual interest rate of 2.6%.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. The Company additionally has a $2.5 billion 364-day revolving bank credit facility with 6 banks that matures in May 2020. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of June 30, 2019, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of June 30, 2019, annual interest rates would have ranged from 2.9% to 3.1%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including covenants requiring the Company to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of June 30, 2019.

6. Dividends

In June 2019, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to $4.32 compared to $3.60 per share, which the Company had paid since June 2018. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2019 dividend payments:

Payment Date	Amount per Share	Total Amount Paid (in millions)
March 19	$ 0.90	$ 860
June 25	1.08	1,024

7. Commitments and Contingencies

Leases

Operating lease costs were $247 million and $485 million for the three and six months ended June 30, 2019, respectively, and included immaterial variable and short-term lease costs. Cash payments made on the Company's operating lease liabilities were $363 million for the six months ended June 30, 2019, which were classified within operating activities in the Condensed Consolidated Statements of Cash Flows. As of June 30, 2019, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.8 years and 4.0%, respectively.

As of June 30, 2019, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Operating Lease Payments
2019	$ 396
2020	760
2021	666
2022	562
2023	463
Thereafter	1,977
Total future minimum lease payments	4,824
Less imputed interest	(806)
Total	$ 4,018

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare and Medicaid Services (CMS), state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional

committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

8. Segment Financial Information

The Company's four reportable segments are UnitedHealthcare, OptumHealth, OptumInsight and OptumRx. For more information on the Company's segments see Part I, Item I, "Business" and Note 13 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K. Total assets at OptumHealth increased to $38.8 billion as of June 30, 2019 compared to $29.8 billion as of December 31, 2018, primarily due to goodwill and other intangibles assets from a second quarter 2019 acquisition and the recognition of ROU assets from ASU 2016-02.

The following tables present reportable segment financial information:

		Optum						
(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum	Corporate and Eliminations	Consolidated
Three Months Ended June 30, 2019								
Revenues — unaffiliated customers:								
Premiums	$ 46,030	$ 1,134	$ —	$ —	$ —	$ 1,134	$ —	$ 47,164
Products	—	9	22	8,322	—	8,353	—	8,353
Services	2,188	1,370	790	148	—	2,308	—	4,496
Total revenues — unaffiliated customers	48,218	2,513	812	8,470	—	11,795	—	60,013
Total revenues — affiliated customers	—	4,449	1,521	10,439	(381)	16,028	(16,028)	—
Investment and other income	376	186	6	14	—	206	—	582
Total revenues	$ 48,594	$ 7,148	$ 2,339	$ 18,923	$ (381)	$ 28,029	$ (16,028)	$ 60,595
Earnings from operations	$ 2,642	$ 688	$ 525	$ 889	$ —	$ 2,102	$ —	$ 4,744
Interest expense	—	—	—	—	—	—	(418)	(418)
Earnings before income taxes	$ 2,642	$ 688	$ 525	$ 889	$ —	$ 2,102	$ (418)	$ 4,326
Three Months Ended June 30, 2018								
Revenues — unaffiliated customers:								
Premiums	$ 43,496	$ 962	$ —	$ —	$ —	$ 962	$ —	$ 44,458
Products	—	12	20	6,972	—	7,004	—	7,004
Services	2,142	1,203	776	148	—	2,127	—	4,269
Total revenues — unaffiliated customers	45,638	2,177	796	7,120	—	10,093	—	55,731
Total revenues — affiliated customers	—	3,640	1,380	9,807	(341)	14,486	(14,486)	—
Investment and other income	208	124	9	14	—	147	—	355
Total revenues	$ 45,846	$ 5,941	$ 2,185	$ 16,941	$ (341)	$ 24,726	$ (14,486)	$ 56,086
Earnings from operations	$ 2,357	$ 570	$ 453	$ 824	$ —	$ 1,847	$ —	$ 4,204
Interest expense	—	—	—	—	—	—	(344)	(344)
Earnings before income taxes	$ 2,357	$ 570	$ 453	$ 824	$ —	$ 1,847	$ (344)	$ 3,860

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
Six Months Ended June 30, 2019								
Revenues — unaffiliated customers:								
Premiums	$ 92,531	$ 2,146	$ —	$ —	$ —	$ 2,146	$ —	$ 94,677
Products	—	17	45	16,363	—	16,425	—	16,425
Services	4,329	2,644	1,544	297	—	4,485	—	8,814
Total revenues — unaffiliated customers	96,860	4,807	1,589	16,660	—	23,056	—	119,916
Total revenues — affiliated customers	—	8,736	2,928	20,052	(740)	30,976	(30,976)	—
Investment and other income	630	318	11	28	—	357	—	987
Total revenues	$ 97,490	$ 13,861	$ 4,528	$ 36,740	$ (740)	$ 54,389	$ (30,976)	$ 120,903
Earnings from operations	$ 5,596	$ 1,314	$ 957	$ 1,709	$ —	$ 3,980	$ —	$ 9,576
Interest expense	—	—	—	—	—	—	(818)	(818)
Earnings before income taxes	$ 5,596	$ 1,314	$ 957	$ 1,709	$ —	$ 3,980	$ (818)	$ 8,758
Six Months Ended June 30, 2018								
Revenues — unaffiliated customers:								
Premiums	$ 86,733	$ 1,809	$ —	$ —	$ —	$ 1,809	$ —	$ 88,542
Products	—	24	43	13,639	—	13,706	—	13,706
Services	4,181	2,391	1,516	285	—	4,192	—	8,373
Total revenues — unaffiliated customers	90,914	4,224	1,559	13,924	—	19,707	—	110,621
Total revenues — affiliated customers	—	7,246	2,684	19,102	(674)	28,358	(28,358)	—
Investment and other income	391	230	11	21	—	262	—	653
Total revenues	$ 91,305	$ 11,700	$ 4,254	$ 33,047	$ (674)	$ 48,327	$ (28,358)	$ 111,274
Earnings from operations	$ 4,757	$ 1,058	$ 848	$ 1,594	$ —	$ 3,500	$ —	$ 8,257
Interest expense	—	—	—	—	—	—	(673)	(673)
Earnings before income taxes	$ 4,757	$ 1,058	$ 848	$ 1,594	$ —	$ 3,500	$ (673)	$ 7,584

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Condensed Consolidated Financial Statements and Notes and with our 2018 10-K, including the Consolidated Financial Statements and Notes in Part II, Item 8, "Financial Statements and Supplementary Data" in that report. Unless the context indicates otherwise, references to the terms "UnitedHealth Group," "we," "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations refer to UnitedHealth Group Incorporated and its consolidated subsidiaries.

Readers are cautioned that the statements, estimates, projections or outlook contained in this Management's Discussion and Analysis of Financial Condition and Results of Operations, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 2, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed or implied in the forward-looking statements. A description of some of the risks and uncertainties is set forth in Part I, Item 1A, "Risk Factors" in our 2018 10-K and in the discussion below.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

Further information on our business is presented in Part I, Item 1, "Business" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K and additional information on our segments can be found in this Item 2 and in Note 8 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Business Trends

Our businesses participate in the United States, South American and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. Overall spending on health care is impacted by inflation; medical technology and pharmaceutical advancement; regulatory requirements; demographic trends in the population and national interest in health and well-being, mitigated by our continued efforts to control health care costs. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which could impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any impact from the Health Insurance Industry Tax. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum medical loss ratio (MLR) thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform

changes. Pricing for contracts that cover some portion of calendar year 2020 will reflect the return of the Health Insurance Industry Tax after a moratorium in 2019.

Government programs in the public and senior sector tend to receive lower rates of increase than the commercial market due to governmental budget pressures and lower cost trends.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high quality, affordable care.

Regulatory Trends and Uncertainties

Following is a summary of management's view of regulatory trends and uncertainties. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business - Government Regulation," Part 1, Item 1A, "Risk Factors" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K.

Medicare Advantage Rates. Final 2020 Medicare Advantage rates resulted in an increase in industry base rates of approximately 2.5%, short of the industry forward medical cost trend, including the return of the Health Insurance Industry Tax, creating continued pressure in the Medicare Advantage program.

Health Insurance Industry Tax. There is a one year moratorium on the Health Insurance Industry Tax in 2019. This moratorium impacts year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following summarizes select second quarter 2019 year-over-year operating comparisons to second quarter 2018.

- Consolidated revenues grew 8%, UnitedHealthcare revenues grew 6% and Optum revenues grew 13%.
- UnitedHealthcare served 705,000 additional people primarily as a result of acquisitions and growth in services to self-funded employers and seniors.
- Earnings from operations increased 13%, including increases of 12% at UnitedHealthcare and 14% at Optum.
- Diluted earnings per common share increased 15%.
- Cash flows from operations for the six months ended June 30, 2019 were $9.1 billion.
- Return on equity was 25.1%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018	Increase/ (Decrease) 2019 vs. 2018		Six Months Ended June 30, 2019	Six Months Ended June 30, 2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues:								
Premiums	$ 47,164	$ 44,458	$ 2,706	6%	$ 94,677	$ 88,542	$ 6,135	7%
Products	8,353	7,004	1,349	19	16,425	13,706	2,719	20
Services	4,496	4,269	227	5	8,814	8,373	441	5
Investment and other income	582	355	227	64	987	653	334	51
Total revenues	60,595	56,086	4,509	8	120,903	111,274	9,629	9
Operating costs:								
Medical costs	39,184	36,427	2,757	8	78,123	72,290	5,833	8
Operating costs	8,415	8,386	29	—	16,932	16,892	40	—
Cost of products sold	7,598	6,471	1,127	17	14,979	12,655	2,324	18
Depreciation and amortization	654	598	56	9	1,293	1,180	113	10
Total operating costs	55,851	51,882	3,969	8	111,327	103,017	8,310	8
Earnings from operations	4,744	4,204	540	13	9,576	8,257	1,319	16
Interest expense	(418)	(344)	(74)	22	(818)	(673)	(145)	22
Earnings before income taxes	4,326	3,860	466	12	8,758	7,584	1,174	15
Provision for income taxes	(941)	(850)	(91)	11	(1,816)	(1,650)	(166)	10
Net earnings	3,385	3,010	375	12	6,942	5,934	1,008	17
Earnings attributable to noncontrolling interests	(92)	(88)	(4)	5	(182)	(176)	(6)	3
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,293	$ 2,922	$ 371	13%	$ 6,760	$ 5,758	$ 1,002	17%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 3.42	$ 2.98	$ 0.44	15%	$ 6.97	$ 5.85	$ 1.12	19%
Medical care ratio (a)	83.1%	81.9%	1.2%		82.5%	81.6%	0.9%	
Operating cost ratio	13.9	15.0	(1.1)		14.0	15.2	(1.2)	
Operating margin	7.8	7.5	0.3		7.9	7.4	0.5	
Tax rate	21.8	22.0	(0.2)		20.7	21.8	(1.1)	
Net earnings margin (b)	5.4	5.2	0.2		5.6	5.2	0.4	
Return on equity (c)	25.1%	24.4%	0.7%		25.9%	24.1%	1.8%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as annualized net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the quarters in the year presented.

2019 RESULTS OF OPERATIONS COMPARED TO 2018 RESULTS OF OPERATIONS

Consolidated Financial Results

Revenue

The increases in revenue were primarily driven by the increase in the number of individuals served through various Medicare products; pricing trends; and growth across the Optum business, primarily due to expansion in pharmacy care services and care delivery; partially offset by the moratorium of the Health Insurance Industry Tax in 2019.

Medical Costs and MCR

Medical costs increased due to growth in people served through Medicare products and medical cost trends, partially offset by increased prior year favorable medical cost development. The MCR increased due to the revenue effects of the Health Insurance Industry Tax moratorium.

Operating Cost Ratio

The operating cost ratio decreased due to the impact of the Health Insurance Industry Tax moratorium and effective operating cost management.

Income Tax Rate

Our effective tax rate decreased due to the impact of the moratorium of the nondeductible Health Insurance Industry Tax.

Reportable Segments

See Note 8 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	Three Months Ended June 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018		Six Months Ended June 30, 2019	2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues								
UnitedHealthcare	$ 48,594	$ 45,846	$ 2,748	6%	$ 97,490	$ 91,305	$ 6,185	7%
OptumHealth	7,148	5,941	1,207	20	13,861	11,700	2,161	18
OptumInsight	2,339	2,185	154	7	4,528	4,254	274	6
OptumRx	18,923	16,941	1,982	12	36,740	33,047	3,693	11
Optum eliminations	(381)	(341)	(40)	12	(740)	(674)	(66)	10
Optum	28,029	24,726	3,303	13	54,389	48,327	6,062	13
Eliminations	(16,028)	(14,486)	(1,542)	11	(30,976)	(28,358)	(2,618)	9
Consolidated revenues	$ 60,595	$ 56,086	$ 4,509	8%	$ 120,903	$ 111,274	$ 9,629	9%
Earnings from operations								
UnitedHealthcare	$ 2,642	$ 2,357	$ 285	12%	$ 5,596	$ 4,757	$ 839	18%
OptumHealth	688	570	118	21	1,314	1,058	256	24
OptumInsight	525	453	72	16	957	848	109	13
OptumRx	889	824	65	8	1,709	1,594	115	7
Optum	2,102	1,847	255	14	3,980	3,500	480	14
Consolidated earnings from operations	$ 4,744	$ 4,204	$ 540	13%	$ 9,576	$ 8,257	$ 1,319	16%
Operating margin								
UnitedHealthcare	5.4%	5.1%	0.3%		5.7%	5.2%	0.5%	
OptumHealth	9.6	9.6	—		9.5	9.0	0.5	
OptumInsight	22.4	20.7	1.7		21.1	19.9	1.2	
OptumRx	4.7	4.9	(0.2)		4.7	4.8	(0.1)	
Optum	7.5	7.5	—		7.3	7.2	0.1	
Consolidated operating margin	7.8%	7.5%	0.3%		7.9%	7.4%	0.5%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	Three Months Ended June 30, 2019	2018	Increase/(Decrease) 2019 vs. 2018		Six Months Ended June 30, 2019	2018	Increase/(Decrease) 2019 vs. 2018	
UnitedHealthcare Employer & Individual	$ 14,032	$ 13,708	$ 324	2%	$ 28,116	$ 27,122	$ 994	4%
UnitedHealthcare Medicare & Retirement	20,855	18,859	1,996	11	41,951	37,784	4,167	11
UnitedHealthcare Community & State	11,186	10,746	440	4	22,368	21,417	951	4
UnitedHealthcare Global	2,521	2,533	(12)	—	5,055	4,982	73	1
Total UnitedHealthcare revenues	$ 48,594	$ 45,846	$ 2,748	6%	$ 97,490	$ 91,305	$ 6,185	7%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	June 30, 2019	June 30, 2018	Increase/ (Decrease) 2019 vs. 2018	
Commercial:				
Risk-based	8,325	8,385	(60)	(1)%
Fee-based	19,090	18,415	675	4
Total commercial	27,415	26,800	615	2
Medicare Advantage	5,190	4,790	400	8
Medicaid	6,360	6,710	(350)	(5)
Medicare Supplement (Standardized)	4,495	4,505	(10)	—
Total public and senior	16,045	16,005	40	—
Total UnitedHealthcare — domestic medical	43,460	42,805	655	2
International	6,070	6,020	50	1
Total UnitedHealthcare — medical	49,530	48,825	705	1%
Supplemental Data:				
Medicare Part D stand-alone	4,430	4,730	(300)	(6)%

Fee-based commercial group business increased primarily due to an acquisition. Medicare Advantage increased due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan in 2018, partially offset by increases in Dual Special Needs Plans.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served through several Medicare products, a higher revenue membership mix and rate increases for underlying medical cost trends. Revenue increases were partially offset by the moratorium on the Health Insurance Industry Tax in 2019. Earnings from operations were also favorably impacted by operating cost management.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of productivity and overall cost management initiatives in addition to the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth primarily due to organic growth and acquisitions in care delivery, increased care services and organic growth in behavioral health. Increased operating earnings were primarily due to care delivery and care services. OptumHealth served approximately 95 million people as of June 30, 2019 compared to 92 million people as of June 30, 2018.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to organic growth in managed services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to acquisitions and organic growth in specialty pharmacy, home delivery services and overall prescription growth. OptumRx fulfilled 343 million and 332 million adjusted scripts in the second quarters of 2019 and 2018, respectively.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	Six Months Ended June 30, 2019	2018	Increase/(Decrease) 2019 vs. 2018
Sources of cash:			
Cash provided by operating activities	$ 9,108	$ 12,376	$ (3,268)
Issuances of commercial paper and long-term debt, net of repayments	5,674	2,683	2,991
Proceeds from common stock issuances	448	478	(30)
Customer funds administered	1,435	3,082	(1,647)
Other	504	—	504
Total sources of cash	17,169	18,619	
Uses of cash:			
Common stock repurchases	(4,501)	(3,150)	(1,351)
Cash paid for acquisitions, net of cash assumed	(4,751)	(2,636)	(2,115)
Purchases of investments, net of sales and maturities	(1,654)	(2,968)	1,314
Purchases of property, equipment and capitalized software	(977)	(960)	(17)
Cash dividends paid	(1,884)	(1,588)	(296)
Other	(529)	(852)	323
Total uses of cash	(14,296)	(12,154)	
Effect of exchange rate changes on cash and cash equivalents	6	(78)	84
Net increase in cash and cash equivalents	$ 2,879	$ 6,387	$ (3,508)

2019 Cash Flows Compared to 2018 Cash Flows

Decreased cash flows provided by operating activities were primarily driven by the increase in unearned revenues in 2018 due to the June 2018 early receipt of our July CMS premium payment of $5.2 billion and the year-over-year impact of the Health Insurance Industry Tax moratorium, partially offset by higher net earnings and changes in working capital accounts.

Other significant changes in sources or uses of cash year-over-year included increased cash paid for acquisitions; common stock repurchases; and issuances of commercial paper and decreased purchases of investments and customer funds administered, due to the early receipt of our CMS payment in 2018 described above.

Financial Condition

As of June 30, 2019, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $50.7 billion included approximately $13.7 billion of cash and cash equivalents (of which $900 million was available for general corporate use), $34.7 billion of debt securities and $2.2 billion of investments in equity securities. Given the significant portion of our portfolio held in cash and cash equivalents, we do not anticipate

fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of "Double A" as of June 30, 2019. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of June 30, 2019, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was approximately 41%.

Long-Term Debt. In July 2019, we issued $5.5 billion in senior unsecured notes. We intend to use the net proceeds from this offering for general corporate purposes, including refinancing commercial paper borrowings, or redeeming, repurchasing or repaying outstanding securities. For more information on our long-term debt, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Credit Ratings. Our credit ratings as of June 30, 2019 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. During the six months ended June 30, 2019, we repurchased 18 million shares at an average price of $246.84 per share. As of June 30, 2019, we had Board authorization to purchase up to 76 million shares of our common stock.

Dividends. In June 2019, our Board increased our quarterly cash dividend to shareholders to an annual dividend rate of $4.32 per share. For more information on our dividend, see Note 6 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

For additional liquidity discussion, see Note 10 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 in our 2018 10-K.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018 was disclosed in our 2018 10-K. During the six months ended June 30, 2019, there were no material changes to this previously disclosed information outside the ordinary course of business. However, we continually evaluate opportunities to expand our operations, including through internal development of new products, programs and technology applications and acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 1 of Notes to the Condensed Consolidated Financial Statements in Part I, Item 1 of this report for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and disclosure of our contingent liabilities. We base our assumptions and estimates primarily on historical experience and consider known and projected trends. On an ongoing basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may materially differ from our calculated estimates, and this difference would be reported in our current operations.

Our critical accounting estimates include medical costs payable and goodwill. For a detailed description of our critical accounting estimates, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in Part II, Item 7 in our 2018 10-K. For a detailed discussion of our significant accounting policies, see Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8, “Financial Statements and Supplementary Data” in our 2018 10-K.

FORWARD-LOOKING STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this document include “forward-looking” statements within the meaning of the PSLRA. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. Generally the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. We caution that actual results could differ materially from those that management expects, depending on the outcome of certain factors.

Some factors that could cause actual results to differ materially from results discussed or implied in the forward-looking statements include: our ability to effectively estimate, price for and manage our medical costs, including the impact of any new coverage requirements; new laws or regulations, or changes in existing laws or regulations, or their enforcement or application, including increases in medical, administrative, technology or other costs or decreases in enrollment resulting from U.S., South American and other jurisdictions’ regulations affecting the health care industry; the outcome of the DOJ’s legal action relating to the risk adjustment submission matter; our ability to maintain and achieve improvement in CMS star ratings and other quality scores that impact revenue; reductions in revenue or delays to cash flows received under Medicare, Medicaid and other government programs, including the effects of a prolonged U.S. government shutdown or debt ceiling constraints; changes in Medicare, including changes in payment methodology, the CMS star ratings program or the application of risk adjustment data validation audits; cyber-attacks or other privacy or data security incidents; failure to comply with privacy and data security regulations; regulatory and other risks and uncertainties of the pharmacy benefits management industry; competitive pressures, which could affect our ability to maintain or

increase our market share; changes in or challenges to our public sector contract awards; our ability to execute contracts on competitive terms with physicians, hospitals and other service providers; failure to achieve targeted operating cost productivity improvements, including savings resulting from technology enhancement and administrative modernization; increases in costs and other liabilities associated with increased litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete or receive anticipated benefits of acquisitions and other strategic transactions, fluctuations in foreign currency exchange rates on our reported shareholders' equity and results of operations; downgrades in our credit ratings; the performance of our investment portfolio; impairment of the value of our goodwill and intangible assets if estimated future results do not adequately support goodwill and intangible assets recorded for our existing businesses or the businesses that we acquire; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; and our ability to obtain sufficient funds from our regulated subsidiaries or the debt or capital markets to fund our obligations, to maintain our debt to total capital ratio at targeted levels, to maintain our quarterly dividend payment cycle or to continue repurchasing shares of our common stock.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our other periodic and current filings with the SEC, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Any or all forward-looking statements we make may turn out to be wrong, and can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by applicable securities laws.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of June 30, 2019 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	June 30, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 337	$ 305	$ (2,456)	$ (5,466)
1	169	152	(1,233)	(2,964)
(1)	(169)	(152)	1,177	3,491
(2)	(337)	(305)	2,034	7,581

ITEM 4. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this quarterly report on Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of June 30, 2019. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of June 30, 2019.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended June 30, 2019 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

A description of our legal proceedings is included in and incorporated by reference to Note 7 of Notes to the Condensed Consolidated Financial Statements contained in Part I, Item 1 of this report.

ITEM 1A. RISK FACTORS

In addition to the other information set forth in this report, you should carefully consider the factors discussed in Part I, Item 1A, "Risk Factors" of our 2018 10-K, which could materially affect our business, financial condition or future results. The risks described in our 2018 10-K are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition or future results.

There have been no material changes to the risk factors disclosed in our 2018 10-K.

ITEM 2. UNREGISTERED SALE OF EQUITY SECURITIES AND USE OF PROCEEDS

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the second quarter 2019, we repurchased approximately 6 million shares at an average price of $235.77 per share. As of June 30, 2019, we had Board authorization to purchase up to 76 million shares of our common stock.

ITEM 6. EXHIBITS*

The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form 8-A/A filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1998, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
10.1	UnitedHealth Group Executive Savings Plan (2019 Statement)
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document — the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

* Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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/ DAVID S. WICHMANN **David S. Wichmann**	Chief Executive Officer (principal executive officer)	Dated: August 6, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	Dated: August 6, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	Dated: August 6, 2019

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

Form 10-Q

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

FOR THE QUARTERLY PERIOD ENDED MARCH 31, 2019

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(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 ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act

Large accelerated filer	☒	Accelerated filer ☐	Non-accelerated filer ☐
Smaller reporting company	☐		Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange, Inc.**

As of April 30, 2019, there were 950,343,113 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. FINANCIAL STATEMENTS

UnitedHealth Group
Condensed Consolidated Balance Sheets
(Unaudited)

(in millions, except per share data)	March 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 12,407	$ 10,866
Short-term investments	3,303	3,458
Accounts receivable, net	12,826	11,388
Other current receivables, net	7,631	6,862
Assets under management	2,951	3,032
Prepaid expenses and other current assets	3,697	3,086
Total current assets	42,815	38,692
Long-term investments	33,553	32,510
Property, equipment and capitalized software, net	8,230	8,458
Goodwill	59,379	58,910
Other intangible assets, net	9,245	9,325
Other assets	7,975	4,326
Total assets	$161,197	$152,221
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 21,139	$ 19,891
Accounts payable and accrued liabilities	16,900	16,705
Commercial paper and current maturities of long-term debt	3,919	1,973
Unearned revenues	2,530	2,396
Other current liabilities	14,445	12,244
Total current liabilities	58,933	53,209
Long-term debt, less current maturities	34,419	34,581
Deferred income taxes	2,786	2,474
Other liabilities	8,554	5,730
Total liabilities	104,692	95,994
Commitments and contingencies (Note 6)		
Redeemable noncontrolling interests	2,054	1,908
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 953 and 960 issued and outstanding	10	10
Retained earnings	55,472	55,846
Accumulated other comprehensive loss	(3,758)	(4,160)
Nonredeemable noncontrolling interests	2,727	2,623
Total equity	54,451	54,319
Total liabilities, redeemable noncontrolling interests and equity	$161,197	$152,221

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Operations
(Unaudited)

(in millions, except per share data)	Three Months Ended March 31, 2019	2018
Revenues:		
Premiums	$47,513	$44,084
Products	8,072	6,702
Services	4,318	4,104
Investment and other income	405	298
Total revenues	60,308	55,188
Operating costs:		
Medical costs	38,939	35,863
Operating costs	8,517	8,506
Cost of products sold	7,381	6,184
Depreciation and amortization	639	582
Total operating costs	55,476	51,135
Earnings from operations	4,832	4,053
Interest expense	(400)	(329)
Earnings before income taxes	4,432	3,724
Provision for income taxes	(875)	(800)
Net earnings	3,557	2,924
Earnings attributable to noncontrolling interests	(90)	(88)
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,467	$ 2,836
Earnings per share attributable to UnitedHealth Group common shareholders:		
Basic	$ 3.62	$ 2.94
Diluted	$ 3.56	$ 2.87
Basic weighted-average number of common shares outstanding	958	966
Dilutive effect of common share equivalents	17	21
Diluted weighted-average number of common shares outstanding	975	987
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	7

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

(in millions)	Three Months Ended March 31, 2019	2018
Net earnings	$3,557	$2,924
Other comprehensive income (loss):		
Gross unrealized gains (losses) on investment securities during the period	520	(378)
Income tax effect	(119)	86
Total unrealized gains (losses), net of tax	401	(292)
Gross reclassification adjustment for net realized losses (gains) included in net earnings	4	(19)
Income tax effect	(1)	4
Total reclassification adjustment, net of tax	3	(15)
Total foreign currency translation losses	(2)	(1)
Other comprehensive income (loss)	402	(308)
Comprehensive income	3,959	2,616
Comprehensive income attributable to noncontrolling interests	(90)	(88)
Comprehensive income attributable to UnitedHealth Group common shareholders	$3,869	$2,528

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Equity
(Unaudited)

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2019	960	$ 10	$ —	$ 55,846	$ (264)	$ (3,896)	$ 2,623	$54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				3,467			60	3,527
Other comprehensive income (loss)					404	(2)		402
Issuances of common stock, and related tax effects	5	—	56					56
Share-based compensation			239					239
Common share repurchases	(12)	—	(34)	(2,968)				(3,002)
Cash dividends paid on common shares ($0.90 per share)				(860)				(860)
Redeemable noncontrolling interests fair value and other adjustments			(152)					(152)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				132	23
Distribution to nonredeemable noncontrolling interests							(83)	(83)
Balance at March 31, 2019	953	$ 10	$ —	$ 55,472	$ 140	$ (3,898)	$ 2,727	$54,451
Balance at January 1, 2018	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				2,836			53	2,889
Other comprehensive loss					(307)	(1)		(308)
Issuances of common stock, and related tax effects	5	—	415					415
Share-based compensation			206					206
Common share repurchases	(12)	—	(2,324)	(326)				(2,650)
Cash dividends paid on common shares ($0.75 per share)				(722)				(722)
Acquisition of nonredeemable noncontrolling interests							423	423
Distribution to nonredeemable noncontrolling interests							(50)	(50)
Balance at March 31, 2018	962	$ 10	$ —	$ 50,494	$ (296)	$ (2,655)	$ 2,483	$50,036

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Cash Flows
(Unaudited)

(in millions)	Three Months Ended March 31, 2019	2018
Operating activities		
Net earnings	$ 3,557	$ 2,924
Noncash items:		
Depreciation and amortization	639	582
Deferred income taxes	134	(74)
Share-based compensation	243	208
Other, net	42	27
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	(1,421)	(1,579)
Other assets	(1,495)	(3,232)
Medical costs payable	1,125	1,313
Accounts payable and other liabilities	318	2,821
Unearned revenues	92	5,379
Cash flows from operating activities	3,234	8,369
Investing activities		
Purchases of investments	(3,540)	(3,891)
Sales of investments	1,510	1,002
Maturities of investments	1,711	1,504
Cash paid for acquisitions, net of cash assumed	(689)	(2,583)
Purchases of property, equipment and capitalized software	(562)	(477)
Other, net	154	(72)
Cash flows used for investing activities	(1,416)	(4,517)
Financing activities		
Common share repurchases	(3,002)	(2,650)
Cash dividends paid	(860)	(722)
Proceeds from common stock issuances	323	295
Repayments of long-term debt	(1,250)	(1,100)
Proceeds from commercial paper, net	3,101	4,259
Customer funds administered	1,784	2,962
Other, net	(368)	(622)
Cash flows (used for) from financing activities	(272)	2,422
Effect of exchange rate changes on cash and cash equivalents	(5)	(12)
Increase in cash and cash equivalents	1,541	6,262
Cash and cash equivalents, beginning of period	10,866	11,981
Cash and cash equivalents, end of period	$12,407	$18,243

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Notes to the Condensed Consolidated Financial Statements
(Unaudited)

1. Basis of Presentation

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and the "Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

The Company has prepared the Condensed Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The year-end condensed consolidated balance sheet was derived from audited financial statements, but does not include all disclosures required by GAAP. In accordance with the rules and regulations of the U.S. Securities and Exchange Commission (SEC), the Company has omitted certain footnote disclosures that would substantially duplicate the disclosures contained in its annual audited Consolidated Financial Statements. Therefore, these Condensed Consolidated Financial Statements should be read together with the Consolidated Financial Statements and the Notes included in Part II, Item 8, "Financial Statements and Supplementary Data" in the Company's Annual Report on Form 10-K for the year ended December 31, 2018 as filed with the SEC (2018 10-K). The accompanying Condensed Consolidated Financial Statements include all normal recurring adjustments necessary to present the interim financial statements fairly.

Use of Estimates

These Condensed Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates include medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Recently Adopted Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11, 2018-20 and 2019-01 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. The Company adopted ASU 2016-02 using a cumulative-effect upon adoption approach as of January 1, 2019. Upon adoption, the Company recognized $3.3 billion of lease right-of-use (ROU) assets and liabilities for operating leases on its Condensed Consolidated Balance Sheet, of which, $668 million were classified as current liabilities. The adoption of ASU 2016-02 was immaterial to the Company's consolidated results of operations, equity and cash flows. The Company has included the disclosures required by ASU 2016-02 below and in Note 6, "Commitments and Contingencies".

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. At the lease commencement date, lease ROU assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period that closely matches the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Condensed Consolidated Balance Sheet.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Condensed Consolidated Financial Statements.

2. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
March 31, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,610	$ 30	$ (19)	$ 3,621
State and municipal obligations	6,566	150	(9)	6,707
Corporate obligations	15,589	95	(58)	15,626
U.S. agency mortgage-backed securities	5,212	37	(51)	5,198
Non-U.S. agency mortgage-backed securities	1,471	13	(6)	1,478
Total debt securities — available-for-sale	32,448	325	(143)	32,630
Debt securities — held-to-maturity:				
U.S. government and agency obligations	265	—	(1)	264
State and municipal obligations	31	1	—	32
Corporate obligations	428	1	—	429
Total debt securities — held-to-maturity	724	2	(1)	725
Total debt securities	$ 33,172	$ 327	$ (144)	$ 33,355
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518

The Company held $2.0 billion of equity securities as of March 31, 2019 and December 31, 2018. The Company's investments in equity securities primarily consist of employee savings plan related investments, shares of Brazilian real denominated fixed-income funds and dividend paying stocks with readily determinable fair values. Additionally, the Company's investments included $1.5 billion of equity method investments in operating businesses in the health care sector as of March 31, 2019 and December 31, 2018.

The amortized cost and fair value of debt securities as of March 31, 2019, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,457	$ 3,455	$ 132	$ 132
Due after one year through five years	12,283	12,304	318	318
Due after five years through ten years	7,314	7,430	131	131
Due after ten years	2,711	2,765	143	144
U.S. agency mortgage-backed securities	5,212	5,198	—	—
Non-U.S. agency mortgage-backed securities	1,471	1,478	—	—
Total debt securities	$ 32,448	$ 32,630	$ 724	$ 725

The fair value of available-for-sale debt securities with gross unrealized losses by security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
March 31, 2019						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ —	$ —	$ 1,329	$ (19)	$ 1,329	$ (19)
State and municipal obligations	—	—	1,274	(9)	1,274	(9)
Corporate obligations	1,461	(7)	5,479	(51)	6,940	(58)
U.S. agency mortgage-backed securities	—	—	2,979	(51)	2,979	(51)
Non-U.S. agency mortgage-backed securities	—	—	546	(6)	546	(6)
Total debt securities — available-for-sale	$ 1,461	$ (7)	$ 11,607	$ (136)	$ 13,068	$ (143)
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$ 12,355	$ (156)	$ 11,002	$ (287)	$ 23,357	$ (443)

The Company's unrealized losses from debt securities as of March 31, 2019 were generated from 11,000 positions out of a total of 30,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of March 31, 2019, the Company did not

have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

3. Fair Value

Certain assets and liabilities are measured at fair value in the Condensed Consolidated Financial Statements or have fair values disclosed in the Notes to the Condensed Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP.

For a description of the methods and assumptions that are used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument, see Note 4 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
March 31, 2019				
Cash and cash equivalents	$ 12,283	$ 124	$ —	$ 12,407
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,319	302	—	3,621
State and municipal obligations	—	6,707	—	6,707
Corporate obligations	17	15,424	185	15,626
U.S. agency mortgage-backed securities	—	5,198	—	5,198
Non-U.S. agency mortgage-backed securities	—	1,478	—	1,478
Total debt securities — available-for-sale	3,336	29,109	185	32,630
Equity securities	1,827	12	—	1,839
Assets under management	896	2,043	12	2,951
Total assets at fair value	$ 18,342	$ 31,288	$ 197	$ 49,827
Percentage of total assets at fair value	37%	63%	—%	100%
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$ 10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$ 47,641
Percentage of total assets at fair value	35%	65%	—%	100%

There were no transfers in or out of Level 3 financial assets or liabilities during the three months ended March 31, 2019 or 2018.

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
March 31, 2019					
Debt securities — held-to-maturity	$ 273	$ 172	$ 280	$ 725	$ 724
Long-term debt and other financing obligations	$ —	$ 37,790	$ —	$ 37,790	$ 35,221
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the three months ended March 31, 2019 or 2018.

4. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the three months ended March 31:

(in millions)	2019	2018
Medical costs payable, beginning of period	$ 19,891	$ 17,871
Acquisitions	35	211
Reported medical costs:		
Current year	39,239	36,153
Prior years	(300)	(290)
Total reported medical costs	38,939	35,863
Medical payments:		
Payments for current year	(22,973)	(21,237)
Payments for prior years	(14,753)	(13,119)
Total medical payments	(37,726)	(34,356)
Medical costs payable, end of period	$ 21,139	$ 19,589

For the three months ended March 31, 2019 and 2018, the medical cost reserve development included no individual factors that were significant. Medical costs payable included reserves for claims incurred by insured customers but not yet reported to the Company of $14.3 billion and $13.2 billion at March 31, 2019 and December 31, 2018, respectively.

5. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	March 31, 2019			December 31, 2018		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 3,134	$ 3,117	$ 3,117	$ —	$ —	$ —
1.700% notes due February 2019	—	—	—	750	750	749
1.625% notes due March 2019	—	—	—	500	500	499
2.300% notes due December 2019	500	496	499	500	494	497
2.700% notes due July 2020	1,500	1,498	1,503	1,500	1,498	1,494
Floating rate notes due October 2020	300	299	300	300	299	298
3.875% notes due October 2020	450	445	457	450	443	456
1.950% notes due October 2020	900	897	890	900	897	884
4.700% notes due February 2021	400	400	413	400	398	412
2.125% notes due March 2021	750	748	744	750	747	734
Floating rate notes due June 2021	350	349	350	350	349	347
3.150% notes due June 2021	400	399	404	400	399	400
3.375% notes due November 2021	500	493	508	500	489	503
2.875% notes due December 2021	750	742	754	750	735	748
2.875% notes due March 2022	1,100	1,063	1,107	1,100	1,051	1,091
3.350% notes due July 2022	1,000	997	1,022	1,000	997	1,005
2.375% notes due October 2022	900	895	891	900	894	872
0.000% notes due November 2022	15	12	13	15	12	13
2.750% notes due February 2023	625	610	625	625	602	611
2.875% notes due March 2023	750	758	754	750	750	739
3.500% notes due June 2023	750	747	773	750	746	756
3.500% notes due February 2024	750	745	772	750	745	755
3.750% notes due July 2025	2,000	1,989	2,088	2,000	1,989	2,025
3.700% notes due December 2025	300	298	312	300	298	303
3.100% notes due March 2026	1,000	996	999	1,000	995	965
3.450% notes due January 2027	750	746	763	750	746	742
3.375% notes due April 2027	625	619	633	625	619	611
2.950% notes due October 2027	950	938	933	950	938	898
3.850% notes due June 2028	1,150	1,142	1,204	1,150	1,142	1,163
3.875% notes due December 2028	850	842	890	850	842	861
4.625% notes due July 2035	1,000	992	1,121	1,000	992	1,060
5.800% notes due March 2036	850	838	1,045	850	838	1,003
6.500% notes due June 2037	500	492	661	500	492	638
6.625% notes due November 2037	650	641	874	650	641	841
6.875% notes due February 2038	1,100	1,076	1,514	1,100	1,076	1,437
5.700% notes due October 2040	300	296	370	300	296	355
5.950% notes due February 2041	350	345	446	350	345	426
4.625% notes due November 2041	600	588	657	600	588	627
4.375% notes due March 2042	502	484	534	502	484	503
3.950% notes due October 2042	625	607	631	625	607	596
4.250% notes due March 2043	750	735	787	750	734	744
4.750% notes due July 2045	2,000	1,973	2,260	2,000	1,973	2,116
4.200% notes due January 2047	750	738	777	750	738	745
4.250% notes due April 2047	725	717	759	725	717	719
3.750% notes due October 2047	950	933	923	950	933	869
4.250% notes due June 2048	1,350	1,329	1,420	1,350	1,329	1,349
4.450% notes due December 2048	1,100	1,087	1,191	1,100	1,087	1,132
Total commercial paper and long-term debt	$ 37,551	$ 37,151	$ 39,688	$ 35,667	$ 35,234	$ 36,591

The Company's long-term debt obligations included $1.2 billion and $1.3 billion of other financing obligations, of which $306 million and $229 million were classified as current as of March 31, 2019 and December 31, 2018, respectively.

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of March 31, 2019, the Company's outstanding commercial paper had a weighted average annual interest rate of 2.7%.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of March 31, 2019, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of March 31, 2019, annual interest rates would have ranged from 3.2% to 3.4%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including covenants requiring the Company to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of March 31, 2019.

6. Commitments and Contingencies

Leases

Operating lease costs were $238 million for the three months ended March 31, 2019 and included immaterial variable and short-term lease costs. Cash payments made on the Company's operating lease liabilities were $181 million for the three months ended March 31, 2019, which were classified within operating activities in the Condensed Consolidated Statements of Cash Flows. As of March 31, 2019, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.5 years and 4.2%, respectively.

As of March 31, 2019, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Operating Lease Payments
2019	$ 480
2020	667
2021	578
2022	481
2023	393
Thereafter	1,553
Total future minimum lease payments	4,152
Less imputed interest	(731)
Total	$ 3,421

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy

organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare and Medicaid Services (CMS), state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

7. Segment Financial Information

The Company's four reportable segments are UnitedHealthcare, OptumHealth, OptumInsight and OptumRx. For more information on the Company's segments see Part I, Item I, "Business" and Note 13 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" in the 2018 10-K.

The following tables present reportable segment financial information:

		Optum						
(in millions)	**UnitedHealthcare**	**OptumHealth**	**OptumInsight**	**OptumRx**	**Optum Eliminations**	**Optum**	**Corporate and Eliminations**	**Consolidated**
Three Months Ended March 31, 2019								
Revenues — unaffiliated customers:								
Premiums	$ 46,501	$ 1,012	$ —	$ —	$ —	$ 1,012	$ —	$ 47,513
Products	—	8	23	8,041	—	8,072	—	8,072
Services	2,141	1,274	754	149	—	2,177	—	4,318
Total revenues — unaffiliated customers	48,642	2,294	777	8,190	—	11,261	—	59,903
Total revenues — affiliated customers	—	4,287	1,407	9,613	(359)	14,948	(14,948)	—
Investment and other income	254	132	5	14	—	151	—	405
Total revenues	$ 48,896	$ 6,713	$ 2,189	$ 17,817	$ (359)	$ 26,360	$ (14,948)	$ 60,308
Earnings from operations	$ 2,954	$ 626	$ 432	$ 820	$ —	$ 1,878	$ —	$ 4,832
Interest expense	—	—	—	—	—	—	(400)	(400)
Earnings before income taxes	$ 2,954	$ 626	$ 432	$ 820	$ —	$ 1,878	$ (400)	$ 4,432
Three Months Ended March 31, 2018								
Revenues — unaffiliated customers:								
Premiums	$ 43,237	$ 847	$ —	$ —	$ —	$ 847	$ —	$ 44,084
Products	—	12	23	6,667	—	6,702	—	6,702
Services	2,039	1,188	740	137	—	2,065	—	4,104
Total revenues — unaffiliated customers	45,276	2,047	763	6,804	—	9,614	—	54,890
Total revenues — affiliated customers	—	3,606	1,304	9,295	(333)	13,872	(13,872)	—
Investment and other income	183	106	2	7	—	115	—	298
Total revenues	$ 45,459	$ 5,759	$ 2,069	$ 16,106	$ (333)	$ 23,601	$ (13,872)	$ 55,188
Earnings from operations	$ 2,400	$ 488	$ 395	$ 770	$ —	$ 1,653	$ —	$ 4,053
Interest expense	—	—	—	—	—	—	(329)	(329)
Earnings before income taxes	$ 2,400	$ 488	$ 395	$ 770	$ —	$ 1,653	$ (329)	$ 3,724

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Condensed Consolidated Financial Statements and Notes and with our 2018 10-K, including the Consolidated Financial Statements and Notes in Part II, Item 8, "Financial Statements and Supplementary Data" in that report. Unless the context indicates otherwise, references to the terms "UnitedHealth Group," "we," "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations refer to UnitedHealth Group Incorporated and its consolidated subsidiaries.

Readers are cautioned that the statements, estimates, projections or outlook contained in this Management's Discussion and Analysis of Financial Condition and Results of Operations, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 2, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed or implied in the forward-looking statements. A description of some of the risks and uncertainties is set forth in Part I, Item 1A, "Risk Factors" in our 2018 10-K and in the discussion below.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

Further information on our business is presented in Part I, Item 1, "Business" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K and additional information on our segments can be found in this Item 2 and in Note 7 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Business Trends

Our businesses participate in the United States, South American and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. We expect overall spending on health care to continue to grow in the future due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any impact from the Health Insurance Industry Tax. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum medical loss ratio (MLR) thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform

changes. Pricing for contracts that cover some portion of calendar year 2020 will reflect the return of the Health Insurance Industry Tax after a moratorium in 2019.

Government programs in the public and senior sector tend to receive lower rates of increase than the commercial market due to governmental budget pressures and lower cost trends.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high quality, affordable care.

Regulatory Trends and Uncertainties

Following is a summary of management's view of regulatory trends and uncertainties. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business - Government Regulation," Part 1, Item 1A, "Risk Factors" and Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our 2018 10-K.

Medicare Advantage Rates. Final 2020 Medicare Advantage rates resulted in an increase in industry base rates of approximately 2.5%, short of the industry forward medical cost trend, including the return of the Health Insurance Industry Tax, creating continued pressure in the Medicare Advantage program.

Health Insurance Industry Tax. There is a one year moratorium on the Health Insurance Industry Tax in 2019. This moratorium impacts year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following summarizes select first quarter 2019 year-over-year operating comparisons to first quarter 2018.

- Consolidated revenues grew 9%, UnitedHealthcare revenues grew 8% and Optum revenues grew 12%.
- UnitedHealthcare served 880,000 additional people primarily as a result of business combinations and growth in services to self-funded employers and seniors.
- Earnings from operations increased 19%, including increases of 23% at UnitedHealthcare and 14% at Optum.
- Diluted earnings per common share increased 24%.
- Cash flows from operations were $3.2 billion.
- Return on Equity was 26.8%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	Three Months Ended March 31, 2019	Three Months Ended March 31, 2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues:				
Premiums	$ 47,513	$ 44,084	$ 3,429	8%
Products	8,072	6,702	1,370	20
Services	4,318	4,104	214	5
Investment and other income	405	298	107	36
Total revenues	60,308	55,188	5,120	9
Operating costs:				
Medical costs	38,939	35,863	3,076	9
Operating costs	8,517	8,506	11	—
Cost of products sold	7,381	6,184	1,197	19
Depreciation and amortization	639	582	57	10
Total operating costs	55,476	51,135	4,341	8
Earnings from operations	4,832	4,053	779	19
Interest expense	(400)	(329)	(71)	22
Earnings before income taxes	4,432	3,724	708	19
Provision for income taxes	(875)	(800)	(75)	9
Net earnings	3,557	2,924	633	22
Earnings attributable to noncontrolling interests	(90)	(88)	(2)	2
Net earnings attributable to UnitedHealth Group common shareholders	$ 3,467	$ 2,836	$ 631	22%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 3.56	$ 2.87	$ 0.69	24%
Medical care ratio (a)	82.0%	81.4%	0.6%	
Operating cost ratio	14.1	15.4	(1.3)	
Operating margin	8.0	7.3	0.7	
Tax rate	19.7	21.5	(1.8)	
Net earnings margin (b)	5.7	5.1	0.6	
Return on equity (c)	26.8%	23.8%	3.0%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as annualized net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the quarters in the year presented.

2019 RESULTS OF OPERATIONS COMPARED TO 2018 RESULTS OF OPERATIONS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through various Medicare products; pricing trends; and growth across the Optum business, primarily due to expansion in

pharmacy care services and care delivery; partially offset by the moratorium of the Health Insurance Industry Tax in 2019.

Medical Costs and MCR

Medical costs increased due to growth in people served through Medicare products and medical cost trends. The MCR increased due to the revenue effects of the Health Insurance Industry Tax moratorium.

Operating Cost Ratio

The operating cost ratio decreased due to the impact of the Health Insurance Industry Tax moratorium and effective operating cost management.

Income Tax Rate

Our effective tax rate decreased due to the impact of the moratorium of the nondeductible Health Insurance Industry Tax.

Reportable Segments

See Note 7 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	Three Months Ended March 31, 2019	2018	Increase/ (Decrease) 2019 vs. 2018	
Revenues				
UnitedHealthcare	$ 48,896	$ 45,459	$ 3,437	8%
OptumHealth	6,713	5,759	954	17
OptumInsight	2,189	2,069	120	6
OptumRx	17,817	16,106	1,711	11
Optum eliminations	(359)	(333)	(26)	8
Optum	26,360	23,601	2,759	12
Eliminations	(14,948)	(13,872)	(1,076)	8
Consolidated revenues	$ 60,308	$ 55,188	$ 5,120	9%
Earnings from operations				
UnitedHealthcare	$ 2,954	$ 2,400	$ 554	23%
OptumHealth	626	488	138	28
OptumInsight	432	395	37	9
OptumRx	820	770	50	6
Optum	1,878	1,653	225	14
Consolidated earnings from operations	$ 4,832	$ 4,053	$ 779	19%
Operating margin				
UnitedHealthcare	6.0%	5.3%	0.7%	
OptumHealth	9.3	8.5	0.8	
OptumInsight	19.7	19.1	0.6	
OptumRx	4.6	4.8	(0.2)	
Optum	7.1	7.0	0.1	
Consolidated operating margin	8.0%	7.3%	0.7%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	Three Months Ended March 31, 2019	2018	Increase/(Decrease) 2019 vs. 2018	
UnitedHealthcare Employer & Individual	$ 14,084	$ 13,414	$ 670	5%
UnitedHealthcare Medicare & Retirement	21,096	18,925	2,171	11
UnitedHealthcare Community & State	11,182	10,671	511	5
UnitedHealthcare Global	2,534	2,449	85	3
Total UnitedHealthcare revenues	$ 48,896	$ 45,459	$ 3,437	8%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	March 31, 2019	2018	Increase/ (Decrease) 2019 vs. 2018	
Commercial:				
Risk-based	8,340	8,335	5	—%
Fee-based	19,175	18,475	700	4
Total commercial	27,515	26,810	705	3
Medicare Advantage	5,165	4,760	405	9
Medicaid	6,425	6,695	(270)	(4)
Medicare Supplement (Standardized)	4,500	4,490	10	—
Total public and senior	16,090	15,945	145	1
Total UnitedHealthcare — domestic medical	43,605	42,755	850	2
International	6,125	6,095	30	—
Total UnitedHealthcare — medical	49,730	48,850	880	2%
Supplemental Data:				
Medicare Part D stand-alone	4,480	4,770	(290)	(6)%

Fee-based commercial group business increased primarily due to a business combination. Medicare Advantage increased due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan in 2018.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served through several Medicare products, a higher revenue membership mix and rate increases for underlying medical cost trends. Revenue increases were partially offset by the moratorium on the Health Insurance Industry Tax in 2019.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of productivity and overall cost management initiatives in addition to the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic growth and business combinations in care delivery and organic growth in behavioral health.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to organic growth in managed services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to business combinations and organic growth in specialty pharmacy, home delivery services and overall prescription growth. OptumRx fulfilled 339 million and 332 million adjusted scripts in the first quarters of 2019 and 2018, respectively.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	Three Months Ended March 31, 2019	2018	Increase/(Decrease) 2019 vs. 2018
Sources of cash:			
Cash provided by operating activities	$ 3,234	$ 8,369	$ (5,135)
Issuances of commercial paper and long-term debt, net of repayments	1,851	3,159	(1,308)
Proceeds from common stock issuances	323	295	28
Customer funds administered	1,784	2,962	(1,178)
Total sources of cash	7,192	14,785	
Uses of cash:			
Common stock repurchases	(3,002)	(2,650)	(352)
Cash paid for acquisitions, net of cash assumed	(689)	(2,583)	1,894
Purchases of investments, net of sales and maturities	(319)	(1,385)	1,066
Purchases of property, equipment and capitalized software	(562)	(477)	(85)
Cash dividends paid	(860)	(722)	(138)
Other	(214)	(694)	480
Total uses of cash	(5,646)	(8,511)	
Effect of exchange rate changes on cash and cash equivalents	(5)	(12)	7
Net increase in cash and cash equivalents	$ 1,541	$ 6,262	$ (4,721)

2019 Cash Flows Compared to 2018 Cash Flows

Decreased cash flows provided by operating activities were primarily driven by the increase in unearned revenues in 2018 due to the March 2018 early receipt of our April CMS premium payment of $5.1 billion and the year-over-year impact of the Health Insurance Industry Tax moratorium, partially offset by higher net earnings.

Other significant changes in sources or uses of cash year-over-year included a decrease in cash paid for acquisitions, increased sales and maturities of investments, decreased issuances of commercial paper and a decrease in customer funds administered due to the early receipt of our CMS payment in 2018 described above.

Financial Condition

As of March 31, 2019, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $47.0 billion included approximately $12.4 billion of cash and cash equivalents (of which $800 million was

available for general corporate use), $32.6 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash and cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Our available-for-sale debt portfolio had a weighted-average duration of 3.5 years and a weighted-average credit rating of "Double A" as of March 31, 2019. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of March 31, 2019, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was approximately 40%.

Long-Term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, such as to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our long-term debt, see Note 5 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Credit Ratings. Our credit ratings as of March 31, 2019 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. During the three months ended March 31, 2019, we repurchased 12 million shares at an average price of $252.76 per share. As of March 31, 2019, we had Board authorization to purchase up to 83 million shares of our common stock.

Dividends. Our quarterly cash dividend to shareholders reflects an annual dividend rate of $3.60 per share.

For additional liquidity discussion, see Note 10 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements and Supplementary Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 in our 2018 10-K.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018 was disclosed in our 2018 10-K. During the three months ended March 31, 2019, there were no material

changes to this previously disclosed information outside the ordinary course of business. However, we continually evaluate opportunities to expand our operations, including through internal development of new products, programs and technology applications and acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 1 of Notes to the Condensed Consolidated Financial Statements in Part I, Item 1 of this report for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and disclosure of our contingent liabilities. We base our assumptions and estimates primarily on historical experience and consider known and projected trends. On an ongoing basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may materially differ from our calculated estimates, and this difference would be reported in our current operations.

Our critical accounting estimates include medical costs payable and goodwill. For a detailed description of our critical accounting estimates, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in Part II, Item 7 in our 2018 10-K. For a detailed discussion of our significant accounting policies, see Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8, “Financial Statements and Supplementary Data” in our 2018 10-K.

FORWARD-LOOKING STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this document include “forward-looking” statements within the meaning of the PSLRA. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. Generally the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. We caution that actual results could differ materially from those that management expects, depending on the outcome of certain factors.

Some factors that could cause actual results to differ materially from results discussed or implied in the forward-looking statements include: our ability to effectively estimate, price for and manage our medical costs, including the impact of any new coverage requirements; new laws or regulations, or changes in existing laws or regulations, or their enforcement or application, including increases in medical, administrative, technology or other costs or decreases in enrollment resulting from U.S., South American and other jurisdictions’ regulations affecting the health care industry; the outcome of the DOJ’s legal action relating to the risk adjustment submission matter; our ability to maintain and achieve improvement in CMS star ratings and other quality scores that impact revenue; reductions in revenue or delays to cash flows received under Medicare, Medicaid and other government programs, including the effects of a prolonged U.S. government shutdown or debt ceiling constraints; changes in Medicare, including changes in payment methodology, the CMS star ratings program or the application of risk adjustment data validation audits; cyber-attacks or other privacy or data security incidents; failure to comply with privacy and data security regulations; regulatory and other risks and uncertainties of the pharmacy benefits management industry; competitive pressures, which could affect our ability to maintain or increase our market share; changes in or challenges to our public sector contract awards; our ability to execute contracts on competitive terms with physicians, hospitals and other service providers; failure to achieve targeted operating cost productivity improvements, including savings resulting from technology enhancement and administrative modernization; increases in costs and other liabilities associated with increased litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete

or receive anticipated benefits of acquisitions and other strategic transactions, fluctuations in foreign currency exchange rates on our reported shareholders' equity and results of operations; downgrades in our credit ratings; the performance of our investment portfolio; impairment of the value of our goodwill and intangible assets if estimated future results do not adequately support goodwill and intangible assets recorded for our existing businesses or the businesses that we acquire; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; and our ability to obtain sufficient funds from our regulated subsidiaries or the debt or capital markets to fund our obligations, to maintain our debt to total capital ratio at targeted levels, to maintain our quarterly dividend payment cycle or to continue repurchasing shares of our common stock.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our other periodic and current filings with the SEC, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Any or all forward-looking statements we make may turn out to be wrong, and can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by applicable securities laws.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of March 31, 2019 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	March 31, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 306	$ 260	$ (2,294)	$ (5,249)
1	153	130	(1,159)	(2,849)
(1)	(153)	(130)	1,115	3,327
(2)	(306)	(260)	2,088	7,327

ITEM 4. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this quarterly report on Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of March 31, 2019. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of March 31, 2019.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended March 31, 2019 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

A description of our legal proceedings is included in and incorporated by reference to Note 6 of Notes to the Condensed Consolidated Financial Statements contained in Part I, Item 1 of this report.

ITEM 1A. RISK FACTORS

In addition to the other information set forth in this report, you should carefully consider the factors discussed in Part I, Item 1A, "Risk Factors" of our 2018 10-K, which could materially affect our business, financial condition or future results. The risks described in our 2018 10-K are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition or future results.

There have been no material changes to the risk factors disclosed in our 2018 10-K.

ITEM 2. UNREGISTERED SALE OF EQUITY SECURITIES AND USE OF PROCEEDS

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the first quarter 2019, we repurchased approximately 12 million shares at an average price of $252.76 per share. As of March 31, 2019, we had Board authorization to purchase up to 83 million shares of our common stock.

ITEM 6. EXHIBITS*

The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Registration Statement on Form 8-A/A filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1998, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2019 filed on May 7, 2019, formatted in XBRL (eXtensible Business Reporting Language): (i) Condensed Consolidated Balance Sheets, (ii) Condensed Consolidated Statements of Operations, (iii) Condensed Consolidated Statements of Comprehensive Income, (iv) Condensed Consolidated Statements of Changes in Equity, (v) Condensed Consolidated Statements of Cash Flows, and (vi) Notes to the Condensed Consolidated Financial Statements.

* Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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/ DAVID S. WICHMANN **David S. Wichmann**	Chief Executive Officer (principal executive officer)	Dated: May 7, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	Dated: May 7, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	Dated: May 7, 2019

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

Form 10-K

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

For the fiscal year ended December 31, 2018

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒
Non-accelerated filer ☐
Accelerated filer ☐
Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2018 was $234,490,429,732 (based on the last reported sale price of $245.34 per share on June 30, 2018, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2019, there were 959,538,515 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2019 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2018, we processed more than three-quarters of a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local-market relationships;

- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.3 million physicians and other health care professionals and more than 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27 million people on behalf of our customers and alliance partners, including employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace,

UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness and disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.9 million people through its Medicare Advantage products as of December 31, 2018.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.5 million in-home preventive care visits in 2018 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across

home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2018, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.7 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 30% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2018, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and people without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2018, UnitedHealthcare Community & State participated in programs in 30 states and the District of Columbia, and served 6.5 million people; including 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care

providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves 6.2 million people with medical benefits, residing principally in Brazil, Chile, Colombia and Peru but also in more than 130 other countries. UnitedHealthcare Global owns and operates more than 300 hospitals, specialty centers, primary care and emergency services clinics in South America and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individual consumers around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil; Chile; Colombia; Peru; and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4.1 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2.2 million people. Amil's members have access to a provider network of physicians and other health care professionals, hospitals, laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and consumers served by the external payer market.

Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru through a network of owned and affiliated clinics, hospitals and care providers. Empresas Banmédica owns and operates hospitals, clinics and outpatient centers.

Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.

- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 93 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 35,000 employed, managed or contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance- based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum—physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.2 million health savings and other accounts approaching $10 billion in assets under management as of

December 31, 2018. During 2018, Optum Bank processed nearly $160 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2018 was $17.0 billion, of which $8.6 billion is expected to be realized within the next 12 months. The aggregate backlog includes $6.2 billion related to intersegment agreements. OptumInsight's aggregate backlog at December 31, 2017, was $15.0 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers

meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves three out of four U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and compounding pharmacies and through the provision of home infusion services. In 2018, OptumRx added capabilities in managing limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology as well as capabilities to serve the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2018, OptumRx managed $91 billion in pharmaceutical spending, including $40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

As of December 31, 2018, OptumRx operated four home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2018, OptumRx's specialty pharmacy operations included more than 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

The Tax Cuts and Jobs Act. In December 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and included numerous provisions that affected our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data

breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to

state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx’s businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, "Risk Factors" for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2018, we employed 300,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2019, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	66	Executive Chair of the Board
David S. Wichmann	56	Chief Executive Officer
Steven H. Nelson	59	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Andrew P. Witty	54	Executive Vice President; Chief Executive Officer of Optum
John F. Rex	56	Executive Vice President; Chief Financial Officer
Thomas E. Roos	46	Senior Vice President; Chief Accounting Officer
Marianne D. Short	67	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	61	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth

Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June 2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then as Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Witty is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2018. He previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, Mr. Witty was CEO and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period

and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2018 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2018 would have been reduced by approximately $305 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company’s claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal district court struck down the ACA in its entirety as unconstitutional in 2018. That opinion has been stayed and appealed. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial

revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans,

as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or

cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care

usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and 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. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard

that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2018. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2018, our goodwill and other intangible assets had a carrying value of $68 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2019, there were 11,948 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2018, our Board of Directors increased the Company's annual cash dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2018, we repurchased 3.3 million shares at an average price of $256.15 per share. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock.

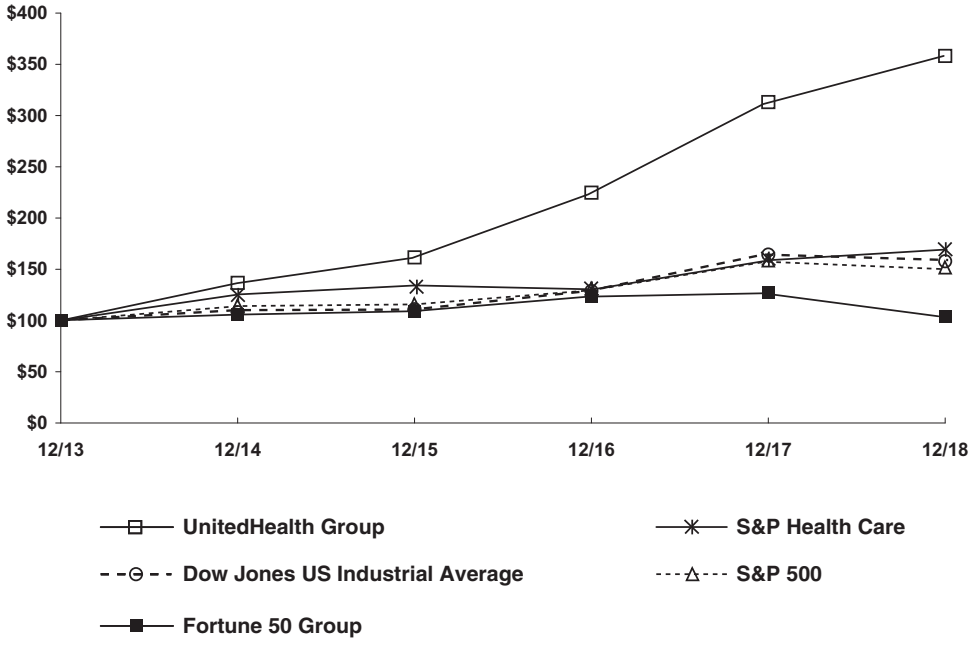
PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2018. We have also included the customized peer group of certain *Fortune 50* companies that we have compared ourselves to in prior years. We believe that these indices provide a more meaningful comparison than the previous subset of the Fortune 50 given our diverse businesses. The comparisons assume the investment of $100 on December 31, 2013 in our common stock and in each index, and that dividends were reinvested when paid.

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. We are not included in this *Fortune 50* Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index, the S&P 500 Index, and Fortune 50 Group



	12/13	12/14	12/15	12/16	12/17	12/18
UnitedHealth Group	**$100.00**	**$136.46**	**$161.37**	**$223.35**	**$312.29**	**$357.64**
S&P Health Care Index	**100.00**	**125.34**	**133.97**	**130.37**	**159.15**	**169.44**
Dow Jones US Industrial Average	**100.00**	**110.04**	**110.28**	**128.47**	**164.58**	**158.85**
S&P 500 Index	**100.00**	**113.69**	**115.26**	**129.05**	**157.22**	**150.33**
Fortune 50 Group	**100.00**	**105.33**	**108.75**	**123.33**	**126.45**	**103.96**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017 (a)	2016	2015 (b)	2014
Consolidated operating results					
Revenues	$226,247	$201,159	$184,840	$157,107	$130,474
Earnings from operations	17,344	15,209	12,930	11,021	10,274
Net earnings attributable to UnitedHealth Group common shareholders	11,986	10,558	7,017	5,813	5,619
Return on equity (c)	24.4%	24.4%	19.4%	17.7%	17.3%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 12.45	$ 10.95	$ 7.37	$ 6.10	$ 5.78
Diluted earnings per share attributable to UnitedHealth Group common shareholders	12.19	10.72	7.25	6.01	5.70
Cash dividends declared per common share	3.45	2.875	2.375	1.875	1.405
Consolidated cash flows from (used for)					
Operating activities	$ 15,713	$ 13,596	$ 9,795	$ 9,740	$ 8,051
Investing activities	(12,385)	(8,599)	(9,355)	(18,395)	(2,534)
Financing activities	(4,365)	(3,441)	(1,011)	12,239	(5,293)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 46,834	$ 43,831	$ 37,143	$ 31,703	$ 28,063
Total assets	152,221	139,058	122,810	111,254	86,300
Total commercial paper and long-term debt	36,554	31,692	32,970	31,965	17,324
Redeemable noncontrolling interests	1,908	2,189	2,012	1,736	1,388
Total equity	54,319	49,833	38,177	33,725	32,454

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2019 reflected the impact of the moratorium. The industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect continued Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2018, we served nearly 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2018, our contracts with value-based elements totaled $74 billion in annual spending, including $18 billion through risk-transfer agreements.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2019 Medicare Advantage rates resulted in an increase in industry base rates of 3.4%, short of the industry forward medical cost trend, which creates continued pressure in the Medicare Advantage program.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products, such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law, including reducing the U.S. corporate income tax rate. In 2018, the impact of Tax Reform was partially offset by the return of the nondeductible Health Insurance Industry Tax.

Health Insurance Industry Tax. After a moratorium in 2017, the industry-wide amount of the Health Insurance Industry Tax in 2018 was $14.3 billion, with our portion being $2.6 billion. The return of the tax impacted year-over-year comparability of our financial results, including revenues, the medical care ratio (MCR), operating cost ratio and effective tax rate. A one year moratorium is imposed on the collection of the Health Insurance Industry Tax in 2019.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2018 year-over-year operating comparisons to 2017.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 12% and Optum revenues grew 11%.
- UnitedHealthcare's addition of 2.2 million people through acquisition and 250,000 through organic growth was offset by 2.9 million fewer people served as a result of completion of its commitment under the TRICARE military health care program.
- Earnings from operations increased by 14%, including increases of 7% at UnitedHealthcare and 23% at Optum.
- Diluted earnings per common share increased 14% to $12.19.
- Cash flows from operations were $15.7 billion, an increase of 16%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Revenues:							
Premiums	$178,087	$158,453	$144,118	$19,634	12%	$14,335	10%
Products	29,601	26,366	26,658	3,235	12	(292)	(1)
Services	17,183	15,317	13,236	1,866	12	2,081	16
Investment and other income	1,376	1,023	828	353	35	195	24
Total revenues	226,247	201,159	184,840	25,088	12	16,319	9
Operating costs:							
Medical costs	145,403	130,036	117,038	15,367	12	12,998	11
Operating costs	34,074	29,557	28,401	4,517	15	1,156	4
Cost of products sold	26,998	24,112	24,416	2,886	12	(304)	(1)
Depreciation and amortization	2,428	2,245	2,055	183	8	190	9
Total operating costs	208,903	185,950	171,910	22,953	12	14,040	8
Earnings from operations	17,344	15,209	12,930	2,135	14	2,279	18
Interest expense	(1,400)	(1,186)	(1,067)	(214)	18	(119)	11
Earnings before income taxes	15,944	14,023	11,863	1,921	14	2,160	18
Provision for income taxes	(3,562)	(3,200)	(4,790)	(362)	11	1,590	(33)
Net earnings	12,382	10,823	7,073	1,559	14	3,750	53
Earnings attributable to noncontrolling interests	(396)	(265)	(56)	(131)	49	(209)	373
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017	$ 1,428	14%	$ 3,541	50%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 12.19	$ 10.72	$ 7.25	$ 1.47	14%	$ 3.47	48%
Medical care ratio (a)	81.6%	82.1%	81.2%	(0.5)%		0.9%	
Operating cost ratio	15.1	14.7	15.4	0.4		(0.7)	
Operating margin	7.7	7.6	7.0	0.1		0.6	
Tax rate	22.3	22.8	40.4	(0.5)		(17.6)	
Net earnings margin (b)	5.3	5.2	3.8	0.1		1.4	
Return on equity (c)	24.4%	24.4%	19.4%	—%		5.0%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2018 RESULTS OF OPERATIONS COMPARED TO 2017 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through risk-based products across our UnitedHealthcare benefits businesses; pricing trends, including the Health Insurance

Industry Tax in 2018; and growth across the Optum business, primarily due to expansion and growth in care delivery, pharmacy care services, managed services and advisory services.

Medical Costs and MCR

Medical costs increased due to growth in people served through risk-based products and medical cost trends. The MCR decreased due to the revenue effects of the Health Insurance Industry Tax, which more than offset business mix changes and a lower level of favorable reserve development.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2016 vs. 2015	
Revenues							
UnitedHealthcare	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%
OptumHealth	24,145	20,570	16,908	3,575	17	3,662	22
OptumInsight	9,008	8,087	7,333	921	11	754	10
OptumRx	69,536	63,755	60,440	5,781	9	3,315	5
Optum eliminations	(1,409)	(1,227)	(1,088)	(182)	15	(139)	13
Optum	101,280	91,185	83,593	10,095	11	7,592	9
Eliminations	(58,509)	(53,283)	(47,334)	(5,226)	10	(5,949)	13
Consolidated revenues	$226,247	$201,159	$184,840	$25,088	12%	$16,319	9%
Earnings from operations							
UnitedHealthcare	$ 9,113	$ 8,498	$ 7,307	$ 615	7%	$ 1,191	16%
OptumHealth	2,430	1,823	1,428	607	33	395	28
OptumInsight	2,243	1,770	1,513	473	27	257	17
OptumRx	3,558	3,118	2,682	440	14	436	16
Optum	8,231	6,711	5,623	1,520	23	1,088	19
Consolidated earnings from operations	$ 17,344	$ 15,209	$ 12,930	$ 2,135	14%	$ 2,279	18%
Operating margin							
UnitedHealthcare	5.0%	5.2%	4.9%	(0.2)%		0.3%	
OptumHealth	10.1	8.9	8.4	1.2		0.5	
OptumInsight	24.9	21.9	20.6	3.0		1.3	
OptumRx	5.1	4.9	4.4	0.2		0.5	
Optum	8.1	7.4	6.7	0.7		0.7	
Consolidated operating margin	7.7%	7.6%	7.0%	0.1%		0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
UnitedHealthcare Employer & Individual	$ 54,761	$ 52,066	$ 53,084	$ 2,695	5%	$ (1,018)	(2)%
UnitedHealthcare Medicare & Retirement	75,473	65,995	56,329	9,478	14	9,666	17
UnitedHealthcare Community & State	43,426	37,443	32,945	5,983	16	4,498	14
UnitedHealthcare Global	9,816	7,753	6,223	2,063	27	1,530	25
Total UnitedHealthcare revenues	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Commercial:							
Risk-based	8,495	8,420	8,820	75	1%	(400)	(5)%
Fee-based	18,420	18,595	18,900	(175)	(1)	(305)	(2)
Fee-based TRICARE	—	2,850	2,860	(2,850)	(100)	(10)	—
Total commercial	26,915	29,865	30,580	(2,950)	(10)	(715)	(2)
Medicare Advantage	4,945	4,430	3,630	515	12	800	22
Medicaid	6,450	6,705	5,890	(255)	(4)	815	14
Medicare Supplement (Standardized)	4,545	4,445	4,265	100	2	180	4
Total public and senior	15,940	15,580	13,785	360	2	1,795	13
Total UnitedHealthcare — domestic medical	42,855	45,445	44,365	(2,590)	(6)	1,080	2
International	6,220	4,080	4,220	2,140	52	(140)	(3)
Total UnitedHealthcare — medical	49,075	49,525	48,585	(450)	(1)%	940	2%
Supplemental Data:							
Medicare Part D stand-alone	4,710	4,940	4,930	(230)	(5)%	10	—%

The overall increase in people served through risk-based benefit plans in the commercial group market was due to growth in services to small groups. Fee-based commercial group business declined primarily due to customers converting their retirees to Medicare Advantage plans, as well as certain customers expanding the number of carriers and reconfiguring geographies served. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan. Medicare Supplement growth reflected strong customer retention and new sales. International growth was primarily driven by an acquisition in the first quarter.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served across its risk-based businesses, a higher revenue membership mix, rate increases for underlying medical cost trends and the impact of the return of the Health Insurance Industry Tax. UnitedHealthcare's operating margin decreased slightly due to the performance of our traditional community-based TANF Medicaid business.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below, as well as productivity and overall cost management initiatives.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery and behavioral health, digital consumer engagement and health financial services.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in data analytics product and service offerings and managed services as well as organic and acquisition-related growth in advisory services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to growth in specialty pharmacy, home delivery services, and overall prescription growth. OptumRx fulfilled 1,343 million and 1,298 million adjusted scripts in 2018 and 2017, respectively.

2017 RESULTS OF OPERATIONS COMPARED TO 2016 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across the Optum business. The increase was partially offset by revenue decreases due to the withdrawals of the ACA-compliant products in the individual market and the effects of the Health Insurance Industry Tax moratorium.

Medical Costs and MCR

Medical costs increased due to risk-based membership growth and medical cost trends. The MCR increased due to the effects of the Health Insurance Industry Tax moratorium, offset primarily by the reduction in individual ACA business, medical management initiatives and an increase in favorable medical cost reserve development.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of Tax Reform and the Health Insurance Tax moratorium. The provision for income taxes included a $1.2 billion benefit from the revaluation of net deferred tax liabilities.

Reportable Segments

UnitedHealthcare

UnitedHealthcare’s revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends, which were partially offset by the reduction of people served in ACA-compliant individual products and the impact of the Health Insurance Industry Tax moratorium.

The increase in UnitedHealthcare's earnings from operations was led by diversified growth and increased operating margin. The 2016 results included losses in ACA-compliant individual products and guaranty fund assessments.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management services and business process services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to client and consumer growth. In 2017, OptumRx fulfilled 1.3 billion adjusted scripts compared to 1.2 billion in 2016.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In both 2018 and 2017, our U.S. regulated subsidiaries paid their parent companies dividends of $3.7 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017	Change 2017 vs. 2016
Sources of cash:					
Cash provided by operating activities	$ 15,713	$ 13,596	$ 9,795	$ 2,117	$ 3,801
Issuances of long-term debt and commercial paper, net of repayments	4,134	—	990	4,134	(990)
Proceeds from common share issuances	838	688	429	150	259
Customer funds administered	—	3,172	1,692	(3,172)	1,480
Other	—	—	37	—	(37)
Total sources of cash	20,685	17,456	12,943		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)	(3,866)	(371)
Cash dividends paid	(3,320)	(2,773)	(2,261)	(547)	(512)
Common share repurchases	(4,500)	(1,500)	(1,280)	(3,000)	(220)
Repayments of long-term debt and commercial paper, net of issuances	—	(2,615)	—	2,615	(2,615)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)	(40)	(318)
Purchases of investments, net of sales and maturities	(4,099)	(4,319)	(5,927)	220	1,608
Other	(1,743)	(539)	(581)	(1,204)	42
Total uses of cash	(21,722)	(15,900)	(13,514)		
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78	(73)	(83)
Net (decrease) increase in cash and cash equivalents	$ (1,115)	$ 1,551	$ (493)	$ (2,666)	$ 2,044

2018 Cash Flows Compared to 2017 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings in 2018 and the impact to 2017 cash flows from operating activities due to a change in net deferred tax liabilities from Tax Reform, partially offset by changes in working capital accounts.

Other significant changes in sources or uses of cash year-over-year included net issuances of debt in 2018 compared to net repayments in 2017, an increase in cash paid for acquisitions, increased share repurchases and a decrease in customer funds administered due to the timing of government payments.

2017 Cash Flows Compared to 2016 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings and changes in working capital accounts, partially offset by the change in net deferred tax liabilities driven by tax reform.

Other significant changes in sources or uses of cash year-over-year included net repayments of debt compared to 2016 net proceeds from debt issuances, which were partially offset by lower net purchases of investments.

Financial Condition

As of December 31, 2018, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $44.7 billion included $10.9 billion of cash and cash equivalents (of which $925 million was

available for general corporate use), $31.9 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of "Double A" as of December 31, 2018. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of December 31, 2018, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2018 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2018, our Board increased our annual cash dividend rate to shareholders to $3.60 per share from $3.00 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2018, under our various contractual obligations and commitments:

(in millions)	2019	2020 to 2021	2022 to 2023	Thereafter	Total
Debt (a)	$ 3,463	$ 8,970	$ 7,396	$ 37,988	$ 57,817
Operating leases	669	1,103	761	1,343	3,876
Purchase and other obligations (b)	1,216	2,205	808	175	4,404
Other liabilities (c)	1,206	260	257	5,213	6,936
Redeemable noncontrolling interests (d)	1,276	380	25	227	1,908
Total contractual obligations	$ 7,830	$ 12,918	$ 9,247	$ 44,946	$ 74,941

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2018.

(c) Includes obligations associated with contingent consideration and payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements, unrecognized tax benefits and other liabilities have been classified as "Thereafter."

(d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as "Thereafter."

Pending Acquisitions. In December 2017, we entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion, which is not reflected in the table above.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2018, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements and Supplementary Data" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of 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 professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2018, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each 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). Medical costs in 2018, 2017 and 2016 included favorable medical cost development related to prior years of $320 million, $690 million and $220 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2018:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 550
(0.50)	366
(0.25)	182
0.25	(181)
0.50	(362)
0.75	(541)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and

mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2018:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 703
2	469
1	234
(1)	(234)
(2)	(469)
(3)	(703)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2018; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2018 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2018 net earnings would have increased or decreased by approximately $140 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS’ retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.” Risk adjustment data for our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for

impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends and the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future. As of October 1, 2018, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset’s (or asset group’s) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its

estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2018.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2018, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2018, we had $14 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2018, $9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2018, $30 billion of our investments were fixed-rate debt securities and $32 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2018 and 2017 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2018			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 276	$ 189	$ (2,242)	$ (5,017)
1	138	94	(1,140)	(2,724)
(1)	(138)	(94)	1,118	3,155
(2)	(276)	(189)	2,196	6,953

	December 31, 2017			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 300	$ 170	$ (1,958)	$ (4,546)
1	150	85	(933)	(2,460)
(1)	(150)	(85)	950	2,923
(2)	(197)	(133)	1,773	6,414

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2017, the assumed hypothetical change in interest rates does not reflect the full 200 basis point reduction in interest income or interest expense in 2017, as the rate cannot fall below zero.

(b) As of December 31, 2018 and 2017, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2018, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $600 million and $1.4 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2018, we had $2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 12, 2019 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinions

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 10,866	$ 11,981
Short-term investments	3,458	3,509
Accounts receivable, net of allowances of $712 and $641	11,388	9,568
Other current receivables, net of allowances of $502 and $440	6,862	6,262
Assets under management	3,032	3,101
Prepaid expenses and other current assets	3,086	2,663
Total current assets	38,692	37,084
Long-term investments	32,510	28,341
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $4,141 and $3,694	8,458	7,013
Goodwill	58,910	54,556
Other intangible assets, net of accumulated amortization of $4,592 and $4,309	9,325	8,489
Other assets	4,326	3,575
Total assets	$ 152,221	$ 139,058
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 19,891	$ 17,871
Accounts payable and accrued liabilities	16,705	15,180
Commercial paper and current maturities of long-term debt	1,973	2,857
Unearned revenues	2,396	2,269
Other current liabilities	12,244	12,286
Total current liabilities	53,209	50,463
Long-term debt, less current maturities	34,581	28,835
Deferred income taxes	2,474	2,182
Other liabilities	5,730	5,556
Total liabilities	95,994	87,036
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,908	2,189
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Nonredeemable noncontrolling interests	2,623	2,057
Total equity	54,319	49,833
Total liabilities, redeemable noncontrolling interests and equity	$ 152,221	$ 139,058

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Premiums	$178,087	$158,453	$144,118
Products	29,601	26,366	26,658
Services	17,183	15,317	13,236
Investment and other income	1,376	1,023	828
Total revenues	226,247	201,159	184,840
Operating costs:			
Medical costs	145,403	130,036	117,038
Operating costs	34,074	29,557	28,401
Cost of products sold	26,998	24,112	24,416
Depreciation and amortization	2,428	2,245	2,055
Total operating costs	208,903	185,950	171,910
Earnings from operations	17,344	15,209	12,930
Interest expense	(1,400)	(1,186)	(1,067)
Earnings before income taxes	15,944	14,023	11,863
Provision for income taxes	(3,562)	(3,200)	(4,790)
Net earnings	12,382	10,823	7,073
Earnings attributable to noncontrolling interests	(396)	(265)	(56)
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 12.45	$ 10.95	$ 7.37
Diluted	$ 12.19	$ 10.72	$ 7.25
Basic weighted-average number of common shares outstanding	963	964	952
Dilutive effect of common share equivalents	20	21	16
Diluted weighted-average number of common shares outstanding	983	985	968
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	5	3

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Net earnings	$12,382	$10,823	$7,073
Other comprehensive (loss) income:			
Gross unrealized (losses) gains on investment securities during the period	(294)	209	(73)
Income tax effect	67	(72)	26
Total unrealized (losses) gains, net of tax	(227)	137	(47)
Gross reclassification adjustment for net realized gains included in net earnings	(62)	(83)	(166)
Income tax effect	14	30	60
Total reclassification adjustment, net of tax	(48)	(53)	(106)
Total foreign currency translation (losses) gains	(1,242)	(70)	806
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	10,865	10,837	7,726
Comprehensive income attributable to noncontrolling interests	(396)	(265)	(56)
Comprehensive income attributable to UnitedHealth Group common shareholders	$10,469	$10,572	$7,670

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2016	953	$ 10	$ 29	$37,125	$ 56	$ (3,390)	$ (105)	$33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares ($2.375 per share)				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interest fair value and other adjustments			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016	952	10	—	40,945	(97)	(2,584)	(97)	38,177
Net earnings				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares ($2.875 per share)				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interest fair value and other adjustments			113					113
Acquisition of nonredeemable noncontrolling interests							2,112	2,112
Distributions to nonredeemable noncontrolling interest							(152)	(152)
Balance at December 31, 2017	969	10	1,703	48,730	(13)	(2,654)	2,057	49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interests fair value and other adjustments			(163)					(163)
Acquisition of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interests							(228)	(228)
Balance at December 31, 2018	960	$ 10	$ —	$55,846	$ (264)	$ (3,896)	$ 2,623	$54,319

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Net earnings	$12,382	$10,823	$ 7,073
Noncash items:			
Depreciation and amortization	2,428	2,245	2,055
Deferred income taxes	42	(965)	81
Share-based compensation	638	597	485
Other, net	(71)	217	(82)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,351)	(1,062)	(1,357)
Other assets	(750)	(630)	(1,601)
Medical costs payable	1,831	1,284	1,849
Accounts payable and other liabilities	526	930	1,494
Unearned revenues	38	157	(202)
Cash flows from operating activities	15,713	13,596	9,795
Investing activities			
Purchases of investments	(14,010)	(14,588)	(17,547)
Sales of investments	3,641	4,623	7,339
Maturities of investments	6,270	5,646	4,281
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)
Other, net	(226)	(126)	37
Cash flows used for investing activities	(12,385)	(8,599)	(9,355)
Financing activities			
Common share repurchases	(4,500)	(1,500)	(1,280)
Cash dividends paid	(3,320)	(2,773)	(2,261)
Proceeds from common stock issuances	838	688	429
Repayments of long-term debt	(2,600)	(4,398)	(2,596)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Customer funds administered	(131)	3,172	1,692
Other, net	(1,386)	(413)	(581)
Cash flows used for financing activities	(4,365)	(3,441)	(1,011)
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78
(Decrease) increase in cash and cash equivalents	(1,115)	1,551	(493)
Cash and cash equivalents, beginning of period	11,981	10,430	10,923
Cash and cash equivalents, end of period	$10,866	$11,981	$10,430
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,410	$ 1,133	$ 1,055
Cash paid for income taxes	3,257	4,004	4,726
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions

premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and compounding pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2018 and 2017, accounts receivables related to products and services were $3.9 billion and $3.7 billion, respectively. In 2018 and 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2018 or 2017.

For the years ended December 31, 2018 and 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2018.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, 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 processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable

contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2018 and 2017, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $4.2 billion and $3.8 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2018.

Intangible Assets

The Company’s intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company’s indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2018.

Other Current Liabilities

Other current liabilities include health savings account deposits ($7.5 billion and $6.4 billion as of December 31, 2018 and 2017, respectively), deposits under the Medicare Part D program, the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2018 and 2017:

(in millions)	2018	2017
Redeemable noncontrolling interests, beginning of period	$2,189	$2,012
Net earnings	123	71
Acquisitions	102	565
Redemptions	(90)	(309)
Distributions	(53)	(38)
Fair value and other adjustments	(363)	(112)
Redeemable noncontrolling interests, end of period	$1,908	$2,189

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A one year moratorium on the collection of the Health Insurance Industry Tax will occur in 2019.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11 and 2018-20 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, the Company elected to not recognize lease assets and lease liabilities and expense the leases over a straight-line basis for the term of those leases. ASU 2016-02 requires new disclosures that depict the amount, timing and uncertainty of cash flows pertaining to an entity's leases. The Company adopted ASU 2016-02 on January 1, 2019, using the cumulative effect upon adoption approach. The adoption resulted in no material impact to the Company's balance sheet, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). Most notably, the new guidance requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 on a prospective basis effective January 1, 2018, as required, and reclassified $24 million from accumulated other comprehensive income to retained earnings.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518
December 31, 2017				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,673	$ 1	$ (30)	$ 2,644
State and municipal obligations	7,596	99	(35)	7,660
Corporate obligations	13,181	57	(44)	13,194
U.S. agency mortgage-backed securities	3,942	7	(38)	3,911
Non-U.S. agency mortgage-backed securities	1,018	3	(6)	1,015
Total debt securities — available-for-sale	28,410	167	(153)	28,424
Debt securities — held-to-maturity:				
U.S. government and agency obligations	254	1	(1)	254
State and municipal obligations	2	—	—	2
Corporate obligations	280	—	—	280
Total debt securities — held-to-maturity	536	1	(1)	536
Total debt securities	$ 28,946	$ 168	$ (154)	$ 28,960

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2018.

The Company held $2.0 billion of equity securities as of December 31, 2018 and December 31, 2017. The Company's investments in equity securities primarily consist of employee savings plan related investments, Brazilian real denominated fixed-income funds and dividend paying stocks, with readily determinable fair values. Additionally, the Company's investments included $1.5 billion and $0.9 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2018 and 2017, respectively.

The amortized cost and fair value of debt securities as of December 31, 2018, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,560	$ 3,551	$ 150	$150
Due after one year through five years	12,432	12,297	213	212
Due after five years through ten years	7,362	7,270	129	129
Due after ten years	2,563	2,570	129	129
U.S. agency mortgage-backed securities	4,947	4,852	—	—
Non-U.S. agency mortgage-backed securities	1,376	1,358	—	—
Total debt securities	$32,240	$31,898	$ 621	$620

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$12,355	$ (156)	$11,002	$ (287)	$23,357	$ (443)
December 31, 2017						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,249	$ (8)	$ 1,027	$ (22)	$ 2,276	$ (30)
State and municipal obligations	2,599	(21)	866	(14)	3,465	(35)
Corporate obligations	5,901	(23)	1,242	(21)	7,143	(44)
U.S. agency mortgage-backed securities	1,657	(12)	1,162	(26)	2,819	(38)
Non-U.S. agency mortgage-backed securities	411	(3)	144	(3)	555	(6)
Total debt securities — available-for-sale	$11,817	$ (67)	$ 4,441	$ (86)	$16,258	$ (153)

The Company's unrealized losses from all securities as of December 31, 2018 were generated from approximately 19,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2018, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

There was no transfers in or out of Level 3 financial assets or liabilities during the year ended December 31, 2018 or 2017.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the year ended December 31, 2018 or 2017.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company

compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds are estimated using valuation techniques that rely heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$47,641
Percentage of total assets at fair value	35%	65%	—%	100%
December 31, 2017				
Cash and cash equivalents	$ 11,718	$ 263	$ —	$11,981
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,428	216	—	2,644
State and municipal obligations	—	7,660	—	7,660
Corporate obligations	65	12,989	140	13,194
U.S. agency mortgage-backed securities	—	3,911	—	3,911
Non-U.S. agency mortgage-backed securities	—	1,015	—	1,015
Total debt securities — available-for-sale	2,493	25,791	140	28,424
Equity securities	1,784	14	194	1,992
Assets under management	1,117	1,984	—	3,101
Total assets at fair value	$ 17,112	$ 28,052	$ 334	$45,498
Percentage of total assets at fair value	38%	61%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554
December 31, 2017					
Debt securities — held-to-maturity	$ 267	$ 4	$ 265	$ 536	$ 536
Long-term debt and other financing obligations	$ —	$ 34,504	$ —	$ 34,504	$ 31,542

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2018	December 31, 2017
Land and improvements	$ 566	$ 405
Buildings and improvements	4,470	3,664
Computer equipment	1,984	1,829
Furniture and fixtures	1,525	1,208
Less accumulated depreciation	(2,787)	(2,488)
Property and equipment, net	5,758	4,618
Capitalized software	4,054	3,601
Less accumulated amortization	(1,354)	(1,206)
Capitalized software, net	2,700	2,395
Total property, equipment and capitalized software, net	$ 8,458	$ 7,013

Depreciation expense for property and equipment for the years ended December 31, 2018, 2017 and 2016 was $924 million, $799 million and $698 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2018, 2017 and 2016 was $606 million, $550 million and $475 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2017	$ 23,854	$ 6,322	$ 4,449	$12,959	$ 47,584
Acquisitions	690	5,189	1,221	—	7,100
Foreign currency effects and adjustments, net	(60)	(23)	4	(49)	(128)
Balance at December 31, 2017	24,484	11,488	5,674	12,910	54,556
Acquisitions	2,723	471	106	1,881	5,181
Foreign currency effects and adjustments, net	(807)	(12)	(8)	—	(827)
Balance at December 31, 2018	$ 26,400	$ 11,947	$ 5,772	$14,791	$ 58,910

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2018			December 31, 2017		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$11,622	$ (3,908)	$7,714	$10,832	$ (3,743)	$7,089
Trademarks and technology	1,122	(512)	610	1,054	(432)	622
Trademarks and other indefinite-lived	745	—	745	561	—	561
Other	428	(172)	256	351	(134)	217
Total	$13,917	$ (4,592)	$9,325	$12,798	$ (4,309)	$8,489

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2018		2017	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$1,355	17 years	$324	13 years
Trademarks and technology	122	4 years	367	11 years
Other	97	9 years	82	6 years
Total acquired finite-lived intangible assets	$1,574	16 years	$773	11 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2019	$889
2020	795
2021	724
2022	632
2023	593

Amortization expense relating to intangible assets for the years ended December 31, 2018, 2017 and 2016 was $898 million, $896 million and $882 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2018	2017	2016
Medical costs payable, beginning of period	$ 17,871	$ 16,391	$ 14,330
Acquisitions	339	83	—
Reported medical costs:			
Current year	145,723	130,726	117,258
Prior years	(320)	(690)	(220)
Total reported medical costs	145,403	130,036	117,038
Medical payments:			
Payments for current year	(127,155)	(113,811)	(101,696)
Payments for prior years	(16,567)	(14,828)	(13,281)
Total medical payments	(143,722)	(128,639)	(114,977)
Medical costs payable, end of period	$ 19,891	$ 17,871	$ 16,391

For the years ended December 31, 2018 and 2016, no individual factors significantly impacted medical cost reserve development. For the year ended December 31, 2017, medical cost reserve development was primarily driven by lower than expected health system utilization levels.

Medical costs payable included IBNR of $13.2 billion and $12.3 billion at December 31, 2018 and 2017, respectively. Substantially all of the IBNR balance as of December 31, 2018 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2018:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2017	2018
2017	$ 130,726	$ 130,441
2018		145,723
Total		$ 276,164

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2017	2018
2017	$ (113,811)	$ (129,778)
2018		(127,155)
Total		(256,933)
Net remaining outstanding liabilities prior to 2017		660
Total medical costs payable		$ 19,891

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2018			December 31, 2017		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ —	$ —	$ —	$ 150	$ 150	$ 150
6.000% notes due February 2018	—	—	—	1,100	1,101	1,106
1.900% notes due July 2018	—	—	—	1,500	1,499	1,501
1.700% notes due February 2019	750	750	749	750	749	747
1.625% notes due March 2019	500	500	499	500	501	497
2.300% notes due December 2019	500	494	497	500	495	501
2.700% notes due July 2020	1,500	1,498	1,494	1,500	1,496	1,517
Floating rate notes due October 2020	300	299	298	300	299	300
3.875% notes due October 2020	450	443	456	450	446	467
1.950% notes due October 2020	900	897	884	900	895	892
4.700% notes due February 2021	400	398	412	400	403	425
2.125% notes due March 2021	750	747	734	750	746	744
Floating rate notes due June 2021	350	349	347	—	—	—
3.150% notes due June 2021	400	399	400	—	—	—
3.375% notes due November 2021	500	489	503	500	493	516
2.875% notes due December 2021	750	735	748	750	741	760
2.875% notes due March 2022	1,100	1,051	1,091	1,100	1,054	1,114
3.350% notes due July 2022	1,000	997	1,005	1,000	996	1,033
2.375% notes due October 2022	900	894	872	900	893	891
0.000% notes due November 2022	15	12	13	15	12	12
2.750% notes due February 2023	625	602	611	625	606	626
2.875% notes due March 2023	750	750	739	750	762	759
3.500% notes due June 2023	750	746	756	—	—	—
3.500% notes due February 2024	750	745	755	—	—	—
3.750% notes due July 2025	2,000	1,989	2,025	2,000	1,987	2,108
3.700% notes due December 2025	300	298	303	—	—	—
3.100% notes due March 2026	1,000	995	965	1,000	995	1,007
3.450% notes due January 2027	750	746	742	750	745	776
3.375% notes due April 2027	625	619	611	625	618	642
2.950% notes due October 2027	950	938	898	950	937	947
3.850% notes due June 2028	1,150	1,142	1,163	—	—	—
3.875% notes due December 2028	850	842	861	—	—	—
4.625% notes due July 2035	1,000	992	1,060	1,000	991	1,165
5.800% notes due March 2036	850	838	1,003	850	837	1,105
6.500% notes due June 2037	500	492	638	500	491	698
6.625% notes due November 2037	650	641	841	650	641	923
6.875% notes due February 2038	1,100	1,076	1,437	1,100	1,075	1,596
5.700% notes due October 2040	300	296	355	300	296	389
5.950% notes due February 2041	350	345	426	350	345	466
4.625% notes due November 2041	600	588	627	600	588	685
4.375% notes due March 2042	502	484	503	502	483	555
3.950% notes due October 2042	625	607	596	625	607	650
4.250% notes due March 2043	750	734	744	750	734	822
4.750% notes due July 2045	2,000	1,973	2,116	2,000	1,972	2,362
4.200% notes due January 2047	750	738	745	750	738	808
4.250% notes due April 2047	725	717	719	725	717	798
3.750% notes due October 2047	950	933	869	950	933	969
4.250% notes due June 2048	1,350	1,329	1,349	—	—	—
4.450% notes due December 2048	1,100	1,087	1,132	—	—	—
Total commercial paper and long-term debt	$35,667	$35,234	$36,591	$31,417	$31,067	$34,029

The Company's long-term debt obligations also included $1.3 billion and $625 million of other financing obligations, of which $229 million and $107 million were current as of December 31, 2018 and 2017, respectively.

Maturities of long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,973
2020	3,350
2021	3,350
2022	3,215
2023	2,325
Thereafter	22,775

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2018, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2018, annual interest rates would have ranged from 3.2% to 3.6%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2018.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2018	2017	2016
Current Provision:			
Federal	$2,897	$3,597	$4,302
State and local	219	314	312
Foreign	404	254	95
Total current provision	3,520	4,165	4,709
Deferred provision (benefit)	42	(965)	81
Total provision for income taxes	$3,562	$3,200	$4,790

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2018		2017		2016	
Tax provision at the U.S. federal statutory rate	$3,348	21.0%	$4,908	35.0%	$4,152	35.0%
Change in tax law	—	—	(1,199)	(8.6)	—	—
State income taxes, net of federal benefit	168	1.0	197	1.4	205	1.7
Share-based awards — excess tax benefit	(161)	(1.0)	(319)	(2.3)	(158)	(1.3)
Non-deductible compensation	117	0.7	175	1.3	128	1.1
Health insurance industry tax	552	3.5	—	—	645	5.4
Foreign rate differential	(203)	(1.3)	(282)	(2.0)	(105)	(0.9)
Other, net	(259)	(1.6)	(280)	(2.0)	(77)	(0.6)
Provision for income taxes	$3,562	22.3%	$3,200	22.8%	$4,790	40.4%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2018	2017
Deferred income tax assets:		
Accrued expenses and allowances	$ 551	$ 544
U.S. federal and state net operating loss carryforwards	190	216
Share-based compensation	91	97
Nondeductible liabilities	184	169
Non-U.S. tax loss carryforwards	426	445
Other-domestic	306	167
Other-non-U.S.	337	198
Subtotal	2,085	1,836
Less: valuation allowances	(84)	(64)
Total deferred income tax assets	2,001	1,772
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,131)	(1,998)
Non-U.S. goodwill and intangible assets	(709)	(602)
Capitalized software	(603)	(530)
Depreciation and amortization	(266)	(236)
Prepaid expenses	(152)	(223)
Outside basis in partnerships	(300)	(279)
Other-non-U.S.	(314)	(86)
Total deferred income tax liabilities	(4,475)	(3,954)
Net deferred income tax liabilities	$(2,474)	$(2,182)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $99 million expire beginning in 2022 through 2037 and $17 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2019 through 2038. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2018, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2018	2017	2016
Gross unrecognized tax benefits, beginning of period	$ 598	$ 263	$ 224
Gross increases:			
Current year tax positions	487	356	37
Prior year tax positions	87	40	24
Gross decreases:			
Prior year tax positions	(84)	(33)	(4)
Settlements	(20)	(24)	(6)
Statute of limitations lapses	(12)	(4)	(12)
Gross unrecognized tax benefits, end of period	$1,056	$ 598	$ 263

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $118 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2018, 2017 and 2016, the Company recognized $6 million, $14 million and $11 million of interest and penalties, respectively. The Company had $95 million and $84 million of accrued interest and penalties for uncertain tax positions as of December 31, 2018 and 2017, respectively. These amounts are not included in the reconciliation above. As of December 31, 2018, there were $716 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2018 and 2017 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2012 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2013 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the United States are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For both the years ended December 31, 2018 and 2017, the Company's regulated subsidiaries paid their parent companies dividends of $3.7 billion, including $1.1 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of $23.7 billion as of December 31, 2018. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $10.3 billion as of December 31, 2018.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2018, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2018 and 2017 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2018**	**2017**
Common share repurchases, shares	19	9
Common share repurchases, average price per share	$236.72	$173.54
Common share repurchases, aggregate cost	$ 4,500	$ 1,500
Board authorized shares remaining	94	42

Dividends

In June 2018, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2018, the Company had 42 million shares available for future grants of share-based awards under the Plan. As of December 31, 2018, there were also 7 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2018 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	37	$ 102		
Granted	7	229		
Exercised	(8)	78		
Forfeited	(1)	162		
Outstanding at end of period	35	131	6.5	$ 4,114
Exercisable at end of period	16	87	5.0	2,560
Vested and expected to vest, end of period	34	129	6.5	4,072

Restricted Shares

Restricted share activity for the year ended December 31, 2018 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	$ 128
Granted	2	229
Vested	(3)	119
Nonvested at end of period	6	163

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2018	2017	2016
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 43	$ 29	$ 20
Total intrinsic value of stock options and SARs exercised	1,431	1,473	595
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	229	163	115
Total fair value of restricted shares vested	$ 521	$ 460	$274
Employee Stock Purchase Plan			
Number of shares purchased	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 638	$ 597	$485
Share-based compensation expense, net of tax effects	587	531	417
Income tax benefit realized from share-based award exercises	239	431	236

(in millions, except years)	December 31, 2018
Unrecognized compensation expense related to share awards	$ 628
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Risk-free interest rate	2.6% - 3.1%	1.9% - 2.1%	1.2% - 1.4%
Expected volatility	18.7% - 19.3%	18.5% - 20.7%	20.8% - 22.5%
Expected dividend yield	1.3% - 1.5%	1.4% - 1.6%	1.8%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.6	5.7	5.6 - 5.9

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2018, 2017 and 2016.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $988 million and $865 million as of December 31, 2018 and 2017, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2018, 2017 and 2016 was $751 million, $710 million and $608 million, respectively.

As of December 31, 2018, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2019	$ 669
2020	592
2021	511
2022	423
2023	338
Thereafter	1,343

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2018, 2017 or 2016.

As of December 31, 2018, the Company had outstanding, undrawn letters of credit with financial institutions of $83 million and surety bonds outstanding with insurance companies of $1.3 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. Those motions were argued in September 2018. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth serves the physical, emotional and health-related financial needs of individuals, enabling population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and compounding pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 30%, 28% and 25% for 2018, 2017 and 2016, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 96% and 97% of consolidated total revenues for 2018, 2017 and 2016, respectively. Long-lived fixed assets located in the United States represented approximately 76% and 77% of the total long-lived fixed assets as of December 31, 2018 and 2017, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428
2017								
Revenues — unaffiliated customers:								
Premiums	$ 154,709	$ 3,744	$ —	$ —	$ —	$ 3,744	$ —	$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues — unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues — affiliated customers	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues	$ 163,257	$ 20,570	$ 8,087	$ 63,755	$ (1,227)	$ 91,185	$ (53,283)	$ 201,159
Earnings from operations	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ —	$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ (1,186)	$ 14,023
Total assets	$ 76,676	$ 26,931	$ 11,273	$ 29,551	$ —	$ 67,755	$ (5,373)	$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245
2016								
Revenues — unaffiliated customers:								
Premiums	$ 140,455	$ 3,663	$ —	$ —	$ —	$ 3,663	$ —	$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues — unaffiliated customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues — affiliated customers	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues	$ 148,581	$ 16,908	$ 7,333	$ 60,440	$ (1,088)	$ 83,593	$ (47,334)	$ 184,840
Earnings from operations	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ —	$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ (1,067)	$ 11,863
Total assets	$ 70,505	$ 18,656	$ 9,017	$ 29,066	$ —	$ 56,739	$ (4,434)	$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2018 and 2017 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	**March 31**	**June 30**	**September 30**	**December 31**
2018				
Revenues	$ 55,188	$ 56,086	$ 56,556	$ 58,417
Operating costs	51,135	51,882	51,966	53,920
Earnings from operations	4,053	4,204	4,590	4,497
Net earnings	2,924	3,010	3,284	3,164
Net earnings attributable to UnitedHealth Group common shareholders	2,836	2,922	3,188	3,040
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.94	3.04	3.31	3.16
Diluted	2.87	2.98	3.24	3.10
2017				
Revenues	$ 48,723	$ 50,053	$ 50,322	$ 52,061
Operating costs	45,310	46,322	46,234	48,084
Earnings from operations	3,413	3,731	4,088	3,977
Net earnings	2,191	2,350	2,561	3,721
Net earnings attributable to UnitedHealth Group common shareholders	2,172	2,284	2,485	3,617
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.28	2.37	2.57	3.73
Diluted	2.23	2.32	2.51	3.65

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2018. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2018.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2018

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2018, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2018, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 12, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2018. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 12, 2019, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Executive Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D
President and Dean
Morehouse School of Medicine

Glenn M. Renwick
Chair
Fiserv, Inc.

David S. Wichmann
Chief Executive Officer
UnitedHealth Group

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and

"Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2018, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	33	$ 135	49[3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	33	$ 135	49

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 1,676,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $59 and an average remaining term of approximately 5 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 7 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2018, and 42 million shares available under the 2011 Stock Incentive Plan as of December 31, 2018. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements and Supplementary Data*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2018 and 2017.
- Consolidated Statements of Operations for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017, and 2016.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)

4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Seventh Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.24 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016)
*10.25	Eighth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 4.9 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-224254, filed on April 12, 2018)
*10.26	Summary of Non-Management Director Compensation, effective as of October 1, 2018

*10.27	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.28	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.29	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.30	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.31	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.32	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.33	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.34	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.35	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.36	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.37	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.38	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.39	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.40	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

*10.41	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.42	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.43	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.44	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.45	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.46	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.47	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.48	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.49	Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson (incorporated by reference to Exhibit 10.51 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017)
*10.50	Employment Agreement, effective as of June 3, 2018, between United HealthCare Services, Inc. and Andrew Witty
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018, filed on February 12, 2019, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, and for each of the three years in the period ended December 31, 2018, and the Company's internal control over financial reporting as of December 31, 2018, and have issued our reports thereon dated February 12, 2019; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 434	$ 359
Other current assets	197	575
Total current assets	631	934
Equity in net assets of subsidiaries	83,244	76,231
Long-term notes receivable from subsidiaries	4,461	4,278
Other assets	972	839
Total assets	$ 89,308	$ 82,282
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 618	$ 502
Current portion of notes payable to subsidiaries	714	466
Commercial paper and current maturities of long-term debt	1,744	2,749
Total current liabilities	3,076	3,717
Long-term debt, less current maturities	33,490	28,318
Long-term notes payable to subsidiaries	560	1,518
Other liabilities	486	953
Total liabilities	37,612	34,506
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Total UnitedHealth Group shareholders' equity	51,696	47,776
Total liabilities and shareholders' equity	$ 89,308	$ 82,282

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Investment and other income	$ 194	$ 527	$ 522
Total revenues	194	527	522
Operating costs:			
Operating costs	35	—	(22)
Interest expense	1,285	1,114	995
Total operating costs	1,320	1,114	973
Loss before income taxes	(1,126)	(587)	(451)
Benefit for income taxes	251	214	165
Loss of parent company	(875)	(373)	(286)
Equity in undistributed income of subsidiaries	12,861	10,931	7,303
Net earnings	11,986	10,558	7,017
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	$10,469	$10,572	$7,670

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Cash flows from operating activities	$ 6,099	$ 2,021	$ 4,294
Investing activities			
Issuances of notes to subsidiaries	(1,420)	—	(824)
Repayments of notes to subsidiaries	1,419	2,071	—
Cash paid for acquisitions	(4,066)	(2,313)	(2,292)
Return of capital to parent company	4,196	3,375	2,143
Capital contributions to subsidiaries	(1,259)	(959)	(765)
Other, net	4	—	168
Cash flows (used for) from investing activities	(1,126)	2,174	(1,570)
Financing activities			
Common stock repurchases	(4,500)	(1,500)	(1,280)
Proceeds from common stock issuances	838	688	429
Cash dividends paid	(3,320)	(2,773)	(2,261)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Repayments of long-term debt	(2,600)	(3,472)	(2,596)
(Repayments) proceeds of notes from subsidiary	(1,127)	1,704	(30)
Other, net	(923)	(446)	(421)
Cash flows used for financing activities	(4,898)	(4,016)	(2,573)
Increase in cash and cash equivalents	75	179	151
Cash and cash equivalents, beginning of period	359	180	29
Cash and cash equivalents, end of period	$ 434	$ 359	$ 180
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,294	$ 1,062	$ 974
Cash paid for income taxes	2,379	3,455	4,557
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —
Conversion of note receivable from subsidiaries to equity	—	4,378	—

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.6 billion, $3.4 billion and $3.7 billion in 2018, 2017 and 2016, respectively. Additionally, $4.2 billion, $3.4 billion and $2.1 billion in cash were received as a return of capital to the parent company during 2018, 2017 and 2016, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $1.3 billion and $625 million at December 31, 2018 and 2017, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,750
2020	3,150
2021	3,150
2022	3,015
2023	2,125
Thereafter	22,477

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 12, 2019

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN

David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN **David S. Wichmann**	Director and Chief Executive Officer (principal executive officer)	February 12, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 12, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 12, 2019
* **William C. Ballard, Jr.**	Director	February 12, 2019
* **Richard T. Burke**	Director	February 12, 2019
* **Timothy P. Flynn**	Director	February 12, 2019
* **Stephen J. Hemsley**	Director	February 12, 2019
* **Michele J. Hooper**	Director	February 12, 2019
* **F. William McNabb III**	Director	February 12, 2019
* **Valerie Montgomery Rice**	Director	February 12, 2019
* **Glenn M. Renwick**	Director	February 12, 2019
* **Gail R. Wilensky**	Director	February 12, 2019

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

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

Form 10-K

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

For the fiscal year ended December 31, 2017

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒ Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2017 was $177,882,211,144 (based on the last reported sale price of $185.42 per share on June 30, 2017, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2018, there were 967,662,919 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2018 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and other individuals. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2017, we processed nearly three-quarters of a trillion dollars in gross billed charges and we managed nearly $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local market relationships;

- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.2 million physicians and other health care professionals and approximately 6,500 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individuals. UnitedHealthcare Employer & Individual provides access to medical services for over 27 million people on behalf of our customers and alliance partners. This includes more than 230,000 employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace,

UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs and consumer education. During 2017, more than 50,000 employer-sponsored benefit plans, including nearly 400 employers in the large group self-funded market, purchased HRA or HSA health benefit products from us.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individuals) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, critical illness and disability product offerings through an integrated approach, using its network of more than 22,000 vision offices and more than 85,000 dental offices, in private and retail settings.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans was the provider of health care services for nearly 3 million active duty and retired military service members and their families under the Department of Defense's (DoD) TRICARE Managed Care Support contract that concluded on January 1, 2018.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. Beneficiaries with special needs are served through UnitedHealthcare Medicare & Retirement Dual, Chronic and Institutional Special Needs Plans (SNPs) in many markets. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and SNPs. Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.4 million people through its Medicare Advantage products as of December 31, 2017.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live

healthier lives. Through UnitedHealth Group's HouseCalls program, nurse practitioners performed nearly 1.3 million in-home preventive care visits in 2017 to address unmet care opportunities and close gaps in care. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and allow care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2017, UnitedHealthcare enrolled 8.9 million people in the Medicare Part D programs, including 4.9 million individuals in the stand-alone Medicare Part D plans with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 28% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2017, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2017, UnitedHealthcare Community & State participated in programs in 28 states and the District of Columbia, and served 6.7 million beneficiaries; including more than 1.1 million people through Medicaid expansion programs in 16 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and its participation are:

- Temporary Assistance to Needy Families, primarily women and children – 26 markets;
- CHIP – 25 markets;
- Aged, Blind and Disabled – 22 markets;

- SNP – 20 markets;
- Medicaid Expansion – 16 markets;
- Long-Term Services and Supports – 14 markets;
- MMP – 2 markets; and
- other programs (e.g., administrative services, childless adults, developmentally disabled) – 9 markets.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can impact people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 40% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model allows UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% of members who are most at risk and drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves more than 4 million people with medical benefits and 2 million with dental benefits, residing principally in Brazil, but also in more than 130 other countries. UnitedHealthcare Global owns and operates nearly 150 hospitals, specialty centers, primary care and emergency services clinics in Brazil and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individuals around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2 million people. Amil's members have

access to both an owned care delivery system, as well as a contracted provider network of nearly 21,000 physicians and other health care professionals, approximately 1,800 hospitals and nearly 7,000 laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and the external payer market.

Lusíadas Saúde provides clinical services in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers, including:

- Global Insurance, which offers expatriate insurance solution for globally mobile employees and their families;
- Assistance and Risk provides a global medical network and evacuation services;
- Global Medical provides remote medical services, telemedicine, supplies and equipment, and end-to-end remote medical services; and
- U.S. Networks assists foreign insurers and employers navigating the U.S. health care system.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 91 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 30,000 employed, managed and contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that put patient health and outcomes first, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' over 240 neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' 200 independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a lower cost than a traditional in-patient hospital setting.

OptumHealth's mobile care delivery business delivers occupational health and medical services to government customers, with a particular focus on the U.S. military.

OptumHealth serves people through population health management services that meet both the preventive care and health intervention needs of consumers across the care continuum—physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 4.8 million health savings and other accounts with over $8 billion in assets under management as of December 31, 2017. During 2017, Optum Bank processed nearly $150 billion in medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, electronic payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on data and analytics, technology and information that help improve the quality of care and drive greater efficiency in the health care system. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under

these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2017, was $15.0 billion, of which $8.3 billion is expected to be realized within the next 12 months. This includes $5.4 billion related to intersegment agreements, all of which are in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2016, was $12.6 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers meet these challenges, with particular focus on clinical performance and quality improvement, population health management, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves approximately 300 health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to more than 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery and specialty pharmacies and through the provision of home infusion services. OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individuals through enhanced services, elevated clinical quality and cost trend management.

In 2017, OptumRx managed approximately $85 billion in pharmaceutical spending, including $35 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

As of December 31, 2017, OptumRx operated four home delivery pharmacies in the United States, which provides patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2017, OptumRx's specialty pharmacy operations included 16 specialty mail order pharmacies located throughout the United States that are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that negatively impact member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

GOVERNMENT REGULATION

Most of our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

The Tax Cuts and Jobs Act. On December 22, 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and includes numerous provisions that will affect our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a third party, and generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. Reports are filed annually with Connecticut, our lead regulator, and with New York, as required by that state’s regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are

contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distributions laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and PBM Regulations

OptumRx’s businesses include home delivery and specialty pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery and specialty pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to

dispense controlled substances. In addition to the laws and regulations in the states where our home delivery and specialty pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery and specialty pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. As certain of our home delivery and specialty pharmacies maintain eligibility as Medicare and state Medicaid providers, their participation in the programs requires them to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our pharmacy care services businesses.

Legislation seeking to regulate PBM activities introduced or enacted in a number of states could impact our business practices. Additionally, organizations like the National Association of Insurance Commissioners periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM, mail or specialty pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients. There is both federal and state legislation affecting the ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the Federal Trade Commission‘s (FTC) Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission (“FCC”) and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank’s compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination

results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs, PBMs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, population health management companies and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, Humana Inc., Kaiser Permanente, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and, with respect to our Brazilian operations, several established competitors in Brazil and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Health Corporation, Express Scripts, Inc. and Prime Therapeutics LLC. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including by maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2017, we employed 260,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 13, 2018, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	65	Executive Chair of the Board
David S. Wichmann	55	Chief Executive Officer
Steven H. Nelson	58	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Larry C. Renfro	64	Vice Chairman; Chief Executive Officer of Optum
John F. Rex	55	Executive Vice President; Chief Financial Officer
Thomas E. Roos	45	Senior Vice President; Chief Accounting Officer
Marianne D. Short	66	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	60	Executive Vice President, Human Capital

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June 2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Renfro is Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum. Mr. Renfro has served as Vice Chairman of UnitedHealth Group since November 2014 and Chief Executive Officer of Optum since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President, Human Capital of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn

out to be wrong. Our forward-looking statements 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. In this regard, federal and state regulatory requirements obligate our commercial, Medicare Advantage and certain state-based Medicaid health plans to maintain minimum MLRs, which could make it more difficult for us to obtain price increases for our products. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2017 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2017 would have been reduced by approximately $235 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other

health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Some states have similar laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being debated, and we cannot predict if the ACA will be further modified or repealed or replaced. Additionally, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based

outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Brazil business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government

benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the local plan level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third-parties. Some of

the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place to detect, contain and respond to data security incidents and provide employee awareness training around phishing, malware and other cyber risks to protect, to the greatest extent possible, against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, in May 2018, the European Union's General Data Protection Regulation will overhaul data protection laws in the European Union. The new regulation will supersede current European Union data protection legislation, may impose more stringent European Union data protection requirements on us or our customers, and may prescribe greater penalties for noncompliance.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty pharmacies and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery or specialty pharmacies or the provision of home infusion services, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply to our pharmacy care services businesses in connection with services for which our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. In addition, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage, and we may face challenges from new technologies and market entrants that could disrupt our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations; practice management companies (which aggregate physician practices for administrative efficiency) and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the

adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Brazil, depend on maintaining satisfactory physician relationships as employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various litigation actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States, where contractual rights, tax

positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete intensely. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2017. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2017, goodwill and other intangible assets had a carrying value of $63 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems

successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There

can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions “Legal Matters” and “Governmental Investigations, Audits and Reviews” in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2018, there were 12,418 registered holders of record of our common stock. The high and low per share common stock sales prices reported by the NYSE and cash dividends declared for our last two fiscal years were as follows:

	High	Low	Cash Dividends Declared
2017			
First quarter	$172.14	$156.09	$0.625
Second quarter	$188.66	$164.25	$0.750
Third quarter	$200.76	$183.86	$0.750
Fourth quarter	$231.77	$186.00	$0.750
2016			
First quarter	$131.10	$107.51	$0.500
Second quarter	$141.31	$125.26	$0.625
Third quarter	$144.48	$132.39	$0.625
Fourth quarter	$164.00	$133.03	$0.625

DIVIDEND POLICY

In June 2017, our Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual dividend rate of $3.00 per share compared to the annual dividend rate of $2.50 per share, which the Company had paid since June 2016. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter 2017, we repurchased 1.6 million shares at an average price of $210.97 per share. As of December 31, 2017, we had Board authorization to purchase up to 42 million shares of our common stock.

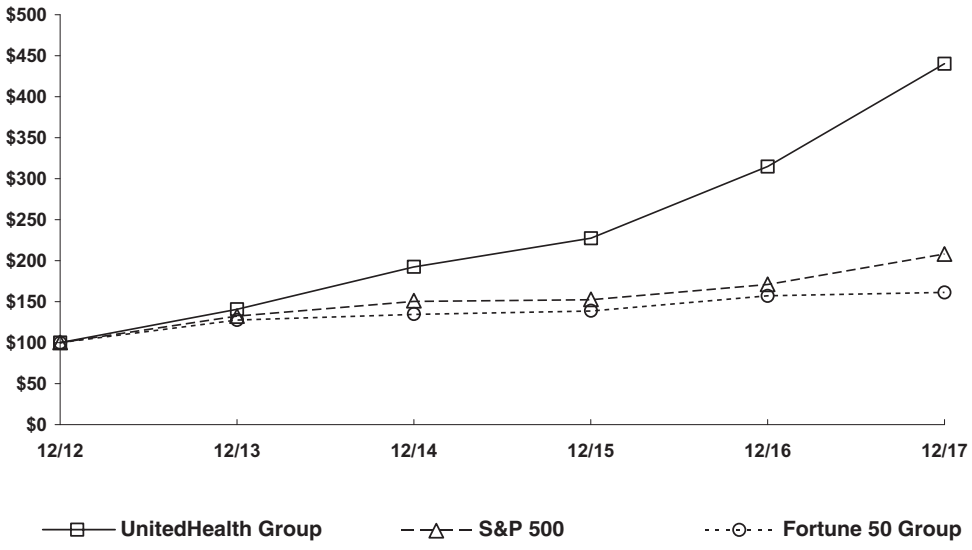
PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain Fortune 50 companies (the "*Fortune 50 Group*") for the five-year period ended December 31, 2017. We are not included in the *Fortune 50* Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2012 in our common stock and in each index, and that dividends were reinvested when paid.

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/12	12/13	12/14	12/15	12/16	12/17
UnitedHealth Group	**$100.00**	**$141.03**	**$192.45**	**$227.59**	**$314.99**	**$440.44**
S&P 500 Index	**100.00**	**132.39**	**150.51**	**152.59**	**170.84**	**208.14**
Fortune 50 Group	**100.00**	**127.82**	**134.63**	**139.01**	**157.63**	**161.63**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Year Ended December 31, 2017 (a)	2016	2015 (b)	2014	2013
Consolidated operating results					
Revenues	$201,159	$184,840	$157,107	$130,474	$122,489
Earnings from operations	15,209	12,930	11,021	10,274	9,623
Net earnings attributable to UnitedHealth Group common shareholders	10,558	7,017	5,813	5,619	5,625
Return on equity (c)	24.4%	19.4%	17.7%	17.3%	17.7%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 10.95	$ 7.37	$ 6.10	$ 5.78	$ 5.59
Diluted earnings per share attributable to UnitedHealth Group common shareholders	10.72	7.25	6.01	5.70	5.50
Cash dividends declared per common share	2.8750	2.3750	1.8750	1.4050	1.0525
Consolidated cash flows from (used for)					
Operating activities	$ 13,596	$ 9,795	$ 9,740	$ 8,051	$ 6,991
Investing activities	(8,599)	(9,355)	(18,395)	(2,534)	(3,089)
Financing activities	(3,441)	(1,011)	12,239	(5,293)	(4,946)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 43,831	$ 37,143	$ 31,703	$ 28,063	$ 28,818
Total assets	139,058	122,810	111,254	86,300	81,800
Total commercial paper and long-term debt	31,692	32,970	31,965	17,324	16,778
Redeemable noncontrolling interests	2,189	2,012	1,736	1,388	1,175
Total equity	49,833	38,177	33,725	32,454	32,149

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data; information and intelligence; and clinical care delivery, management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2016 Federal Budget imposed a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2018 reflected the impact of the returning Health Insurance Industry Tax. Conversely, the industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect continued Medicaid revenue growth due to anticipated increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin

percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2017, we served nearly 16 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2017, our contracts with value-based elements total nearly $65 billion in annual spending.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business — Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2018 Medicare Advantage rates resulted in an increase in industry base rates of approximately 0.45%, well short of the industry forward medical cost trend of 3%, as well as the return of the Health Insurance Industry Tax in 2018, described below, which creates continued pressure in the Medicare Advantage program. The impact of this funding shortfall in Medicare Advantage is partially mitigated by reductions in provider payments for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service payment rates. These factors can affect our plan benefit designs, pricing, growth prospects and earnings expectations for our Medicare Advantage plans.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, and adjust members' benefits, implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, Star ratings affect the amount of savings a plan can use to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. For the 2017 payment year, approximately 80% of our Medicare Advantage members were in plans rated four stars or higher. We expect that at least 85% of our Medicare Advantage members will be in plans rated four stars or higher for payment year 2018. We continue to dedicate substantial resources to advance our quality scores and Star ratings to strengthen our local market programs and further improve our performance.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law including reducing the U.S. corporate income tax rate. The Company re-measured deferred taxes as of the date of enactment, which resulted in a $1.2 billion reduction to the net deferred tax liability and corresponding increase to earnings in 2017. With Tax Reform, we expect that our effective tax rate in 2018 will be approximately 24%.

Health Insurance Industry Tax. A provision in the 2016 Federal Budget imposed a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax. In 2018, the industry-wide amount of the Health Insurance Industry Tax will be $14.3 billion and we expect our portion to be approximately $2.8 billion. A one year moratorium on the collection of the Health Insurance Industry Tax will occur in 2019.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2017	2016	2015	Change 2017 vs. 2016		Change 2016 vs. 2015	
Revenues:							
Premiums	$158,453	$144,118	$127,163	$14,335	10%	$16,955	13%
Products	26,366	26,658	17,312	(292)	(1)	9,346	54
Services	15,317	13,236	11,922	2,081	16	1,314	11
Investment and other income	1,023	828	710	195	24	118	17
Total revenues	201,159	184,840	157,107	16,319	9	27,733	18
Operating costs:							
Medical costs	130,036	117,038	103,875	12,998	11	13,163	13
Operating costs	29,557	28,401	24,312	1,156	4	4,089	17
Cost of products sold	24,112	24,416	16,206	(304)	(1)	8,210	51
Depreciation and amortization	2,245	2,055	1,693	190	9	362	21
Total operating costs	185,950	171,910	146,086	14,040	8	25,824	18
Earnings from operations	15,209	12,930	11,021	2,279	18	1,909	17
Interest expense	(1,186)	(1,067)	(790)	(119)	11	(277)	35
Earnings before income taxes	14,023	11,863	10,231	2,160	18	1,632	16
Provision for income taxes	(3,200)	(4,790)	(4,363)	1,590	(33)	(427)	10
Net earnings	10,823	7,073	5,868	3,750	53	1,205	21
Earnings attributable to noncontrolling interests	(265)	(56)	(55)	(209)	373	(1)	2
Net earnings attributable to UnitedHealth Group common shareholders	$ 10,558	$ 7,017	$ 5,813	$ 3,541	50%	$ 1,204	21%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 10.72	$ 7.25	$ 6.01	$ 3.47	48%	$ 1.24	21%
Medical care ratio (a)	82.1%	81.2%	81.7%	0.9%		(0.5)%	
Operating cost ratio	14.7	15.4	15.5	(0.7)		(0.1)	
Operating margin	7.6	7.0	7.0	0.6		—	
Tax rate	22.8	40.4	42.6	(17.6)		(2.2)	
Net earnings margin (b)	5.2	3.8	3.7	1.4		0.1	
Return on equity (c)	24.4%	19.4%	17.7%	5.0%		1.7%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.
(b) Net earnings margin attributable to UnitedHealth Group shareholders.
(c) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2017 year-over-year operating comparisons to 2016 and other 2017 significant items.

- Consolidated revenues increased by 9%, UnitedHealthcare revenues increased 10% and Optum revenues grew 9%.

- UnitedHealthcare grew to serve an additional 1.1 million people domestically.
- Earnings from operations increased by 18%, including increases of 16% at UnitedHealthcare and 19% at Optum.
- Diluted earnings per common share increased 48% to $10.72, including $1.22 per share due to the impact of Tax Reform.
- Cash flows from operations were $13.6 billion, an increase of 39%.

2017 RESULTS OF OPERATIONS COMPARED TO 2016 RESULTS.

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across the Optum business. The increase was partially offset by revenue decreases due to the withdrawals of the ACA-compliant products in the individual market and the effects of the Health Insurance Industry Tax moratorium.

Medical Costs and MCR

Medical costs increased due to risk-based membership growth and medical cost trends. The MCR increased due to the effects of the Health Insurance Industry Tax moratorium, offset primarily by the reduction in individual ACA business, medical management initiatives and an increase in favorable medical cost reserve development.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of Tax Reform and the Health Insurance Tax moratorium. The provision for income taxes included the $1.2 billion benefit from the revaluation of net deferred tax liabilities.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2017	2016	2015	Change 2017 vs. 2016		Change 2016 vs. 2015	
Revenues							
UnitedHealthcare	$163,257	$148,581	$131,343	$14,676	10%	$17,238	13%
OptumHealth	20,570	16,908	13,927	3,662	22	2,981	21
OptumInsight	8,087	7,333	6,196	754	10	1,137	18
OptumRx	63,755	60,440	48,272	3,315	5	12,168	25
Optum eliminations	(1,227)	(1,088)	(791)	(139)	13	(297)	38
Optum	91,185	83,593	67,604	7,592	9	15,989	24
Eliminations	(53,283)	(47,334)	(41,840)	(5,949)	13	(5,494)	13
Consolidated revenues	$201,159	$184,840	$157,107	$16,319	9%	$27,733	18%
Earnings from operations							
UnitedHealthcare	$ 8,498	$ 7,307	$ 6,754	$ 1,191	16%	$ 553	8%
OptumHealth	1,823	1,428	1,240	395	28	188	15
OptumInsight	1,770	1,513	1,278	257	17	235	18
OptumRx	3,118	2,682	1,749	436	16	933	53
Optum	6,711	5,623	4,267	1,088	19	1,356	32
Consolidated earnings from operations	$ 15,209	$ 12,930	$ 11,021	$ 2,279	18%	$ 1,909	17%
Operating margin							
UnitedHealthcare	5.2%	4.9%	5.1%	0.3%		(0.2)%	
OptumHealth	8.9	8.4	8.9	0.5		(0.5)	
OptumInsight	21.9	20.6	20.6	1.3		—	
OptumRx	4.9	4.4	3.6	0.5		0.8	
Optum	7.4	6.7	6.3	0.7		0.4	
Consolidated operating margin	7.6%	7.0%	7.0%	0.6%		—%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2017	2016	2015	Change 2017 vs. 2016		Change 2016 vs. 2015	
UnitedHealthcare Employer & Individual	$ 52,066	$ 53,084	$ 47,194	$ (1,018)	(2)%	$ 5,890	12%
UnitedHealthcare Medicare & Retirement	65,995	56,329	49,735	9,666	17	6,594	13
UnitedHealthcare Community & State	37,443	32,945	28,911	4,498	14	4,034	14
UnitedHealthcare Global	7,753	6,223	5,503	1,530	25	720	13
Total UnitedHealthcare revenues	$163,257	$148,581	$131,343	$14,676	10%	$17,238	13%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2017	2016	2015	Change 2017 vs. 2016		Change 2016 vs. 2015	
Commercial risk-based — group	7,935	7,470	7,095	465	6%	375	5%
Commercial risk-based — individual	485	1,350	1,190	(865)	(64)	160	13
Commercial fee-based	18,595	18,900	18,565	(305)	(2)	335	2
Fee-based TRICARE	2,850	2,860	2,880	(10)	—	(20)	(1)
Total commercial	29,865	30,580	29,730	(715)	(2)	850	3
Medicare Advantage	4,430	3,630	3,235	800	22	395	12
Medicaid	6,705	5,890	5,305	815	14	585	11
Medicare Supplement (Standardized)	4,445	4,265	4,035	180	4	230	6
Total public and senior	15,580	13,785	12,575	1,795	13	1,210	10
Total UnitedHealthcare — domestic medical	45,445	44,365	42,305	1,080	2	2,060	5
International	4,080	4,220	4,090	(140)	(3)	130	3
Total UnitedHealthcare — medical	49,525	48,585	46,395	940	2%	2,190	5%
Supplemental Data:							
Medicare Part D stand-alone	4,940	4,930	5,060	10	—%	(130)	(3)%

In the commercial group market, broad-based growth was across group sizes and regions, led by gains in services to small groups and resulted in the overall increase in people served through risk-based benefit plans. Fee-based commercial group business declined due to the non-renewal of one public sector customer. Membership in individual business decreased due to our reduced participation in ACA-compliant products in 2017. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. Medicaid growth was driven by the combination of new state-based awards and growth in established programs. Medicare Supplement growth reflected strong customer retention and new sales.

UnitedHealthcare's revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends, which were partially offset by the reduction of people served in ACA-compliant individual products and the impact of the Health Insurance Industry Tax moratorium.

The increase in UnitedHealthcare's earnings from operations was led by diversified growth and increased operating margin. The 2016 results included losses in ACA-complaint individual products and guaranty fund assessments.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management services and business process services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to client and consumer growth. In 2017, OptumRx fulfilled 1.3 billion adjusted scripts compared to 1.2 billion in 2016.

2016 RESULTS OF OPERATIONS COMPARED TO 2015 RESULTS

Our results of operations were affected by our acquisition of Catamaran in the third quarter of 2015.

Consolidated Financial Results

Revenues

The increases in revenues were primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across all of our Optum services businesses.

Medical Costs

Medical costs increased due to risk-based membership growth and medical cost trends, partially offset by medical management initiatives.

Income Tax Rate

Our effective tax rate decreased primarily due to the adoption of "Compensation-Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting," which we adopted in the first quarter of 2016.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends.

UnitedHealthcare's operating earnings increased due to diversified growth, offset by guaranty fund assessments recorded in the fourth quarter of 2016.

Optum

Total revenues and operating earnings increased as each reporting segment increased revenues and earnings from operations by double-digit percentages as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to growth in its health care delivery businesses as well as expansion of behavioral services into new Medicaid markets. Strong performance in business supporting UnitedHealthcare partially offset by investments in the health care delivery business drove the increase in earnings from operations.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management, business process outsourcing and technology services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to the full-year impact of Catamaran and organic growth. In 2016, OptumRx fulfilled 1.2 billion adjusted scripts compared to 932 million in 2015.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In 2017, our U.S. regulated subsidiaries paid their parent companies dividends of $3.7 billion. For the year ended December 31, 2016, our U.S. regulated subsidiaries paid their parent companies dividends of $3.9 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2017	2016	2015	Change 2017 vs. 2016	Change 2016 vs. 2015
Sources of cash:					
Cash provided by operating activities	$ 13,596	$ 9,795	$ 9,740	$ 3,801	$ 55
Issuances of long-term debt and commercial paper, net of repayments	—	990	14,607	(990)	(13,617)
Proceeds from common share issuances	688	429	402	259	27
Customer funds administered	3,172	1,692	768	1,480	924
Other	—	37	—	(37)	37
Total sources of cash	17,456	12,943	25,517		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed	(2,131)	(1,760)	(16,164)	(371)	14,404
Cash dividends paid	(2,773)	(2,261)	(1,786)	(512)	(475)
Common share repurchases	(1,500)	(1,280)	(1,200)	(220)	(80)
Repayments of long-term debt and commercial paper, net of issuances	(2,615)	—	—	(2,615)	—
Purchases of property, equipment and capitalized software	(2,023)	(1,705)	(1,556)	(318)	(149)
Purchases of investments, net of sales and maturities	(4,319)	(5,927)	(531)	1,608	(5,396)
Other	(539)	(581)	(696)	42	115
Total uses of cash	(15,900)	(13,514)	(21,933)		
Effect of exchange rate changes on cash and cash equivalents	(5)	78	(156)	(83)	234
Net increase (decrease) in cash and cash equivalents	$ 1,551	$ (493)	$ 3,428	$ 2,044	$ (3,921)

2017 Cash Flows Compared to 2016 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings and changes in working capital accounts, partially offset by the change in net deferred tax liabilities driven by tax reform.

Other significant changes in sources or uses of cash year-over-year included net repayments of debt compared to 2016 net proceeds from debt issuances, which were partially offset by lower net purchases of investments.

2016 Cash Flows Compared to 2015 Cash Flows

Cash flows provided by operating activities increased slightly as higher net earnings were mostly offset by increased CMS receivables and other operating items.

Other significant changes in sources or uses of cash year-over-year included increased net purchases of investments in 2016 and the decreases in cash paid for acquisitions and proceeds from debt issuances due to the 2015 acquisition of Catamaran.

Financial Condition

As of December 31, 2017, our cash, cash equivalent and available-for-sale investment balances of $42.4 billion included $12.0 billion of cash and cash equivalents (of which approximately $800 million was available for

general corporate use), $28.4 billion of debt securities and $2.0 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.2 years and a weighted-average credit rating of "Double A" as of December 31, 2017. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 55%. As of December 31, 2017, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was approximately 37%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements."

Credit Ratings. Our credit ratings as of December 31, 2017 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Negative [(a)]	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

(a) In January 2018, S&P Global affirmed our ratings and changed our outlook to Stable.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2017, we had Board authorization to purchase up to 42 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2017, our Board increased our quarterly cash dividend to shareholders by 20% to an annual dividend rate of $3.00 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2017, under our various contractual obligations and commitments:

(in millions)	2018	2019 to 2020	2021 to 2022	Thereafter	Total
Debt (a)	$ 4,006	$ 7,017	$ 7,241	$ 30,609	$ 48,873
Operating leases	538	884	851	809	3,082
Purchase and other obligations (b)	833	866	462	293	2,454
Other liabilities (c)	823	284	284	5,589	6,980
Redeemable noncontrolling interests (d)	1,575	358	25	231	2,189
Total contractual obligations	$ 7,775	$ 9,409	$ 8,863	$ 37,531	$ 63,578

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2017.

(c) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements and other liabilities have been classified as "Thereafter."

(d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as "Thereafter."

Pending Acquisitions. In December 2017, we entered into agreements to acquire two companies in the health care sector for a total of approximately $7.7 billion, which are not reflected in the table above. One of the acquisitions closed in January 2018; the other is expected to close later in 2018, subject to regulatory approval and other customary closing conditions.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2017, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of 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 professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2017, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each 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). Medical costs in 2017, 2016 and 2015 included favorable medical cost development related to prior years of $690 million, $220 million and $320 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2017:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 486
(0.50)	323
(0.25)	161
0.25	(160)
0.50	(320)
0.75	(478)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as

gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2017:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 623
2	415
1	208
(1)	(208)
(2)	(415)
(3)	(623)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2017; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2017 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2017 net earnings would have increased or decreased by $110 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS’ retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.” Risk adjustment data for our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends above and the discussion in the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future. We completed our annual impairment tests for goodwill as of October 1, 2017. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset’s (or asset group’s) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2017.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2017, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real.

As of December 31, 2017, we had $15 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2017, $8.5 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts. The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2017, $25.9 billion of our investments were fixed-rate debt securities and $28.7 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2017 and 2016 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2017			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 300	$ 170	$ (1,958)	$ (4,546)
1	150	85	(933)	(2,460)
(1)	(150)	(85)	950	2,923
(2)	(197)	(133)	1,773	6,414

	December 31, 2016			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 263	$ 245	$ (1,711)	$ (3,470)
1	132	122	(873)	(1,860)
(1)	(105)	(95)	855	2,244
(2)	nm	nm	1,562	4,784

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2017 and 2016, the assumed hypothetical change in interest rates does not reflect the full 100 and 200 basis point reduction, respectively, in interest income or interest expense, in 2017 and 2016, respectively, as the rate cannot fall below zero.

(b) As of December 31, 2017 and 2016, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of UnitedHealthcare Brazil's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Brazil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2017, a hypothetical 10% and 25% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $500 million and $1.1 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2017, we had $2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2017 and 2016, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 13, 2018, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinions

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 13, 2018

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2017	December 31, 2016
Assets		
Current assets:		
Cash and cash equivalents	$ 11,981	$ 10,430
Short-term investments	3,509	2,845
Accounts receivable, net of allowances of $641 and $514	9,568	8,152
Other current receivables, net of allowances of $440 and $409	6,262	7,499
Assets under management	3,101	3,105
Prepaid expenses and other current assets	2,663	1,848
Total current assets	37,084	33,879
Long-term investments	28,341	23,868
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $3,694 and $3,749	7,013	5,901
Goodwill	54,556	47,584
Other intangible assets, net of accumulated amortization of $4,309 and $3,847	8,489	8,541
Other assets	3,575	3,037
Total assets	$139,058	$122,810
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 17,871	$ 16,391
Accounts payable and accrued liabilities	15,180	13,361
Commercial paper and current maturities of long-term debt	2,857	7,193
Unearned revenues	2,269	1,968
Other current liabilities	12,286	10,339
Total current liabilities	50,463	49,252
Long-term debt, less current maturities	28,835	25,777
Deferred income taxes	2,182	2,761
Other liabilities	5,556	4,831
Total liabilities	87,036	82,621
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	2,189	2,012
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 969 and 952 issued and outstanding	10	10
Additional paid-in capital	1,703	—
Retained earnings	48,730	40,945
Accumulated other comprehensive loss	(2,667)	(2,681)
Nonredeemable noncontrolling interests	2,057	(97)
Total equity	49,833	38,177
Total liabilities, redeemable noncontrolling interests and equity	$139,058	$122,810

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2017	2016	2015
Revenues:			
Premiums	$158,453	$144,118	$127,163
Products	26,366	26,658	17,312
Services	15,317	13,236	11,922
Investment and other income	1,023	828	710
Total revenues	201,159	184,840	157,107
Operating costs:			
Medical costs	130,036	117,038	103,875
Operating costs	29,557	28,401	24,312
Cost of products sold	24,112	24,416	16,206
Depreciation and amortization	2,245	2,055	1,693
Total operating costs	185,950	171,910	146,086
Earnings from operations	15,209	12,930	11,021
Interest expense	(1,186)	(1,067)	(790)
Earnings before income taxes	14,023	11,863	10,231
Provision for income taxes	(3,200)	(4,790)	(4,363)
Net earnings	10,823	7,073	5,868
Earnings attributable to noncontrolling interests	(265)	(56)	(55)
Net earnings attributable to UnitedHealth Group common shareholders	$ 10,558	$ 7,017	$ 5,813
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 10.95	$ 7.37	$ 6.10
Diluted	$ 10.72	$ 7.25	$ 6.01
Basic weighted-average number of common shares outstanding	964	952	953
Dilutive effect of common share equivalents	21	16	14
Diluted weighted-average number of common shares outstanding	985	968	967
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	5	3	8
Cash dividends declared per common share	$ 2.875	$ 2.375	$ 1.875

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2017	2016	2015
Net earnings	$10,823	$7,073	$ 5,868
Other comprehensive income (loss):			
Gross unrealized gains (losses) on investment securities during the period	209	(73)	(123)
Income tax effect	(72)	26	44
Total unrealized gains (losses), net of tax	137	(47)	(79)
Gross reclassification adjustment for net realized gains included in net earnings	(83)	(166)	(141)
Income tax effect	30	60	53
Total reclassification adjustment, net of tax	(53)	(106)	(88)
Total foreign currency translation (losses) gains	(70)	806	(1,775)
Other comprehensive income (loss)	14	653	(1,942)
Comprehensive income	10,837	7,726	3,926
Comprehensive income attributable to noncontrolling interests	(265)	(56)	(55)
Comprehensive income attributable to UnitedHealth Group common shareholders	$10,572	$7,670	$ 3,871

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2015	954	$ 10	$ —	$ 33,836	$ 223	$ (1,615)	$ —	$32,454
Net earnings				5,813			26	5,839
Other comprehensive loss					(167)	(1,775)		(1,942)
Issuances of common stock, and related tax effects	10	—	127					127
Share-based compensation, and related tax benefits			589					589
Common share repurchases	(11)	—	(462)	(738)				(1,200)
Cash dividends paid on common shares				(1,786)				(1,786)
Redeemable noncontrolling interests fair value and other adjustments			(225)					(225)
Acquisition of nonredeemable noncontrolling interest							9	9
Distributions to nonredeemable noncontrolling interest							(140)	(140)
Balance at December 31, 2015	953	10	29	37,125	56	(3,390)	(105)	33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interest fair value and other adjustments			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016	952	10	—	40,945	(97)	(2,584)	(97)	38,177
Net earnings				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interests fair value and other adjustments			113					113
Acquisition of nonredeemable noncontrolling interests							2,112	2,112
Distributions to nonredeemable noncontrolling interests							(152)	(152)
Balance at December 31, 2017	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$49,833

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2017	2016	2015
Operating activities			
Net earnings	$ 10,823	$ 7,073	$ 5,868
Noncash items:			
Depreciation and amortization	2,245	2,055	1,693
Deferred income taxes	(965)	81	(73)
Share-based compensation	597	485	406
Other, net	217	(82)	(235)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,062)	(1,357)	(591)
Other assets	(630)	(1,601)	(1,430)
Medical costs payable	1,284	1,849	2,585
Accounts payable and other liabilities	930	1,494	1,280
Unearned revenues	157	(202)	237
Cash flows from operating activities	13,596	9,795	9,740
Investing activities			
Purchases of investments	(14,588)	(17,547)	(9,939)
Sales of investments	4,623	7,339	6,054
Maturities of investments	5,646	4,281	3,354
Cash paid for acquisitions, net of cash assumed	(2,131)	(1,760)	(16,164)
Purchases of property, equipment and capitalized software	(2,023)	(1,705)	(1,556)
Other, net	(126)	37	(144)
Cash flows used for investing activities	(8,599)	(9,355)	(18,395)
Financing activities			
Common share repurchases	(1,500)	(1,280)	(1,200)
Cash dividends paid	(2,773)	(2,261)	(1,786)
Proceeds from common stock issuances	688	429	402
Repayments of long-term debt	(4,398)	(2,596)	(1,041)
(Repayments of) proceeds from commercial paper, net	(3,508)	(382)	3,666
Proceeds from issuance of long-term debt	5,291	3,968	11,982
Customer funds administered	3,172	1,692	768
Other, net	(413)	(581)	(552)
Cash flows (used for) from financing activities	(3,441)	(1,011)	12,239
Effect of exchange rate changes on cash and cash equivalents	(5)	78	(156)
Increase (decrease) in cash and cash equivalents	1,551	(493)	3,428
Cash and cash equivalents, beginning of period	10,430	10,923	7,495
Cash and cash equivalents, end of period	$ 11,981	$ 10,430	$ 10,923
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,133	$ 1,055	$ 639
Cash paid for income taxes	4,004	4,726	4,401
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ 2,164	$ —	$ —

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise to help meet the demands of the health system. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions

premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2017, accounts receivables related to products and services were $3.7 billion. In 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheet as of December 31, 2017.

For the year ended December 31, 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2017.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, 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 processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its mail and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the

manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates from two to five months after billing. As of December 31, 2017 and 2016, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $3.8 billion and $3.3 billion, respectively.

As of December 31, 2017 and 2016, the Company's Medicare Part D receivables amounted to $0.5 billion and $1.5 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2017.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2017.

Other Current Liabilities

Other current liabilities include health savings account deposits ($6.4 billion and $5.7 billion as of December 31, 2017 and 2016, respectively), deposits under the Medicare Part D program ($1.6 billion, and $0.7 billion as of

December 31, 2017 and 2016, respectively), the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2017 and 2016:

(in millions)	2017	2016
Redeemable noncontrolling interests, beginning of period	$2,012	$1,736
Net earnings	71	16
Acquisitions	565	34
Redemptions	(309)	(123)
Distributions	(38)	(11)
Fair value and other adjustments	(112)	360
Redeemable noncontrolling interests, end of period	$2,189	$2,012

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and any unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets. A provision in the 2016 Federal Budget imposed a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" (ASU 2016-02). Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity may elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing and uncertainty of cash flows pertaining to an entity's leases. Companies are currently required to adopt the new standard using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption of ASU 2016-02 is permitted. When adopted, the Company does not expect ASU 2016-02 to have a material impact on its results of operations, equity or cash flows. The impact of ASU 2016-02 on the Company's consolidated financial position will be based on leases outstanding at the time of adoption.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). The new guidance changes the current accounting related to (i) the classification and measurement of certain equity investments, (ii) the presentation of changes in the fair value of financial liabilities measured under the fair value option that are due to instrument-specific credit risk, and (iii) certain disclosures associated with the fair value of financial instruments. Most notably, ASU 2016-01 requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 effective January 1, 2018 as required. ASU 2016-01 did not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" as modified by subsequently issued ASUs 2015-14, 2016-08, 2016-10, 2016-12 and 2016-20 (collectively ASU 2014-09). ASU 2014-09 superseded existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Company early adopted the new standard effective January 1, 2017, as allowed, using the modified retrospective approach. A significant majority of the Company's revenues are not subject to the new guidance. The adoption of ASU 2014-09 did not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows as of the adoption date or for the year ended December 31, 2017.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2017				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,673	$ 1	$ (30)	$ 2,644
State and municipal obligations	7,596	99	(35)	7,660
Corporate obligations	13,181	57	(44)	13,194
U.S. agency mortgage-backed securities	3,942	7	(38)	3,911
Non-U.S. agency mortgage-backed securities	1,018	3	(6)	1,015
Total debt securities — available-for-sale	28,410	167	(153)	28,424
Equity securities	2,026	7	(41)	1,992
Debt securities — held-to-maturity:				
U.S. government and agency obligations	254	1	(1)	254
State and municipal obligations	2	—	—	2
Corporate obligations	280	—	—	280
Total debt securities — held-to-maturity	536	1	(1)	536
Total investments	$ 30,972	$ 175	$ (195)	$30,952
December 31, 2016				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,294	$ 1	$ (31)	$ 2,264
State and municipal obligations	7,120	40	(101)	7,059
Corporate obligations	10,944	41	(58)	10,927
U.S. agency mortgage-backed securities	2,963	7	(43)	2,927
Non-U.S. agency mortgage-backed securities	1,009	3	(10)	1,002
Total debt securities — available-for-sale	24,330	92	(243)	24,179
Equity securities	2,036	52	(47)	2,041
Debt securities — held-to-maturity:				
U.S. government and agency obligations	250	1	—	251
State and municipal obligations	5	—	—	5
Corporate obligations	238	—	—	238
Total debt securities — held-to-maturity	493	1	—	494
Total investments	$ 26,859	$ 145	$ (290)	$26,714

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2017.

The amortized cost and fair value of debt securities as of December 31, 2017, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,630	$ 3,628	$ 155	$ 155
Due after one year through five years	10,658	10,631	131	130
Due after five years through ten years	6,894	6,932	103	103
Due after ten years	2,268	2,307	147	148
U.S. agency mortgage-backed securities	3,942	3,911	—	—
Non-U.S. agency mortgage-backed securities	1,018	1,015	—	—
Total debt securities	$ 28,410	$28,424	$ 536	$ 536

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2017						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,249	$ (8)	$1,027	$ (22)	$ 2,276	$ (30)
State and municipal obligations	2,599	(21)	866	(14)	3,465	(35)
Corporate obligations	5,901	(23)	1,242	(21)	7,143	(44)
U.S. agency mortgage-backed securities	1,657	(12)	1,162	(26)	2,819	(38)
Non-U.S. agency mortgage-backed securities	411	(3)	144	(3)	555	(6)
Total debt securities — available-for-sale	$11,817	$ (67)	$4,441	$ (86)	$16,258	$ (153)
Equity securities	$ 97	$ (5)	$ 105	$ (36)	$ 202	$ (41)
December 31, 2016						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,794	$ (31)	$ —	$ —	$ 1,794	$ (31)
State and municipal obligations	4,376	(101)	—	—	4,376	(101)
Corporate obligations	5,128	(56)	137	(2)	5,265	(58)
U.S. agency mortgage-backed securities	2,247	(40)	79	(3)	2,326	(43)
Non-U.S. agency mortgage-backed securities	544	(7)	97	(3)	641	(10)
Total debt securities — available-for-sale	$14,089	$ (235)	$ 313	$ (8)	$14,402	$ (243)
Equity securities	$ 93	$ (5)	$ 91	$ (42)	$ 184	$ (47)

The Company's unrealized losses from all securities as of December 31, 2017 were generated from approximately 13,000 positions out of a total of 29,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase.

As of December 31, 2017, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors. Additionally, as of December 31, 2017, the Company's investments included $898 million of equity method investments in operating businesses in the health care sector.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

	For the Years Ended December 31,		
(in millions)	**2017**	**2016**	**2015**
Total other-than-temporary impairment recognized in earnings	$ (9)	$ (45)	$ (22)
Gross realized losses from sales	(33)	(44)	(28)
Gross realized gains from sales	125	255	191
Net realized gains (included in investment and other income on the Consolidated Statements of Operations)	83	166	141
Income tax effect (included in provision for income taxes on the Consolidated Statements of Operations)	(30)	(60)	(53)
Realized gains, net of taxes	$ 53	$ 106	$ 88

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there was no transfer between Levels 1, 2 or 3 of any financial assets or liabilities during the year ended December 31, 2017 or 2016.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the year ended December 31, 2017 or 2016.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2017				
Cash and cash equivalents	$ 11,718	$ 263	$ —	$11,981
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,428	216	—	2,644
State and municipal obligations	—	7,660	—	7,660
Corporate obligations	65	12,989	140	13,194
U.S. agency mortgage-backed securities	—	3,911	—	3,911
Non-U.S. agency mortgage-backed securities	—	1,015	—	1,015
Total debt securities — available-for-sale	2,493	25,791	140	28,424
Equity securities	1,784	14	194	1,992
Assets under management	1,117	1,984	—	3,101
Total assets at fair value	$ 17,112	$ 28,052	$ 334	$45,498
Percentage of total assets at fair value	38%	61%	1%	100%
December 31, 2016				
Cash and cash equivalents	$ 10,386	$ 44	$ —	$10,430
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,017	247	—	2,264
State and municipal obligations	—	7,059	—	7,059
Corporate obligations	21	10,804	102	10,927
U.S. agency mortgage-backed securities	—	2,927	—	2,927
Non-U.S. agency mortgage-backed securities	—	1,002	—	1,002
Total debt securities — available-for-sale	2,038	22,039	102	24,179
Equity securities	1,591	13	437	2,041
Assets under management	1,064	2,041	—	3,105
Total assets at fair value	$ 15,079	$ 24,137	$ 539	$39,755
Percentage of total assets at fair value	38%	61%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2017					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 251	$ 3	$ —	$ 254	$ 254
State and municipal obligations	—	—	2	2	2
Corporate obligations	16	1	263	280	280
Total debt securities — held-to-maturity	$ 267	$ 4	$ 265	$ 536	$ 536
Long-term debt and other financing obligations	$ —	$ 34,504	$ —	$34,504	$31,542
December 31, 2016					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 251	$ —	$ —	$ 251	$ 250
State and municipal obligations	—	—	5	5	5
Corporate obligations	20	8	210	238	238
Total debt securities — held-to-maturity	$ 271	$ 8	$ 215	$ 494	$ 493
Long-term debt and other financing obligations	$ —	$ 31,295	$ —	$31,295	$29,337

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2017	December 31, 2016
Land and improvements	$ 405	$ 324
Buildings and improvements	3,664	3,148
Computer equipment	1,829	2,021
Furniture and fixtures	1,208	999
Less accumulated depreciation	(2,488)	(2,621)
Property and equipment, net	4,618	3,871
Capitalized software	3,601	3,158
Less accumulated amortization	(1,206)	(1,128)
Capitalized software, net	2,395	2,030
Total property, equipment and capitalized software, net	$ 7,013	$ 5,901

Depreciation expense for property and equipment for the years ended December 31, 2017, 2016 and 2015 was $799 million, $698 million and $613 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2017, 2016 and 2015 was $550 million, $475 million and $430 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2016	$ 22,925	$ 5,660	$ 4,296	$ 11,572	$ 44,453
Acquisitions	526	683	—	1,387	2,596
Foreign currency effects and adjustments, net	403	(21)	153	—	535
Balance at December 31, 2016	23,854	6,322	4,449	12,959	47,584
Acquisitions	690	5,189	1,221	—	7,100
Foreign currency effects and adjustments, net	(60)	(23)	4	(49)	(128)
Balance at December 31, 2017	$ 24,484	$ 11,488	$ 5,674	$ 12,910	$ 54,556

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2017			December 31, 2016		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$10,832	$ (3,743)	$ 7,089	$10,942	$ (3,416)	$7,526
Trademarks and technology	1,054	(432)	622	720	(323)	397
Trademarks and other indefinite-lived	561	—	561	468	—	468
Other	351	(134)	217	258	(108)	150
Total	$12,798	$ (4,309)	$ 8,489	$12,388	$ (3,847)	$8,541

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2017		2016	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$324	13 years	$785	17 years
Trademarks and technology	367	11 years	82	4 years
Other	82	6 years	22	5 years
Total acquired finite-lived intangible assets	$773	11 years	$889	16 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2018	$833
2019	756
2020	665
2021	600
2022	528

Amortization expense relating to intangible assets for the years ended December 31, 2017, 2016 and 2015 was $896 million, $882 million and $650 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2017	2016	2015
Medical costs payable, beginning of period	$ 16,391	$ 14,330	$ 12,040
Acquisitions	83	—	—
Reported medical costs:			
Current year	130,726	117,258	104,195
Prior years	(690)	(220)	(320)
Total reported medical costs	130,036	117,038	103,875
Medical payments:			
Payments for current year	(113,811)	(101,696)	(90,630)
Payments for prior years	(14,828)	(13,281)	(10,955)
Total medical payments	(128,639)	(114,977)	(101,585)
Medical costs payable, end of period	$ 17,871	$ 16,391	$ 14,330

For the year ended December 31, 2017, medical cost reserve development was primarily driven by lower than expected health system utilization levels. For the years ended December 31, 2016 and 2015, no individual factors were significant.

Medical costs payable included IBNR of $12.3 billion and $11.6 billion at December 31, 2017 and 2016, respectively. Substantially all of the IBNR balance as of December 31, 2017 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2017:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2016	2017
2016	$ 117,258	$ 116,622
2017		130,726
Total		$ 247,348

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2016	2017
2016	$ (101,696)	$ (116,187)
2017		(113,811)
Total		(229,998)
Net remaining outstanding liabilities prior to 2016		521
Total medical costs payable		$ 17,871

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2017			December 31, 2016		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 150	$ 150	$ 150	$ 3,633	$ 3,633	$ 3,633
Floating rate notes due January 2017	—	—	—	750	750	750
6.000% notes due June 2017	—	—	—	441	446	450
1.450% notes due July 2017	—	—	—	750	750	751
1.400% notes due October 2017	—	—	—	625	624	626
6.000% notes due November 2017	—	—	—	156	159	163
1.400% notes due December 2017	—	—	—	750	751	750
6.000% notes due February 2018	1,100	1,101	1,106	1,100	1,107	1,153
1.900% notes due July 2018	1,500	1,499	1,501	1,500	1,496	1,507
1.700% notes due February 2019	750	749	747	750	748	748
1.625% notes due March 2019	500	501	497	500	501	498
2.300% notes due December 2019	500	495	501	500	498	504
2.700% notes due July 2020	1,500	1,496	1,517	1,500	1,495	1,523
Floating rate notes due October 2020	300	299	300	—	—	—
3.875% notes due October 2020	450	446	467	450	450	474
1.950% notes due October 2020	900	895	892	—	—	—
4.700% notes due February 2021	400	403	425	400	409	433
2.125% notes due March 2021	750	746	744	750	745	741
3.375% notes due November 2021	500	493	516	500	497	519
2.875% notes due December 2021	750	741	760	750	748	760
2.875% notes due March 2022	1,100	1,054	1,114	1,100	1,057	1,114
3.350% notes due July 2022	1,000	996	1,033	1,000	995	1,030
2.375% notes due October 2022	900	893	891	—	—	—
0.000% notes due November 2022	15	12	12	15	11	12
2.750% notes due February 2023	625	606	626	625	609	622
2.875% notes due March 2023	750	762	759	750	771	753
3.750% notes due July 2025	2,000	1,987	2,108	2,000	1,986	2,070
3.100% notes due March 2026	1,000	995	1,007	1,000	994	986
3.450% notes due January 2027	750	745	776	750	745	762
3.375% notes due April 2027	625	618	642	—	—	—
2.950% notes due October 2027	950	937	947	—	—	—
4.625% notes due July 2035	1,000	991	1,165	1,000	991	1,090
5.800% notes due March 2036	850	837	1,105	850	837	1,034
6.500% notes due June 2037	500	491	698	500	491	643
6.625% notes due November 2037	650	641	923	650	640	850
6.875% notes due February 2038	1,100	1,075	1,596	1,100	1,075	1,497
5.700% notes due October 2040	300	296	389	300	296	366
5.950% notes due February 2041	350	345	466	350	345	437
4.625% notes due November 2041	600	588	685	600	588	634
4.375% notes due March 2042	502	483	555	502	483	509
3.950% notes due October 2042	625	607	650	625	606	609
4.250% notes due March 2043	750	734	822	750	734	765
4.750% notes due July 2045	2,000	1,972	2,362	2,000	1,972	2,203
4.200% notes due January 2047	750	738	808	750	737	759
4.250% notes due April 2047	725	717	798	—	—	—
3.750% notes due October 2047	950	933	969	—	—	—
Total commercial paper and long-term debt	$31,417	$31,067	$34,029	$33,022	$32,770	$34,728

In 2017, the Company repaid $926 million in debt assumed in connection with an acquisition. The Company's long-term debt obligations also included $625 million and $200 million of other financing obligations, of which $107 million and $80 million were current as of December 31, 2017 and 2016, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2018	$ 2,857
2019	1,850
2020	3,250
2021	2,500
2022	3,115
Thereafter	18,470

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2017, the Company's outstanding commercial paper had a weighted-average annual interest rate of 1.5%.

The Company has $3.0 billion five-year, $3.0 billion three-year and $4.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2022, December 2020 and December 2018, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2017, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2017, annual interest rates would have ranged from 2.4% to 2.7%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 55%. The Company was in compliance with its debt covenants as of December 31, 2017.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2017	2016	2015
Current Provision:			
Federal	$3,597	$4,302	$4,109
State and local	314	312	281
Foreign	254	95	46
Total current provision	4,165	4,709	4,436
Deferred (benefit) provision	(965)	81	(73)
Total provision for income taxes	$3,200	$4,790	$4,363

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2017		2016		2015	
Tax provision at the U.S. federal statutory rate	$ 4,908	35.0%	$4,152	35.0%	$3,581	35.0%
Change in tax law	(1,199)	(8.6)	—	—	—	—
State income taxes, net of federal benefit	197	1.4	205	1.7	145	1.4
Share-based awards — excess tax benefit	(319)	(2.3)	(158)	(1.3)	—	—
Non-deductible compensation	175	1.3	128	1.1	103	1.0
Health insurance industry tax	—	—	645	5.4	627	6.1
Foreign rate differential	(282)	(2.0)	(105)	(0.9)	(34)	(0.3)
Other, net	(280)	(2.0)	(77)	(0.6)	(59)	(0.6)
Provision for income taxes	$ 3,200	22.8%	$4,790	40.4%	$4,363	42.6%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2017	2016
Deferred income tax assets:		
Accrued expenses and allowances	$ 544	$ 820
U.S. federal and state net operating loss carryforwards	216	147
Share-based compensation	97	126
Nondeductible liabilities	169	236
Non-U.S. tax loss carryforwards	445	434
Other-domestic	167	476
Other-non-U.S.	198	175
Subtotal	1,836	2,414
Less: valuation allowances	(64)	(55)
Total deferred income tax assets	1,772	2,359
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(1,998)	(3,055)
Non-U.S. goodwill and intangible assets	(602)	(584)
Capitalized software	(530)	(707)
Depreciation and amortization	(236)	(332)
Prepaid expenses	(223)	(228)
Outside basis in partnerships	(279)	(132)
Other-non-U.S.	(86)	(82)
Total deferred income tax liabilities	(3,954)	(5,120)
Net deferred income tax liabilities	$(2,182)	$(2,761)

On December 22, 2017, the U.S. federal government enacted a tax bill, H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Tax Reform). Tax Reform changed existing United States tax law, including a reduction of the U.S. corporate income tax rate. The Company re-measured deferred taxes as of the date of enactment, which resulted in the $1.2 billion reduction of net deferred income tax liabilities. The Company's measurement of the income tax effects of Tax Reform for the year ended December 31, 2017 is reasonably estimated and, therefore, included in these financial statements in accordance with SEC Staff Accounting Bulletin No. 118.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $235 million expire beginning in 2022 through 2037; state net operating loss carryforwards expire beginning in 2018 through 2037. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2017, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2017	2016	2015
Gross unrecognized tax benefits, beginning of period	$263	$224	$ 92
Gross increases:			
Current year tax positions	356	37	—
Prior year tax positions	40	24	55
Acquired reserves	—	—	89
Gross decreases:			
Prior year tax positions	(33)	(4)	(2)
Settlements	(24)	(6)	(1)
Statute of limitations lapses	(4)	(12)	(9)
Gross unrecognized tax benefits, end of period	$598	$263	$224

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $210 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2017, 2016 and 2015, the Company recognized $14 million, $11 million and $11 million of interest and penalties, respectively. The Company had $84 million and $70 million of accrued interest and penalties for uncertain tax positions as of December 31, 2017 and 2016, respectively. These amounts are not included in the reconciliation above. As of December 31, 2017, there were $472 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2011 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2012 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the United States are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National

Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2017, the Company's regulated subsidiaries paid their parent companies dividends of $3.7 billion, including $1.1 billion of extraordinary dividends. For the year ended December 31, 2016, the Company's regulated subsidiaries paid their parent companies dividends of $3.9 billion, including $3.3 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of $20.7 billion as of December 31, 2017. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $12.2 billion as of December 31, 2017.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, common equity Tier 1 risk-based capital and total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2017, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2014, the Board renewed the Company's share repurchase program with an authorization to
repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2017 and 2016 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2017**	**2016**
Common share repurchases, shares	9	10
Common share repurchases, average price per share	$173.54	$128.97
Common share repurchases, aggregate cost	$ 1,500	$ 1,280
Board authorized shares remaining	42	51

Dividends

In June 2017, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to equal an annual dividend rate of $3.00 per share compared to the annual dividend rate of $2.50 per share, which the Company had paid since June 2016. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2017, the Company had 51 million shares available for future grants of share-based awards under the Plan. As of December 31, 2017, there were also 9 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2017 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	36	$ 84		
Granted	15	111		
Exercised	(12)	55		
Forfeited	(2)	125		
Outstanding at end of period	37	102	6.6	$ 4,443
Exercisable at end of period	16	67	4.8	2,412
Vested and expected to vest, end of period	36	101	6.6	4,363

Restricted Shares

Restricted share activity for the year ended December 31, 2017 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	$ 96
Granted	3	163
Vested	(3)	84
Nonvested at end of period	7	128

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2017	2016	2015
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 29	$ 20	$ 22
Total intrinsic value of stock options and SARs exercised	1,473	595	482
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	163	115	110
Total fair value of restricted shares vested	$ 460	$274	$460
Employee Stock Purchase Plan			
Number of shares purchased	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 597	$485	$406
Share-based compensation expense, net of tax effects	531	417	348
Income tax benefit realized from share-based award exercises	431	236	247

(in millions, except years)	December 31, 2017
Unrecognized compensation expense related to share awards	$ 593
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2017	2016	2015
Risk-free interest rate	1.9% -2.1%	1.2% -1.4%	1.6% -1.7%
Expected volatility	18.5% -20.7%	20.8% -22.5%	22.3% -24.1%
Expected dividend yield	1.4% - 1.6%	1.8%	1.4% - 1.7%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.7	5.6 - 5.9	5.5 - 6.1

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2017, 2016 and 2015.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $865 million and $672 million as of December 31, 2017 and 2016, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2017, 2016 and 2015 was $710 million, $608 million and $555 million, respectively.

As of December 31, 2017, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2018	$ 538
2019	470
2020	414
2021	350
2022	501
Thereafter	809

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2017, 2016 or 2015.

As of December 31, 2017, the Company had outstanding, undrawn letters of credit with financial institutions of $72 million and surety bonds outstanding with insurance companies of $1.4 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into agreements to acquire two companies in the health care sector for a total of approximately $7.7 billion. One of the acquisitions closed in January 2018; the other is expected to close later in 2018, subject to regulatory approval and other customary closing conditions.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company, along with a number of other Medicare Advantage plans, made improper risk adjustment submissions and violated the False Claims Act. On March 24, 2017, DOJ intervened in a separate lawsuit initially asserted against the Company and filed by a whistleblower in 2009 concerning risk adjustment submissions by Medicare Advantage plans. On October 5, 2017, in one of the cases, the district court dismissed certain of DOJ's claims with prejudice, and

dismissed all of DOJ's remaining claims with leave to file a further amended complaint; on October 12, the DOJ filed a notice of dismissal without prejudice of the case. The other case is now pending in the U.S. District Court for the Central District of California. The Company cannot reasonably estimate the outcome that may result from this remaining matter given its current posture.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* serves the physical, emotional and health-related financial needs of individuals, enabling population health management through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery and specialty pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 28%, 25% and 26% for 2017, 2016 and 2015, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 97% and 96% of consolidated total revenues for 2017, 2016 and 2015, respectively. Long-lived fixed assets located in the United States represented approximately 77% and 75% of the total long-lived fixed assets as of December 31, 2017 and 2016, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum: OptumHealth	Optum: OptumInsight	Optum: OptumRx	Optum: Optum Eliminations	Optum: Optum	Corporate and Eliminations	Consolidated
2017								
Revenues — unaffiliated customers:								
Premiums	$ 154,709	$ 3,744	$ —	$ —	$ —	$ 3,744	$ —	$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues — unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues — affiliated customers	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues	$ 163,257	$ 20,570	$ 8,087	$ 63,755	$ (1,227)	$91,185	$ (53,283)	$ 201,159
Earnings from operations	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ —	$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ (1,186)	$ 14,023
Total assets	$ 76,676	$ 26,931	$ 11,273	$ 29,551	$ —	$67,755	$ (5,373)	$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245
2016								
Revenues — unaffiliated customers:								
Premiums	$ 140,455	$ 3,663	$ —	$ —	$ —	$ 3,663	$ —	$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues — unaffiliated customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues — affiliated customers	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues	$ 148,581	$ 16,908	$ 7,333	$ 60,440	$ (1,088)	$83,593	$ (47,334)	$ 184,840
Earnings from operations	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ —	$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ (1,067)	$ 11,863
Total assets	$ 70,505	$ 18,656	$ 9,017	$ 29,066	$ —	$56,739	$ (4,434)	$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055
2015								
Revenues — unaffiliated customers:								
Premiums	$ 124,011	$ 3,152	$ —	$ —	$ —	$ 3,152	$ —	$ 127,163
Products	2	31	108	17,171	—	17,310	—	17,312
Services	6,776	2,375	2,390	381	—	5,146	—	11,922
Total revenues — unaffiliated customers	130,789	5,558	2,498	17,552	—	25,608	—	156,397
Total revenues — affiliated customers	—	8,216	3,697	30,718	(791)	41,840	(41,840)	—
Investment and other income	554	153	1	2	—	156	—	710
Total revenues	$ 131,343	$ 13,927	$ 6,196	$ 48,272	$ (791)	$67,604	$ (41,840)	$ 157,107
Earnings from operations	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ —	$ 11,021
Interest expense	—	—	—	—	—	—	(790)	(790)
Earnings before income taxes	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ (790)	$ 10,231
Total assets	$ 64,212	$ 14,600	$ 8,335	$ 26,844	$ —	$49,779	$ (2,737)	$ 111,254
Purchases of property, equipment and capitalized software	653	252	572	79	—	903	—	1,556
Depreciation and amortization	718	251	492	232	—	975	—	1,693

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2017 and 2016 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	**March 31**	**June 30**	**September 30**	**December 31**
2017				
Revenues	$48,723	$50,053	$50,322	$52,061
Operating costs	45,310	46,322	46,234	48,084
Earnings from operations	3,413	3,731	4,088	3,977
Net earnings	2,191	2,350	2,561	3,721
Net earnings attributable to UnitedHealth Group common shareholders	2,172	2,284	2,485	3,617
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.28	2.37	2.57	3.73
Diluted	2.23	2.32	2.51	3.65
2016				
Revenues	$44,527	$46,485	$46,293	$47,535
Operating costs	41,567	43,282	42,713	44,348
Earnings from operations	2,960	3,203	3,580	3,187
Net earnings	1,627	1,760	1,978	1,708
Net earnings attributable to UnitedHealth Group common shareholders	1,611	1,754	1,968	1,684
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.69	1.84	2.07	1.77
Diluted	1.67	1.81	2.03	1.74

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2017. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2017.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2017 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2017

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2017. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2017, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2017, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

Report of Independent Registered Public Accounting Firm

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinions on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2017, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control – Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2017, of the Company and our report dated February 13, 2018, expressed an unqualified opinion on consolidated financial statements.

Basis for Opinions

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2017. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 13, 2018

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 13, 2018, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Executive Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council, a company focused on improving the governance processes of corporate boards

Rodger A. Lawson
Executive Chair
E*TRADE Financial Corporation and
Retired President and Chief Executive Officer
Fidelity Investments – Financial Services

Valerie Montgomery Rice, M.D
President and Dean
Morehouse School of Medicine

Glenn M. Renwick
Chair
Fiserv, Inc.

Kenneth I. Shine, M.D.
Professor of Medicine at the Dell Medical School
University of Texas

David S. Wichmann
Chief Executive Officer
UnitedHealth Group

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE, an international health foundation

Andrew P. Witty
Former Chief Executive Officer
GlaxoSmithKline
Chancellor
University of Nottingham

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2018 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2018 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2017, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	35	$ 106	60[3]
Equity compensation plans not approved by shareholders [2]	–	–	–
Total [2]	35	$ 106	60

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 ESPP, as amended.

(2) Excludes 2,818,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $61 and an average remaining term of approximately 3 years. The options are administered pursuant to the terms of the plan under which the options originally were granted. No future awards will be granted under this acquired plan.

(3) Includes 9 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2017, and 51 million shares available under the 2011 Stock Incentive Plan as of December 31, 2017. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2018 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2018 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2018 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2017 and 2016.
- Consolidated Statements of Operations for the years ended December 31, 2017, 2016, and 2015.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2017, 2016, and 2015.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2017, 2016, and 2015.
- Consolidated Statements of Cash Flows for the years ended December 31, 2017, 2016, and 2015.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)

4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2015 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on June 5, 2015)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Seventh Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.24 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016)
*10.25	Summary of Non-Management Director Compensation, effective as of August 15, 2017 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)

*10.26	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.27	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.28	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.29	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.30	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.31	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.32	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.33	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.34	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.35	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.36	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.37	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.38	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.39	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.40	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)

*10.41	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.42	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.43	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.44	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.45	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.46	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.47	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.48	Amendment to Employment Agreement, effective as of August 15, 2017, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.49	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.50	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.51	Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017, filed on February 13, 2018, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2017 and 2016, and for each of the three years in the period ended December 31, 2017, and the Company's internal control over financial reporting as of December 31, 2017, and have issued our reports thereon dated February 13, 2018; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 13, 2018

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2017	December 31, 2016
Assets		
Current assets:		
Cash and cash equivalents	$ 359	$ 180
Short-term notes receivable from subsidiaries	—	755
Other current assets	575	140
Total current assets	934	1,075
Equity in net assets of subsidiaries	76,231	60,593
Long-term notes receivable from subsidiaries	4,278	9,912
Other assets	839	248
Total assets	$ 82,282	$ 71,828
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 502	$ 452
Current portion of notes payable to subsidiaries	466	280
Commercial paper and current maturities of long-term debt	2,749	7,113
Total current liabilities	3,717	7,845
Long-term debt, less current maturities	28,318	25,657
Long-term notes payable to subsidiaries	1,518	—
Other liabilities	953	52
Total liabilities	34,506	33,554
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value - 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 969 and 952 issued and outstanding	10	10
Additional paid-in capital	1,703	—
Retained earnings	48,730	40,945
Accumulated other comprehensive loss	(2,667)	(2,681)
Total UnitedHealth Group shareholders' equity	47,776	38,274
Total liabilities and shareholders' equity	$ 82,282	$ 71,828

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2017	2016	2015
Revenues:			
Investment and other income	$ 527	$ 522	$ 396
Total revenues	527	522	396
Operating costs:			
Operating costs	—	(22)	(17)
Interest expense	1,114	995	717
Total operating costs	1,114	973	700
Loss before income taxes	(587)	(451)	(304)
Benefit for income taxes	214	165	111
Loss of parent company	(373)	(286)	(193)
Equity in undistributed income of subsidiaries	10,931	7,303	6,006
Net earnings	10,558	7,017	5,813
Other comprehensive income (loss)	14	653	(1,942)
Comprehensive income	$10,572	$ 7,670	$ 3,871

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2017	2016	2015
Operating activities			
Cash flows from operating activities	$ 2,021	$ 4,294	$ 1,727
Investing activities			
Repayments (issuances) of notes to subsidiaries	2,071	(824)	(5,064)
Cash paid for acquisitions	(2,313)	(2,292)	(12,270)
Return of capital to parent company	3,375	2,143	4,375
Capital contributions to subsidiaries	(959)	(765)	(1,109)
Other, net	—	168	140
Cash flows from (used for) investing activities	2,174	(1,570)	(13,928)
Financing activities			
Common stock repurchases	(1,500)	(1,280)	(1,200)
Proceeds from common stock issuances	688	429	402
Cash dividends paid	(2,773)	(2,261)	(1,786)
(Repayments of) proceeds from commercial paper, net	(3,508)	(382)	3,666
Proceeds from issuance of long-term debt	5,291	3,968	11,982
Repayments of long-term debt	(3,472)	(2,596)	(1,041)
Proceeds (repayments) of notes from subsidiary	1,704	(30)	95
Other, net	(446)	(421)	(447)
Cash flows (used for) from financing activities	(4,016)	(2,573)	11,671
Increase (decrease) in cash and cash equivalents	179	151	(530)
Cash and cash equivalents, beginning of period	180	29	559
Cash and cash equivalents, end of period	$ 359	$ 180	$ 29
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,062	$ 974	$ 573
Cash paid for income taxes	3,455	4,557	4,294
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ 2,164	$ —	$ —
Conversion of note receivable from subsidiaries to equity	4,378	—	—

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $3.4 billion, $3.7 billion and $4.8 billion in 2017, 2016 and 2015, respectively. Additionally, $3.4 billion, $2.1 billion and $4.4 billion in cash were received as a return of capital to the parent company during 2017, 2016 and 2015, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $625 million and $200 million at December 31, 2017 and 2016, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2018	$ 2,750
2019	1,750
2020	3,150
2021	2,400
2022	3,015
Thereafter	18,352

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 13, 2018

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN
David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN **David S. Wichmann**	Director and Chief Executive Officer (principal executive officer)	February 13, 2018
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 13, 2018
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 13, 2018
* **William C. Ballard, Jr.**	Director	February 13, 2018
* **Richard T. Burke**	Director	February 13, 2018
* **Timothy P. Flynn**	Director	February 13, 2018
* **Stephen J. Hemsley**	Director	February 13, 2018
* **Michele J. Hooper**	Director	February 13, 2018
* **Rodger A. Lawson**	Director	February 13, 2018
* **Valerie Montgomery Rice**	Director	February 13, 2018
* **Glenn M. Renwick**	Director	February 13, 2018
* **Kenneth I. Shine**	Director	February 13, 2018
* **Gail R. Wilensky**	Director	February 13, 2018
* **Andrew P. Witty**	Director	February 13, 2018

*By /s/ MARIANNE D. SHORT
Marianne D. Short,
As Attorney-in-Fact

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

Form 10-K

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

For the fiscal year ended December 31, 2016

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2016 was $132,269,813,351 (based on the last reported sale price of $141.20 per share on June 30, 2016, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2017, there were 951,165,192 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2017 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and helping to make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and other individuals. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes UnitedHealthcare Brazil, a health care company providing health and dental benefits and hospital and clinical services to employer groups and individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2016, we processed more than one half trillion dollars in gross billed charges and we managed more than $200 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1 million physicians and other health care professionals and approximately 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individuals. UnitedHealthcare Employer & Individual provides access to medical services for over 30 million people on behalf of our customers and alliance partners. This includes more than 200,000 employer customers across all 50 states. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers.

UnitedHealthcare Employer & Individual also distributes its products through professional employer organizations, associations and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. Direct-to-consumer sales are supported by participation in multi-carrier health insurance marketplaces for individuals and small groups through exchanges. In 2017, UnitedHealthcare Employer & Individual will participate in individual public exchanges in three states, a reduction from 34 states in 2016.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet the coverage needs of employers of all sizes. The market for health benefit products is shifting, with benefit and network offerings shaped, at least in part, by the requirements and effects of the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations, increased employer focus on quality and employee engagement and the urgent need to align the system around value. Cost pressures are stimulating demand for improved health care affordability and more coordinated care. UnitedHealthcare Employer & Individual is responding to this demand with medical network and contracting constructs (such as performance incentives and benefit designs that direct more patients to higher-performing care providers), alternative access to affordable and convenient care (such as through telehealth appointments with registered nurses and physicians) and a consumer-responsive service called Advocate4Me.

UnitedHealthcare Employer & Individual offers affordable products and actionable information to enable better health outcomes and to help employers attract and retain talent. UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs and consumer education. During 2016, more than 40,000 employer-sponsored benefit plans, including nearly 400 employers in the large group self-funded market, purchased HRA or HSA products from us.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individuals) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;

- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, critical illness and disability product offerings through an integrated approach, including a network of more than 20,000 vision offices and more than 80,000 dental offices, in private and retail settings.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans is the provider of health care services for nearly 3 million active duty and retired military service members and their families in 21 states under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract that began on April 1, 2013 is scheduled to conclude in 2017 and has not been renewed.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. Beneficiaries with special needs are served through UnitedHealthcare Medicare & Retirement Dual, Chronic and Institutional Special Needs Plans (SNPs) in many markets. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and SNPs. Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 3.6 million people through its Medicare Advantage products as of December 31, 2016.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through UnitedHealth Group's HouseCalls program, nurse practitioners performed more than 1 million in-home preventative care visits in 2016 to address unmet care opportunities and close gaps in care. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to reach out to those members and create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2016, UnitedHealthcare enrolled 8.6 million people in the Medicare Part D programs, including 4.9 million individuals in the stand-alone Medicare Part D plans with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.7 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover the various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 25% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2016, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2016,

UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served 5.9 million beneficiaries. The Affordable Care Act provided for optional Medicaid expansion effective January 1, 2014. As of December 31, 2016, UnitedHealthcare Community & State served more than 1 million people through Medicaid expansion programs in 15 states.

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and its participation are:

- Temporary Assistance to Needy Families, primarily women and children – 22 markets;
- CHIP – 21 markets;
- Aged, Blind and Disabled – 20 markets;
- SNP – 15 markets;
- Medicaid Expansion – 15 markets;
- Long-Term Services and Supports – 12 markets;
- childless adult programs for the uninsured – 2 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 5 markets; and
- MMP – 2 markets.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 40% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state-carve-ins of populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated management of physical, behavioral, long-term care services and supports and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model allows UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% of members who are most at risk and drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare Global's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals around the world. UnitedHealthcare Global's goal is to create health care business solutions that are based on local expertise, infrastructure, culture and needs. As of December 31, 2016, UnitedHealthcare Global provided medical benefits to 4.2 million people, principally in Brazil, but also residing in more than 125 other countries.

UnitedHealthcare Brazil. UnitedHealthcare Brazil provides medical and dental benefits to nearly 6 million people. UnitedHealthcare Brazil owns and operates more than 40 acute hospitals and more than 50 specialty, primary care and emergency services clinics across Brazil, principally for the benefit of its members. UnitedHealthcare Brazil's patients are also treated in its contracted provider network of nearly 22,000 physicians and other health care professionals, approximately 1,900 hospitals and nearly 7,000 laboratories and diagnostic imaging centers. UnitedHealthcare Brazil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. UnitedHealthcare Brazil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Global Offerings. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three reportable segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 83 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by coordinating care for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies).

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of over 20,000 employed, managed and contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that put patient health and outcomes first, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through OptumHealth's strategic partnerships, alliances and ownership arrangements it helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care.

MedExpress' nearly 200 neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach.

The HouseCalls program provides in-home health assessments that engage individuals, understand their health status and needs, and close gaps in care. In 2016, HouseCalls conducted more than 1 million in-home health assessments.

OptumHealth's mobile care delivery business delivers occupational health and medical services to government customers, with a particular focus on the U.S. military.

OptumHealth serves people through population health management services that meet both the preventative care and health intervention needs of consumers across the care continuum — physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through over 4.6 million health savings and other accounts with $7 billion in assets under management as of December 31,

2016. During 2016, Optum Bank processed over $100 billion in medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, electronic payment systems.

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on data and analytics, technology and information that help improve the quality of care and drive greater efficiency in the health care system. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2016, was $12.6 billion, of which $6.9 billion is expected to be realized within the next 12 months. This includes $4.5 billion related to intersegment agreements, all of which are in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2015, was $10.4 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and tens of thousands of physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers meet these challenges, with particular focus on clinical performance and quality improvement, population health management, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves approximately 300 health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to more than 65 million people in the United States through its network of more than 67,000 retail pharmacies and multiple home delivery facilities throughout the country. In 2016, OptumRx managed more than $80 billion in pharmaceutical spending, including more than $30 billion in specialty pharmaceutical spending. OptumRx provides retail network contracting, purchasing and clinical capabilities and works with customers to develop an optimal set of programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management to achieve a high-quality, low-cost pharmacy offering. OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individuals through enhanced services and cost trend management.

OptumRx provides pharmacy care services to non-affiliated clients, including a number of health plans, large national employer plans, unions and trusts and government entities; as well as a substantial majority of UnitedHealthcare members. Additionally, OptumRx manages specialty pharmacy care services, including patient support and clinical programs designed to ensure quality and deliver value for consumers. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs), risk adjustment and reinsurance data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations

relating to the administration of contracts with federal agencies. Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Affordable Care Act. The ACA expanded access to coverage and modified aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system.

Among other requirements, the ACA expanded dependent coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain MLRs are not satisfied, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, introduced new risk sharing programs, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

The ACA is affecting how we do business and could impact our results of operations, financial position and cash flows. See also Part I, Item 1A, “Risk Factors” for a discussion of the risks related to the ACA and related matters.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a third party, and generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners has adopted model regulations that, where implemented by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. Reports are filed annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distributions laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Guaranty Fund Assessments. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Some states have similar laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. Assessments are generally based on a formula relating to our premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets or through premiums. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Pharmacy Regulation. OptumRx's businesses include home delivery and specialty pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery and specialty pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to the laws and regulations in the

states where our home delivery and specialty pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery and specialty pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. As certain of our home delivery and specialty pharmacies maintain eligibility as Medicare and state Medicaid providers, their participation in the programs requires them to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering,

promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, population health management companies and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, Humana Inc., Kaiser Permanente, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and, with respect to our Brazilian operations, several established competitors in Brazil and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Health Corporation, Express Scripts, Inc. and Prime Therapeutics LLC. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including by maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2016, we employed more than 230,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 8, 2017, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	64	Chief Executive Officer
David S. Wichmann	54	President
Larry C. Renfro	63	Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum
John F. Rex	54	Executive Vice President and Chief Financial Officer
Thomas E. Roos	44	Senior Vice President and Chief Accounting Officer
Marianne D. Short	65	Executive Vice President and Chief Legal Officer
D. Ellen Wilson	59	Executive Vice President, Human Capital

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. From May 1999 to November 2014, Mr. Hemsley also served as President of UnitedHealth Group.

Mr. Wichmann is President of UnitedHealth Group. Mr. Wichmann has served as President of UnitedHealth Group since November 2014. From January 2011 to June 2016, Mr. Wichmann also served as Chief Financial Officer. From April 2008 to November 2014, Mr. Wichmann also served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Renfro is Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum. Mr. Renfro has served as Vice Chairman of UnitedHealth Group since November 2014 and Chief Executive Officer of Optum since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President, Human Capital of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, federal and state regulatory requirements obligate our commercial, Medicare Advantage and certain state-based Medicaid health plans to maintain minimum MLRs, which could make it more difficult for us to obtain price increases for our products. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies is typically at a fixed monthly rate per individual served for a 12-month period and is generally priced one to six

months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2016 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2016 would have been reduced by approximately $240 million, excluding any offsetting impact from risk adjustment, reinsurance or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Some states have similar laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company’s claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations, debt collection laws, banking regulations, distributor and producer licensing requirements, state corporate practice of medicine doctrines, fee-splitting rules, health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing

laws and rules apply to us, including subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Brazil business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

The ACA could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity and continued uncertainty, the ACA's impact remains difficult to predict and could adversely affect us. The ACA includes specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. In addition, if we do not maintain certain MLRs, we are required to rebate ratable portions of our premiums to our customers. These requirements can cause significant disruptions in local health care markets and adjustments to our business, all of which could materially and adversely affect our results of operations, financial position and cash flows.

Our results of operations, financial position and cash flows could be materially and adversely affected if the number of individuals who gain coverage under the ACA varies from our expectations, if the demand for the ACA related products and capabilities offered by our Optum businesses is less than anticipated or if our costs are greater than anticipated.

The Trump Administration and Congressional Leaders have expressed their intentions to repeal and replace the ACA. We cannot predict if the ACA will be modified, repealed or replaced, but changes to this law could materially impact our operating results, require us to revise the ways in which we conduct business or put us at risk for loss of business.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs, CHIP and our TRICARE contract with the DoD, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. In the event any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA,

CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the local plan level. The star rating system considers various measures adopted by CMS, including, among other things, quality of care, preventative services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect our membership levels, results of operations, financial position and cash flows. In addition, under the ACA, Congress authorized CMS and the states to implement MMP managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MMP demonstration programs for dually eligible beneficiaries, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with coding and other requirements under the Medicare risk-adjustment model, our chart review programs and related processes. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to

HIPAA imposed further restrictions on our ability to collect, disclose and use sensitive personal information and imposed additional compliance requirements on our business. In addition, the General Data Protection Regulation of the European Union imposes higher potential penalties and more stringent compliance and data security requirements on our ability to collect, process and transfer personal data relating to our European businesses.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business through home delivery and specialty pharmacies, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including potential new regulations regarding the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals and pharmacy network reimbursement methodologies.

Our pharmacy care services businesses would be materially and adversely affected by our inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our home delivery or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our home delivery or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the

fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our pharmacy care services businesses in connection with services for which our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, Brazil and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. Additionally, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits, health care usage, and in the effective navigation of the health care system we may be challenged by new technologies and market entrants that could disrupt our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, distract managements' attention and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our

operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of certain businesses, including OptumHealth and UnitedHealthcare Brazil, depend on maintaining satisfactory physician employment relationships. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various litigation actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims

(including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. Success in completing acquisitions is also dependent upon efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars

or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through independent producers and consultants with whom we do not have exclusive contracts and for whose services and allegiance we must compete intensely. Our sales would be materially and adversely affected if we were unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, they could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2016. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2016, goodwill and other intangible assets had a carrying value of $56 billion, representing 46% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of

consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third-parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Litigation Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2017, there were 13,035 registered holders of record of our common stock. The high and low per share common stock sales prices reported by the NYSE and cash dividends declared for our last two fiscal years were as follows:

	High	Low	Cash Dividends Declared
2016			
First quarter	$131.10	$107.51	$ 0.500
Second quarter	$141.31	$125.26	$ 0.625
Third quarter	$144.48	$132.39	$ 0.625
Fourth quarter	$164.00	$133.03	$ 0.625
2015			
First quarter	$123.76	$ 98.46	$ 0.375
Second quarter	$124.11	$111.12	$ 0.500
Third quarter	$126.21	$ 95.00	$ 0.500
Fourth quarter	$125.99	$109.61	$ 0.500

DIVIDEND POLICY

In June 2016, our Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual dividend rate of $2.50 per share compared to the annual dividend rate of $2.00 per share, which the Company had paid since June 2015. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter 2016, we repurchased approximately 1 million shares at an average price of $141.54 per share. As of December 31, 2016, we had Board authorization to purchase up to 51 million shares of our common stock.

PERFORMANCE GRAPHS

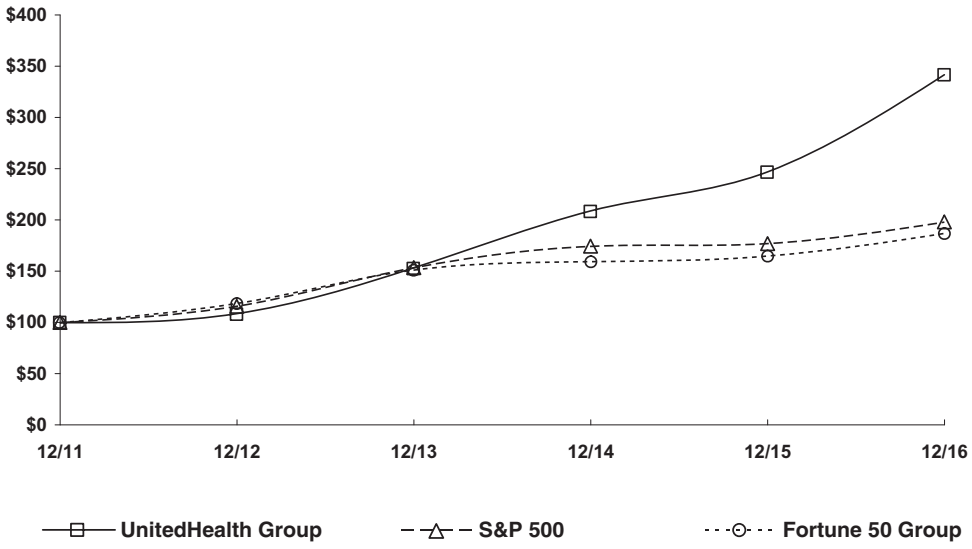
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group") for the five-year period ended December 31, 2016. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2016. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2011 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/11	12/12	12/13	12/14	12/15	12/16
UnitedHealth Group	**$100.00**	**$108.59**	**$153.15**	**$208.98**	**$247.13**	**$342.05**
S&P 500 Index	**100.00**	**116.00**	**153.58**	**174.60**	**177.01**	**198.18**
Fortune 50 Group	**100.00**	**118.48**	**151.44**	**159.51**	**164.70**	**186.76**

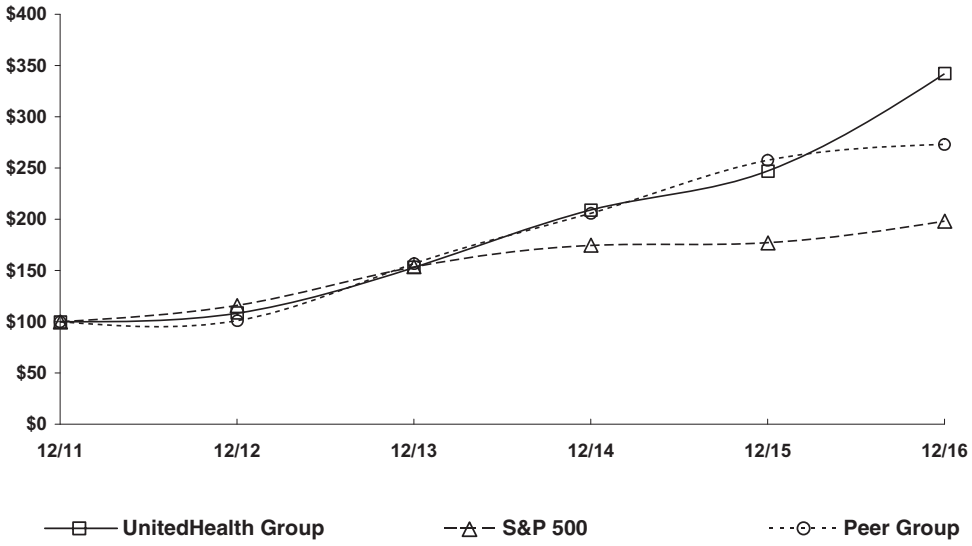
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Anthem Inc., Cigna Corporation and Humana Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and a Peer Group



	12/11	12/12	12/13	12/14	12/15	12/16
UnitedHealth Group	$100.00	$108.59	$153.15	$208.98	$247.13	$342.05
S&P 500 Index	100.00	116.00	153.58	174.60	177.01	198.18
Peer Group	100.00	101.01	156.96	206.09	257.48	273.12

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Year Ended December 31, 2016	2015 (a)	2014	2013	2012
Consolidated operating results					
Revenues	$184,840	$157,107	$130,474	$122,489	$110,618
Earnings from operations	12,930	11,021	10,274	9,623	9,254
Net earnings attributable to UnitedHealth Group common shareholders	7,017	5,813	5,619	5,625	5,526
Return on equity (b)	19.4%	17.7%	17.3%	17.7%	18.7%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 7.37	$ 6.10	$ 5.78	$ 5.59	$ 5.38
Diluted earnings per share attributable to UnitedHealth Group common shareholders	7.25	6.01	5.70	5.50	5.28
Cash dividends declared per common share	2.3750	1.8750	1.4050	1.0525	0.8000
Consolidated cash flows from (used for)					
Operating activities	$ 9,795	$ 9,740	$ 8,051	$ 6,991	$ 7,155
Investing activities	(9,355)	(18,395)	(2,534)	(3,089)	(8,649)
Financing activities	(1,011)	12,239	(5,293)	(4,946)	471
Consolidated financial condition (as of December 31)					
Cash and investments	$ 37,143	$ 31,703	$ 28,063	$ 28,818	$ 29,148
Total assets (c)	122,810	111,254	86,300	81,800	80,811
Total commercial paper and long-term debt (c)	32,970	31,965	17,324	16,778	16,680
Redeemable noncontrolling interests	2,012	1,736	1,388	1,175	2,121
Total equity	38,177	33,725	32,454	32,149	31,178

(a) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters of the year presented.

(c) In the first quarter of 2016, the Company adopted Financial Accounting Standards Board (FASB) Accounting Standard Update (ASU) No. 2015-03 (ASU 2015-03), retrospectively as required. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on the adoption of ASU 2015-03.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and helping to make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data; information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Recent Developments

We have recognized in our financial results for the fourth quarter 2016 and the year ended December 31, 2016 the previously disclosed $350 million impact of our estimated share of guaranty association assessments resulting from the liquidation of Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), following accounting, legal and regulatory consultations in connection with our 10-K filing. This charge will be funded over several years and affected by premium tax credits over time.

For more detail related to the Penn Treaty liquidation, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the United States, Brazilian and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations. Our review of regulatory considerations involves a focus on minimum MLR thresholds and the risk adjustment that impacts the small group and individual markets. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2016 Federal Budget imposes a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover some portion of calendar year 2017 will reflect the impact of the moratorium. Additionally, the industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in “Regulatory Trends and Uncertainties.”

We expect continued Medicaid revenue growth due to anticipated increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid net margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases with medical management. Our 2017 management activities include managing costs across all health care categories, including specialty pharmacy spending, as new therapies are introduced at high costs and older drugs experience price increases.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2016, we served more than 15 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2016, our contracts with value-based elements total nearly $53 billion in annual spending.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management’s view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 “Business — Government Regulation” and Item 1A, “Risk Factors.”

Medicare Advantage Rates. Final 2017 Medicare Advantage rates resulted in an increase in industry base rates of approximately 0.85%, well short of the industry forward medical cost trend of 3%, which creates continued pressure in the Medicare Advantage program. The impact of this funding shortfall in Medicare Advantage is partially mitigated by reductions in provider payments for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service payment rates. These factors can affect our plan benefit designs, pricing, growth prospects and earnings expectations for our Medicare Advantage plans.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase the member premiums that supplement the monthly payments we receive from the government and decide on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

As provided in the ACA, our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, Star ratings affect the amount of savings a plan can use to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. For the 2016 payment year, approximately 57% of our Medicare Advantage members were in plans rated four stars or higher. We expect that at least 80% of our Medicare Advantage members will be in plans rated four stars or higher for payment year 2017. We continue to dedicate substantial resources to advance our quality scores and Star ratings to strengthen our local market programs and further improve our performance.

Health Insurance Industry Tax and Premium Stabilization Programs. The industry-wide amount of the Health Insurance Industry Tax was $11.3 billion in 2016 and we paid our portion of the tax, which was $1.8 billion, in September 2016. A provision in the 2016 Federal Budget imposes a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax. The Health Insurance Industry Tax is scheduled to be imposed for 2018 and beyond. In 2018, the industry-wide amount of the Health Insurance Industry Tax is expected to be $14.3 billion. The ACA also included three programs designed to stabilize the health insurance markets. These programs encompassed: a transitional reinsurance program; a temporary risk corridors program; and a permanent risk adjustment program. The transitional reinsurance and temporary risk corridors programs expired at the end of 2016.

Individual Public Exchanges. In 2016, we participated in individual public exchanges in 34 states and offered individual ACA compliant products. We recorded a premium deficiency reserve for a portion of our estimated 2016 losses in our 2015 results for in-force contracts as of January 1, 2016. During 2016, we incurred additional losses in our individual ACA compliant products and, for 2017, reduced our participation to three individual public exchanges. We expect to reduce the number of consumers we serve through individual insurance plans by nearly 1 million people in 2017, which will reduce our premium revenues by more than $4 billion.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2016	2015	2014	Change 2016 vs. 2015		Change 2015 vs. 2014	
Revenues:							
Premiums	$144,118	$127,163	$115,302	$16,955	13%	$11,861	10%
Products	26,658	17,312	4,242	9,346	54	13,070	308
Services	13,236	11,922	10,151	1,314	11	1,771	17
Investment and other income	828	710	779	118	17	(69)	(9)
Total revenues	184,840	157,107	130,474	27,733	18	26,633	20
Operating costs:							
Medical costs	117,038	103,875	93,633	13,163	13	10,242	11
Operating costs	28,401	24,312	21,263	4,089	17	3,049	14
Cost of products sold	24,416	16,206	3,826	8,210	51	12,380	324
Depreciation and amortization	2,055	1,693	1,478	362	21	215	15
Total operating costs	171,910	146,086	120,200	25,824	18	25,886	22
Earnings from operations	12,930	11,021	10,274	1,909	17	747	7
Interest expense	(1,067)	(790)	(618)	(277)	35	(172)	28
Earnings before income taxes	11,863	10,231	9,656	1,632	16	575	6
Provision for income taxes	(4,790)	(4,363)	(4,037)	(427)	10	(326)	8
Net earnings	7,073	5,868	5,619	1,205	21	249	4
Earnings attributable to noncontrolling interests	(56)	(55)	—	(1)	2	(55)	nm
Net earnings attributable to UnitedHealth Group common shareholders	$ 7,017	$ 5,813	$ 5,619	$ 1,204	21%	$ 194	3%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 7.25	$ 6.01	$ 5.70	$ 1.24	21%	$ 0.31	5%
Medical care ratio (a)	81.2%	81.7%	81.2%	(0.5)%		0.5%	
Operating cost ratio	15.4	15.5	16.3	(0.1)		(0.8)	
Operating margin	7.0	7.0	7.9	—		(0.9)	
Tax rate	40.4	42.6	41.8	(2.2)		0.8	
Net earnings margin (b)	3.8	3.7	4.3	0.1		(0.6)	
Return on equity (c)	19.4%	17.7%	17.3%	1.7%		0.4%	

nm = not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2016 year-over-year operating comparisons to 2015 and other 2016 significant items.

- Consolidated revenues increased by 18%, UnitedHealthcare revenues increased 13% and Optum revenues grew 24%.
- UnitedHealthcare grew to serve an additional 2.1 million people domestically.
- Earnings from operations increased by 17%, including increases of 8% at UnitedHealthcare and 32% at Optum.
- Diluted earnings per common share increased 21% to $7.25.
- Cash flows from operations were $9.8 billion.

2016 RESULTS OF OPERATIONS COMPARED TO 2015 RESULTS

Our results of operations were affected by our acquisition of Catamaran in the third quarter of 2015.

Consolidated Financial Results

Revenues

The increases in revenues were primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across all of our Optum services businesses.

Medical Costs

Medical costs increased due to risk-based membership growth and medical cost trends, partially offset by medical management initiatives.

Income Tax Rate

Our effective tax rate decreased primarily due to the adoption of the ASU 2016-09, which we adopted in the first quarter of 2016. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, of this report for more information about the adoption of ASU 2016-09.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on our segments. The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change		Change	
(in millions, except percentages)	2016	2015	2014	2016 vs. 2015		2015 vs. 2014	
Revenues							
UnitedHealthcare	$148,581	$131,343	$119,798	$17,238	13%	$11,545	10%
OptumHealth	16,908	13,927	11,032	2,981	21	2,895	26
OptumInsight	7,333	6,196	5,227	1,137	18	969	19
OptumRx	60,440	48,272	31,976	12,168	25	16,296	51
Optum eliminations	(1,088)	(791)	(489)	(297)	38	(302)	62
Optum	83,593	67,604	47,746	15,989	24	19,858	42
Eliminations	(47,334)	(41,840)	(37,070)	(5,494)	13	(4,770)	13
Consolidated revenues	$184,840	$157,107	$130,474	$27,733	18%	$26,633	20%
Earnings from operations							
UnitedHealthcare	$ 7,307	$ 6,754	$ 6,992	$ 553	8%	$ (238)	(3)%
OptumHealth	1,428	1,240	1,090	188	15	150	14
OptumInsight	1,513	1,278	1,002	235	18	276	28
OptumRx	2,682	1,749	1,190	933	53	559	47
Optum	5,623	4,267	3,282	1,356	32	985	30
Consolidated earnings from operations	$ 12,930	$ 11,021	$ 10,274	$ 1,909	17%	$ 747	7%
Operating margin							
UnitedHealthcare	4.9%	5.1%	5.8%	(0.2)%		(0.7)%	
OptumHealth	8.4	8.9	9.9	(0.5)		(1.0)	
OptumInsight	20.6	20.6	19.2	—		1.4	
OptumRx	4.4	3.6	3.7	0.8		(0.1)	
Optum	6.7	6.3	6.9	0.4		(0.6)	
Consolidated operating margin	7.0%	7.0%	7.9%	—%		(0.9)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2016	2015	2014	Change 2016 vs. 2015		Change 2015 vs. 2014	
UnitedHealthcare Employer & Individual	$ 53,084	$ 47,194	$ 43,017	$ 5,890	12%	$ 4,177	10%
UnitedHealthcare Medicare & Retirement	56,329	49,735	46,258	6,594	13	3,477	8
UnitedHealthcare Community & State	32,945	28,911	23,586	4,034	14	5,325	23
UnitedHealthcare Global	6,223	5,503	6,937	720	13	(1,434)	(21)
Total UnitedHealthcare revenues	$148,581	$131,343	$119,798	$17,238	13%	$11,545	10%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2016	2015	2014	Change 2016 vs. 2015		Change 2015 vs. 2014	
Commercial risk-based — group	7,470	7,095	6,765	375	5%	330	5%
Commercial risk-based — individual	1,350	1,190	740	160	13	450	61
Commercial fee-based	18,900	18,565	18,350	335	2	215	1
Fee-based TRICARE	2,860	2,880	2,895	(20)	(1)	(15)	(1)
Total commercial	30,580	29,730	28,750	850	3	980	3
Medicare Advantage	3,630	3,235	3,005	395	12	230	8
Medicaid	5,890	5,305	5,055	585	11	250	5
Medicare Supplement (Standardized)	4,265	4,035	3,750	230	6	285	8
Total public and senior	13,785	12,575	11,810	1,210	10	765	6
Total UnitedHealthcare — domestic medical	44,365	42,305	40,560	2,060	5	1,745	4
International	4,220	4,090	4,425	130	3	(335)	(8)
Total UnitedHealthcare — medical	48,585	46,395	44,985	2,190	5%	1,410	3%
Supplemental Data:							
Medicare Part D stand-alone	4,930	5,060	5,165	(130)	(3)%	(105)	(2)%

Growth in services to the public sector, mid-sized employers, small groups and individuals led the overall increase in people served through risk-based benefit plans in the commercial market. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. Medicaid growth was driven by the combination of new state-based awards and growth in established programs. Medicare Supplement growth reflected strong customer retention and new sales.

UnitedHealthcare's revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends.

The increase in UnitedHealthcare's operating earnings was due to diversified growth, offset by guaranty fund assessments recorded in the fourth quarter of 2016. For more information on these assessments, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Operating earnings in 2015 included the establishment of premium deficiency reserves for 2016, primarily for individual ACA compliant business.

Optum

Total revenues and operating earnings increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth primarily due to growth in its health care delivery businesses as well as expansion of behavioral services into new Medicaid markets. Strong performance in business supporting UnitedHealthcare partially offset by investments in the health care delivery business drove the increase in earnings from operations.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management, business process outsourcing and technology services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to the full-year impact of Catamaran and organic growth. In 2016, OptumRx fulfilled 1.24 billion adjusted scripts compared to 932 million in 2015.

2015 RESULTS OF OPERATIONS COMPARED TO 2014 RESULTS

Consolidated Financial Results

Revenues

The increase in revenues was primarily driven by the effect of the Catamaran acquisition and organic growth in the number of individuals served across our benefits businesses and across all of Optum's businesses.

Medical Costs

Medical costs increased primarily due to risk-based membership growth in our benefits businesses. Medical costs also included losses on individual ACA compliant products related to 2015, and the establishment of premium deficiency reserves related to the 2016 policy year for anticipated future losses for in-force individual ACA compliant contracts and a new state Medicaid contract.

Operating Cost Ratio

The decrease in our operating cost ratio was due to the inclusion of Catamaran and growth in government benefits programs, both of which have lower operating cost ratios and Company wide productivity gains.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth during the year ended December 31, 2015 was due to growth in the number of individuals served across its businesses and price increases reflecting underlying medical cost trends.

UnitedHealthcare's operating earnings for the year ended December 31, 2015 decreased as the combined individual ACA compliant losses and premium deficiency reserves totaling $815 million more than offset strong growth across the business, improved medical cost management and increased productivity.

Optum

Total revenues and operating earnings increased for the year ended December 31, 2015 as each reporting segment increased revenues and earnings from operations by double-digit percentages as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth during the year ended December 31, 2015 primarily due to growth in its care delivery businesses and the impact of acquisitions in patient care centers and population health management services. The operating margins for the year ended December 31, 2015 decreased from the prior year primarily due to investments made to develop future growth opportunities.

OptumInsight

Revenue, earnings from operations and operating margins at OptumInsight for the year ended December 31, 2015 increased primarily due to expansion and growth in care provider revenue management services and payer services.

OptumRx

Revenue and earnings from operations for the year ended December 31, 2015 increased due to the mid-year acquisition of Catamaran as well as strong organic growth. Operating margins for the year ended December 31, 2015 decreased slightly due to the inclusion of lower margin Catamaran business.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In 2016, our U.S. regulated subsidiaries paid their parent companies dividends of $3.9 billion. For the year ended December 31, 2015, our U.S. regulated subsidiaries paid their parent companies dividends of $4.4 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2016	2015	2014	Change 2016 vs. 2015	Change 2015 vs. 2014
Sources of cash:					
Cash provided by operating activities	$ 9,795	$ 9,740	$ 8,051	$ 55	$ 1,689
Issuances of long-term debt and commercial paper, net of repayments	990	14,607	391	(13,617)	14,216
Proceeds from common share issuances	429	402	462	27	(60)
Sales and maturities of investments, net of purchases	—	—	799	—	(799)
Customer funds administered	1,692	768	—	924	768
Other	37	—	115	37	(115)
Total sources of cash	12,943	25,517	9,818		
Uses of cash:					
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed	(2,017)	(16,282)	(1,923)	14,265	(14,359)
Cash dividends paid	(2,261)	(1,786)	(1,362)	(475)	(424)
Common share repurchases	(1,280)	(1,200)	(4,008)	(80)	2,808
Purchases of property, equipment and capitalized software	(1,705)	(1,556)	(1,525)	(149)	(31)
Purchases of investments, net of sales and maturities	(5,927)	(531)	—	(5,396)	(531)
Customer funds administered	—	—	(638)	—	638
Other	(324)	(578)	(138)	254	(440)
Total uses of cash	(13,514)	(21,933)	(9,594)		
Effect of exchange rate changes on cash and cash equivalents	78	(156)	(5)	234	(151)
Net (decrease) increase in cash and cash equivalents	$ (493)	$ 3,428	$ 219	$ (3,921)	$ 3,209

2016 Cash Flows Compared to 2015 Cash Flows

Cash flows provided by operating activities increased slightly as higher net earnings were mostly offset by increased CMS receivables and other operating items.

Other significant changes in sources or uses of cash year-over-year included increased net purchases of investments in 2016 and the decreases in cash paid for acquisitions and proceeds from debt issuances due to the 2015 acquisition of Catamaran.

2015 Cash Flows Compared to 2014 Cash Flows

Cash flows provided by operating activities in 2015 increased primarily due to growth in risk-based products, which increased medical costs payable and an increase in CMS risk share payables, which increased other liabilities. These increases were partially offset by an increase in pharmacy rebates, which increased other receivables, the increase in the payment of the 2015 Health Insurance Industry Tax and the payment of Reinsurance Program fees in 2015.

Other significant changes in sources or uses of cash year-over-year included increased cash paid for acquisitions and net debt issuances and decreased share repurchases, all due to the Catamaran acquisition.

Financial Condition

As of December 31, 2016, our cash, cash equivalent and available-for-sale investment balances of $36.7 billion included $10.4 billion of cash and cash equivalents (of which approximately $700 million was available for general corporate use), $24.2 billion of debt securities and $2.0 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of "AA" as of December 31, 2016. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 55%. As of December 31, 2016, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities was approximately 44%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. In February 2016, we issued debt to repay commercial paper borrowings, which were incurred for general corporate and working capital purposes, and to repay our 5.375% notes that were due March 15, 2016. In December 2016, we issued debt to repay commercial paper borrowings, which were incurred for general corporate and working capital purposes. For more information on these debt issuances, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements."

Credit Ratings. Our credit ratings as of December 31, 2016 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Negative	A+	Negative	A-	Negative	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2016, we had Board authorization to purchase up to an additional 51 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2016, our Board increased our quarterly cash dividend to shareholders to an annual dividend rate of $2.50 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2016, under our various contractual obligations and commitments:

(in millions)	2017	2018 to 2019	2020 to 2021	Thereafter	Total
Debt (a)	$ 8,262	$ 6,282	$ 6,059	$ 27,899	$48,502
Operating leases	453	771	587	499	2,310
Purchase and other obligations (b)	623	617	297	170	1,707
Future policy benefits (c)	133	271	273	1,980	2,657
Unrecognized tax benefits (d)	19	—	—	234	253
Other liabilities recorded on the Consolidated Balance Sheet (e)	269	14	5	2,288	2,576
Redeemable noncontrolling interests (f)	958	1,054	—	—	2,012
Total contractual obligations	$10,717	$ 9,009	$ 7,221	$ 33,070	$60,017

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2016.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter."

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."

(f) Includes commitments for redeemable shares of our subsidiaries.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2016, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of 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 professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2016, our days outstanding in medical payables was 51 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each 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). Medical costs in 2016, 2015 and 2014 included favorable medical cost development related to prior years of $220 million, $320 million and $420 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2016:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 437
(0.50)	291
(0.25)	145
0.25	(144)
0.50	(288)
0.75	(430)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and by reviewing a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2016:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 557
2	371
1	186
(1)	(186)
(2)	(371)
(3)	(557)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2016; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2016 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2016 net earnings would have increased or decreased by $90 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS’ retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial

Statements." Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us to CMS.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analysis. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the "Medical Cost Trend" section of Executive Overview-Business Trends above and the discussion in the "Medical Costs Payable" critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. We completed our annual impairment tests for goodwill as of October 1, 2016. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2016.

Investments

Our investments are principally classified as available-for-sale and are recorded at fair value. We continually monitor the difference between the cost and fair value of our investments.

Other-Than-Temporary Impairment Assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

The judgments and estimates related to other-than-temporary impairment may ultimately prove to be inaccurate due to many factors, including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2016, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real.

As of December 31, 2016, we had $13.2 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2016, $12.4 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2016, $21.9 billion of our investments were fixed-rate debt securities and $25.2 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2016 and 2015 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2016			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 263	$ 245	$ (1,711)	$ (3,470)
1	132	122	(873)	(1,860)
(1)	(105)	(95)	855	2,244
(2)	nm	nm	1,562	4,784

	December 31, 2015			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 258	$ 257	$ (1,388)	$ (3,233)
1	129	128	(702)	(1,746)
(1)	(80)	(55)	677	2,085
(2)	nm	nm	1,132	4,442

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2016 and 2015, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2016 and 2015, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of UnitedHealthcare Brazil's operating results at the average exchange rate over the accounting period, and

UnitedHealthcare Brazil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2016, a hypothetical 10% and 25% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $400 million and $900 million, respectively. We manage exposure to foreign currency earnings risk by conducting our international business operations primarily in their functional currencies.

As of December 31, 2016, we had $2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates. Valuations in venture capital funds are subject to conditions affecting health care and technology stocks and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2016, based on the criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 8, 2017, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 8, 2017

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$ 10,430	$ 10,923
Short-term investments	2,845	1,988
Accounts receivable, net of allowances of $514 and $333	8,152	6,523
Other current receivables, net of allowances of $409 and $138	7,499	6,801
Assets under management	3,105	2,998
Prepaid expenses and other current assets	1,848	2,406
Total current assets	33,879	31,639
Long-term investments	23,868	18,792
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $3,749 and $3,173	5,901	4,861
Goodwill	47,584	44,453
Other intangible assets, net of accumulated amortization of $3,847 and $3,128	8,541	8,391
Other assets	3,037	3,118
Total assets	$ 122,810	$ 111,254
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 16,391	$ 14,330
Accounts payable and accrued liabilities	13,361	11,994
Commercial paper and current maturities of long-term debt	7,193	6,634
Unearned revenues	1,968	2,142
Other current liabilities	10,339	7,798
Total current liabilities	49,252	42,898
Long-term debt, less current maturities	25,777	25,331
Future policy benefits	2,524	2,496
Deferred income taxes	2,761	3,587
Other liabilities	2,307	1,481
Total liabilities	82,621	75,793
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	2,012	1,736
Equity:		
Preferred stock, $0.001 par value —10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value—3,000 shares authorized; 952 and 953 issued and outstanding	10	10
Additional paid-in capital	—	29
Retained earnings	40,945	37,125
Accumulated other comprehensive loss	(2,681)	(3,334)
Nonredeemable noncontrolling interest	(97)	(105)
Total equity	38,177	33,725
Total liabilities, redeemable noncontrolling interests and equity	$ 122,810	$ 111,254

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2016	2015	2014
Revenues:			
Premiums	$144,118	$127,163	$115,302
Products	26,658	17,312	4,242
Services	13,236	11,922	10,151
Investment and other income	828	710	779
Total revenues	184,840	157,107	130,474
Operating costs:			
Medical costs	117,038	103,875	93,633
Operating costs	28,401	24,312	21,263
Cost of products sold	24,416	16,206	3,826
Depreciation and amortization	2,055	1,693	1,478
Total operating costs	171,910	146,086	120,200
Earnings from operations	12,930	11,021	10,274
Interest expense	(1,067)	(790)	(618)
Earnings before income taxes	11,863	10,231	9,656
Provision for income taxes	(4,790)	(4,363)	(4,037)
Net earnings	7,073	5,868	5,619
Earnings attributable to noncontrolling interests	(56)	(55)	—
Net earnings attributable to UnitedHealth Group common shareholders	$ 7,017	$ 5,813	$ 5,619
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 7.37	$ 6.10	$ 5.78
Diluted	$ 7.25	$ 6.01	$ 5.70
Basic weighted-average number of common shares outstanding	952	953	972
Dilutive effect of common share equivalents	16	14	14
Diluted weighted-average number of common shares outstanding	968	967	986
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	3	8	6
Cash dividends declared per common share	$ 2.375	$ 1.875	$ 1.405

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2016	2015	2014
Net earnings	$ 7,073	$ 5,868	$ 5,619
Other comprehensive income (loss):			
Gross unrealized (losses) gains on investment securities during the period	(73)	(123)	476
Income tax effect	26	44	(173)
Total unrealized (losses) gains, net of tax	(47)	(79)	303
Gross reclassification adjustment for net realized gains included in net earnings	(166)	(141)	(211)
Income tax effect	60	53	77
Total reclassification adjustment, net of tax	(106)	(88)	(134)
Total foreign currency translation gains (losses)	806	(1,775)	(653)
Other comprehensive income (loss)	653	(1,942)	(484)
Comprehensive income	7,726	3,926	5,135
Comprehensive income attributable to noncontrolling interests	(56)	(55)	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$ 7,670	$ 3,871	$ 5,135

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interest	Total Equity
Balance at January 1, 2014	988	$ 10	$ —	$ 33,047	$ 54	$ (962)	$ —	$32,149
Net earnings				5,619				5,619
Other comprehensive income (loss)					169	(653)		(484)
Issuances of common stock, and related tax effects	15	—	146					146
Share-based compensation, and related tax benefits			394					394
Common share repurchases	(49)	—	(540)	(3,468)				(4,008)
Cash dividends paid on common shares				(1,362)				(1,362)
Balance at December 31, 2014	954	10	—	33,836	223	(1,615)	—	32,454
Net earnings				5,813			26	5,839
Other comprehensive loss					(167)	(1,775)		(1,942)
Issuances of common stock, and related tax effects	10	—	127					127
Share-based compensation, and related tax benefits			589					589
Common share repurchases	(11)	—	(462)	(738)				(1,200)
Cash dividends paid on common shares				(1,786)				(1,786)
Redeemable noncontrolling interests fair value and other adjustments			(225)					(225)
Acquisition of nonredeemable noncontrolling interest							9	9
Distributions to nonredeemable noncontrolling interest							(140)	(140)
Balance at December 31, 2015	953	10	29	37,125	56	(3,390)	(105)	33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interests fair value and other adjustments			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016	952	$ 10	$ —	$ 40,945	$ (97)	$ (2,584)	$ (97)	$38,177

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2016	2015	2014
Operating activities			
Net earnings	$ 7,073	$ 5,868	$ 5,619
Noncash items:			
Depreciation and amortization	2,055	1,693	1,478
Deferred income taxes	81	(73)	(117)
Share-based compensation	485	406	364
Other, net	(82)	(235)	(298)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,357)	(591)	(911)
Other assets	(1,601)	(1,430)	(590)
Medical costs payable	1,849	2,585	484
Accounts payable and other liabilities	1,494	1,280	1,637
Unearned revenues	(202)	237	385
Cash flows from operating activities	9,795	9,740	8,051
Investing activities			
Purchases of investments	(17,547)	(9,939)	(9,928)
Sales of investments	7,339	6,054	7,701
Maturities of investments	4,281	3,354	3,026
Cash paid for acquisitions, net of cash assumed	(1,760)	(16,164)	(1,923)
Purchases of property, equipment and capitalized software	(1,705)	(1,556)	(1,525)
Other, net	37	(144)	115
Cash flows used for investing activities	(9,355)	(18,395)	(2,534)
Financing activities			
Acquisition of redeemable noncontrolling interest shares	(257)	(118)	—
Common share repurchases	(1,280)	(1,200)	(4,008)
Cash dividends paid	(2,261)	(1,786)	(1,362)
Proceeds from common stock issuances	429	402	462
Repayments of long-term debt	(2,596)	(1,041)	(812)
(Repayments of) proceeds from commercial paper, net	(382)	3,666	(794)
Proceeds from issuance of long-term debt	3,968	11,982	1,997
Customer funds administered	1,692	768	(638)
Other, net	(324)	(434)	(138)
Cash flows (used for) from financing activities	(1,011)	12,239	(5,293)
Effect of exchange rate changes on cash and cash equivalents	78	(156)	(5)
(Decrease) increase in cash and cash equivalents	(493)	3,428	219
Cash and cash equivalents, beginning of period	10,923	7,495	7,276
Cash and cash equivalents, end of period	$ 10,430	$ 10,923	$ 7,495
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,055	$ 639	$ 644
Cash paid for income taxes	4,726	4,401	4,024

See Notes to the Consolidated Financial Statements

UnitedHealth Group

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to helping people live healthier lives and helping to make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within the Company's two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other current liabilities and other current receivables and valuations of certain investments. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time on either a time and materials basis, or ratably as services are performed or made available to customers.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2016.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes

available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, 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 processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation).

For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its mail and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and records rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates from two to five months after billing. As of December 31, 2016 and 2015, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $3.3 billion and $2.6 billion, respectively.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to premium revenues in the Consolidated Statements of Operations and other current liabilities or other current receivables in the Consolidated Balance Sheets.
- *Drug Discount.* The ACA mandated a consumer discount on brand name prescription drugs for Medicare Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as premium revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in unearned revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy care costs and administrative costs under the contract are expensed as incurred and are recognized in medical costs and operating costs, respectively, in the Consolidated Statements of Operations.

The final 2016 risk-share amount is expected to be settled during the second half of 2017, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2016			December 31, 2015		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$ 934	$ 543	$ —	$ 1,703	$ 423	$ —
Other current liabilities	—	267	471	—	58	496

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2016.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2016.

Accounts Payable and Accrued Liabilities

The Company had checks outstanding of $1.5 billion and $1.6 billion as of December 31, 2016 and 2015, respectively, which were classified as accounts payable and accrued liabilities and the change in this balance has been reflected within other financing activities in the Consolidated Statements of Cash Flows.

Other Current Liabilities

Other current liabilities include health savings account deposits ($5.7 billion and $3.6 billion as of December 31, 2016 and 2015, respectively), the RSF associated with the AARP Program, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Future Policy Benefits

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2016 and 2015:

(in millions)	2016	2015
Redeemable noncontrolling interests, beginning of period	$1,736	$1,388
Net earnings	16	29
Acquisitions	34	196
Redemptions	(123)	(116)
Distributions	(11)	(19)
Fair value and other adjustments	360	258
Redeemable noncontrolling interests, end of period	$2,012	$1,736

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably; primarily over two to five years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP) eligible employees are allowed to purchase the Company's

stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP, (collectively, common stock equivalents) using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and any unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method of allocation over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets. A provision in the 2016 Federal Budget imposed a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax.

Premium Stabilization Programs

The ACA included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program).

The risk-adjustment provisions apply to market reform compliant individual and small group plans in the commercial markets. Under the program, each covered member is assigned a risk score based upon demographic information and applicable diagnostic codes from the current year paid claims, in order to determine an average risk score for each plan in a particular state and market risk pool. Generally, a plan with a risk score that is less than the state's average risk score will pay into the pool, while a plan with a risk score that is greater than the state's average will receive money from the pool. The temporary risk corridors provisions are intended to limit the gains and losses of individual and small group qualified health plans. Plans are required to calculate the U.S. Department of Health and Human Services (HHS) risk corridor ratio of allowable costs to the defined target amount. Qualified health plans with ratios below 97% are required to make payments to HHS, while plans with ratios greater than 103% expect to receive funds from HHS. The Reinsurance Program and temporary risk corridors program expired at the end of 2016.

For the Premium Stabilization Programs, the Company records a receivable or payable as an adjustment to premium revenue based on year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final adjustments or recoverable amounts to the Premium Stabilization Programs are determined by HHS in the year following the policy year.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" (ASU 2016-02). Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. Companies are required to adopt the new standard using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption of ASU 2016-02 is permitted. When adopted, the Company does not expect ASU 2016-02 to have a material impact on its results of operations, equity or cash flows. The impact of ASU 2016-02 on the Company's consolidated financial position will be based on leases outstanding at the time of adoption.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments — Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). The new guidance changes the current accounting related to (i) the classification and measurement of certain equity investments, (ii) the presentation of changes in the fair value of financial liabilities measured under the fair value option that are due to instrument-specific credit risk, and (iii) certain disclosures associated with the fair value of financial instruments. Most notably, ASU 2016-01 requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The new guidance is effective for annual and interim reporting periods beginning after December 15, 2017. As of December 31, 2016, based on equity securities held, the Company does not expect ASU 2016-01 to have a material impact on its consolidated financial position, results of operations, equity or cash flows. The Company will continue to evaluate any changes in its mix of investments or market conditions and the related impact of ASU 2016-01.

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09) as modified by ASU No. 2015-14, "Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date," ASU 2016-08, "Revenue from Contracts with Customers (Topic 606): Principal versus Agent Considerations (Reporting Revenue Gross versus Net)," ASU No. 2016-10, "Revenue from Contracts with Customers (Topic 606): Identifying Performance Obligations and Licensing," ASU No. 2016-12, "Revenue from Contracts with Customers (Topic 606): Narrow-Scope Improvements and Practical Expedients," and ASU 2016-20, "Revenue from Contracts with Customers (Topic 606): Technical Corrections and Improvements." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies may adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. The Company early adopted the new standard effective January 1, 2017, as allowed, using the modified retrospective approach. As the majority of the Company's revenues are not subject to the new guidance, the adoption of ASU 2014-09 did not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In March 2016, the FASB issued ASU No. 2016-09, "Compensation-Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting" (ASU 2016-09). ASU 2016-09 modifies several aspects of the accounting for share-based payment awards, including income tax consequences, and classification on the statement of cash flows. The Company early adopted ASU 2016-09 in the first quarter of 2016. The provisions of ASU 2016-09 related to the timing of when excess tax benefits are recognized, minimum statutory

withholding requirements and forfeitures were adopted using a modified retrospective transition method by means of a cumulative-effect adjustment to equity as of January 1, 2016. The provisions of ASU 2016-09 related to the recognition of excess tax benefits in the income statement and classification in the statement of cash flows were adopted prospectively and the prior periods were not retrospectively adjusted. The adoption of ASU 2016-09 did not materially impact the Company's consolidated financial position, results of operations, equity or cash flows.

In November 2015, the FASB issued ASU No. 2015-17, "Income Taxes (Topic 740): Balance Sheet Classification of Deferred Taxes" (ASU 2015-17). ASU 2015-17 requires entities to present deferred tax assets and deferred tax liabilities as noncurrent on the balance sheet. Prior to the issuance of ASU 2015-17, deferred taxes were required to be presented as a net current asset or liability and a net noncurrent asset or liability. The Company adopted ASU 2015-17 on a prospective basis in the first quarter of 2016 and the prior period was not retrospectively adjusted. The adoption of ASU 2015-17 did not impact the Company's consolidated financial position, results of operations, equity or cash flows.

In May 2015, the FASB issued ASU No. 2015-09, "Financial Services — Insurance (Topic 944): Disclosures about Short-Duration Contracts" (ASU 2015-09). ASU 2015-09 requires insurance entities to provide additional disclosures about short-duration insurance liabilities, including incurred and paid medical costs information by year. The Company adopted the disclosure requirements of ASU 2015-09 and has included the new disclosures within Notes 2 and 7.

In April 2015, the FASB issued ASU No. 2015-03, "Interest-Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs" (ASU 2015-03). ASU 2015-03 requires debt issuance costs to be presented as a reduction of the carrying amount of the related debt liability. Prior to the issuance of ASU 2015-03, debt issuance costs were required to be presented as an asset on the balance sheet. The Company adopted ASU 2015-03 on a retrospective basis, as required, in the first quarter of 2016. The Company reclassified $129 million and $82 million in debt issuance costs that were recorded in other assets to long-term debt, less current maturities on the Consolidated Balance Sheet as of December 31, 2015 and 2014, respectively.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2016				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,294	$ 1	$ (31)	$ 2,264
State and municipal obligations	7,120	40	(101)	7,059
Corporate obligations	10,944	41	(58)	10,927
U.S. agency mortgage-backed securities	2,963	7	(43)	2,927
Non-U.S. agency mortgage-backed securities	1,009	3	(10)	1,002
Total debt securities — available-for-sale	24,330	92	(243)	24,179
Equity securities	2,036	52	(47)	2,041
Debt securities — held-to-maturity:				
U.S. government and agency obligations	250	1	—	251
State and municipal obligations	5	—	—	5
Corporate obligations	238	—	—	238
Total debt securities — held-to-maturity	493	1	—	494
Total investments	$ 26,859	$ 145	$ (290)	$26,714
December 31, 2015				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,982	$ 1	$ (6)	$ 1,977
State and municipal obligations	6,022	149	(3)	6,168
Corporate obligations	7,446	41	(81)	7,406
U.S. agency mortgage-backed securities	2,127	13	(16)	2,124
Non-U.S. agency mortgage-backed securities	962	5	(11)	956
Total debt securities — available-for-sale	18,539	209	(117)	18,631
Equity securities	1,638	58	(57)	1,639
Debt securities — held-to-maturity:				
U.S. government and agency obligations	163	1	—	164
State and municipal obligations	8	—	—	8
Corporate obligations	339	—	—	339
Total debt securities — held-to-maturity	510	1	—	511
Total investments	$ 20,687	$ 268	$ (174)	$20,781

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2016.

The amortized cost and fair value of debt securities as of December 31, 2016, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 2,893	$ 2,895	$ 151	$ 151
Due after one year through five years	9,646	9,625	153	153
Due after five years through ten years	5,706	5,645	124	124
Due after ten years	2,113	2,085	65	66
U.S. agency mortgage-backed securities	2,963	2,927	—	—
Non-U.S. agency mortgage-backed securities	1,009	1,002	—	—
Total debt securities	$ 24,330	$24,179	$ 493	$ 494

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2016						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,794	$ (31)	$ —	$ —	$ 1,794	$ (31)
State and municipal obligations	4,376	(101)	—	—	4,376	(101)
Corporate obligations	5,128	(56)	137	(2)	5,265	(58)
U.S. agency mortgage-backed securities	2,247	(40)	79	(3)	2,326	(43)
Non-U.S. agency mortgage-backed securities	544	(7)	97	(3)	641	(10)
Total debt securities — available-for-sale	$14,089	$ (235)	$ 313	$ (8)	$14,402	$ (243)
Equity securities	$ 93	$ (5)	$ 91	$ (42)	$ 184	$ (47)
December 31, 2015						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,473	$ (6)	$ —	$ —	$ 1,473	$ (6)
State and municipal obligations	650	(3)	—	—	650	(3)
Corporate obligations	4,629	(63)	339	(18)	4,968	(81)
U.S. agency mortgage-backed securities	1,304	(12)	116	(4)	1,420	(16)
Non-U.S. agency mortgage-backed securities	593	(7)	127	(4)	720	(11)
Total debt securities — available-for-sale	$ 8,649	$ (91)	$ 582	$ (26)	$ 9,231	$ (117)
Equity securities	$ 112	$ (11)	$ 89	$ (46)	$ 201	$ (57)

The Company's unrealized losses from all securities as of December 31, 2016 were generated from approximately 12,000 positions out of a total of 27,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2016, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, venture capital funds and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

	For the Years Ended December 31,		
(in millions)	2016	2015	2014
Total other-than-temporary impairment recognized in earnings	$ (45)	$ (22)	$ (26)
Gross realized losses from sales	(44)	(28)	(47)
Gross realized gains from sales	255	191	284
Net realized gains (included in investment and other income on the Consolidated Statements of Operations)	166	141	211
Income tax effect (included in provision for income taxes on the Consolidated Statements of Operations)	(60)	(53)	(77)
Realized gains, net of taxes	$ 106	$ 88	$ 134

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there was no transfer between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2016 or 2015.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2016 or 2015.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Other Assets. The fair values of the Company's other assets are estimated and classified using the same methodologies as the Company's investments in debt securities.

Interest Rate Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information, including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2016				
Cash and cash equivalents	$ 10,386	$ 44	$ —	$10,430
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,017	247	—	2,264
State and municipal obligations	—	7,059	—	7,059
Corporate obligations	21	10,804	102	10,927
U.S. agency mortgage-backed securities	—	2,927	—	2,927
Non-U.S. agency mortgage-backed securities	—	1,002	—	1,002
Total debt securities — available-for-sale	2,038	22,039	102	24,179
Equity securities	1,591	13	437	2,041
Assets under management	1,064	2,041	—	3,105
Interest rate swap assets	—	55	—	55
Total assets at fair value	$ 15,079	$ 24,192	$ 539	$39,810
Percentage of total assets at fair value	38%	61%	1%	100%
Interest rate swap liabilities	$ —	$ 14	$ —	$ 14
December 31, 2015				
Cash and cash equivalents	$ 10,906	$ 17	$ —	$10,923
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,779	198	—	1,977
State and municipal obligations	—	6,168	—	6,168
Corporate obligations	5	7,308	93	7,406
U.S. agency mortgage-backed securities	—	2,124	—	2,124
Non-U.S. agency mortgage-backed securities	—	951	5	956
Total debt securities — available-for-sale	1,784	16,749	98	18,631
Equity securities	1,223	14	402	1,639
Assets under management	832	2,166	—	2,998
Interest rate swap assets	—	93	—	93
Total assets at fair value	$ 14,745	$ 19,039	$ 500	$34,284
Percentage of total assets at fair value	43%	56%	1%	100%
Interest rate swap liabilities	$ —	$ 11	$ —	$ 11

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2016					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 251	$ —	$ —	$ 251	$ 250
State and municipal obligations	—	—	5	5	5
Corporate obligations	20	8	210	238	238
Total debt securities — held-to-maturity	$ 271	$ 8	$ 215	$ 494	$ 493
Other assets	$ —	$ 476	$ —	$ 476	$ 471
Long-term debt and other financing obligations	$ —	$ 31,295	$ —	$31,295	$29,337
December 31, 2015					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 164	$ —	$ —	$ 164	$ 163
State and municipal obligations	—	—	8	8	8
Corporate obligations	91	10	238	339	339
Total debt securities — held-to-maturity	$ 255	$ 10	$ 246	$ 511	$ 510
Other assets	$ —	$ 493	$ —	$ 493	$ 500
Long-term debt and other financing obligations	$ —	$ 29,455	$ —	$29,455	$27,978

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2016			December 31, 2015			December 31, 2014		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 98	$ 402	$500	$ 74	$ 310	$384	$ 42	$ 269	$ 311
Purchases	12	100	112	27	106	133	32	105	137
Sales	(9)	(29)	(38)	(4)	(24)	(28)	(1)	(180)	(181)
Net unrealized gains (losses) in accumulated other comprehensive income	1	(13)	(12)	2	5	7	1	6	7
Net realized (losses) gains in investment and other income	—	(23)	(23)	(1)	5	4	—	110	110
Balance at end of period	$ 102	$ 437	$539	$ 98	$ 402	$500	$ 74	$ 310	$ 384

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
December 31, 2016					
Equity securities:					
Venture capital portfolios	$ 404	Market approach — comparable companies	Revenue multiple	1.0	6.0
			EBITDA multiple	8.0	12.0
	33	Market approach — recent transactions	Inactive market transactions	N/A	N/A
Total equity securities	$ 437				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $102 million of available-for-sale debt securities as of December 31, 2016, which were not significant.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2016	December 31, 2015
Land and improvements	$ 324	$ 237
Buildings and improvements	3,148	2,420
Computer equipment	2,021	1,945
Furniture and fixtures	999	790
Less accumulated depreciation	(2,621)	(2,163)
Property and equipment, net	3,871	3,229
Capitalized software	3,158	2,642
Less accumulated amortization	(1,128)	(1,010)
Capitalized software, net	2,030	1,632
Total property, equipment and capitalized software, net	$ 5,901	$ 4,861

Depreciation expense for property and equipment for the years ended December 31, 2016, 2015 and 2014 was $698 million, $613 million and $532 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2016, 2015 and 2014 was $475 million, $430 million and $422 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2015	$ 24,030	$ 3,834	$ 4,236	$ 840	$ 32,940
Acquisitions	128	1,817	89	10,732	12,766
Foreign currency effects and adjustments, net	(1,233)	9	(29)	—	(1,253)
Balance at December 31, 2015	22,925	5,660	4,296	11,572	44,453
Acquisitions	526	683	—	1,387	2,596
Foreign currency effects and adjustments, net	403	(21)	153	—	535
Balance at December 31, 2016	$ 23,854	$ 6,322	$ 4,449	$ 12,959	$ 47,584

During the third quarter of 2015, the Company acquired all of the outstanding common shares of Catamaran Corporation and funded Catamaran's payoff of its outstanding debt and credit facility for a total of $14.3 billion in cash. This combination diversified OptumRx's customer and business mix and enhanced OptumRx's technology capabilities and flexible service offerings. The total consideration exceeded the estimated fair value of the net tangible assets acquired by $16.0 billion, of which $5.4 billion has been allocated to finite-lived intangible assets and $10.6 billion to goodwill. The goodwill is not deductible for income tax purposes.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2016			December 31, 2015		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$10,942	$ (3,416)	$ 7,526	$10,270	$ (2,796)	$ 7,474
Trademarks and technology	720	(323)	397	682	(249)	433
Trademarks — indefinite-lived	468	—	468	358	—	358
Other	258	(108)	150	209	(83)	126
Total	$12,388	$ (3,847)	$ 8,541	$11,519	$ (3,128)	$ 8,391

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2016		2015	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$785	17 years	$5,518	19 years
Trademarks and technology	82	4 years	194	4 years
Other	22	5 years	—	
Total acquired finite-lived intangible assets	$889	16 years	$5,712	19 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2017	$865
2018	755
2019	679
2020	596
2021	536

Amortization expense relating to intangible assets for the years ended December 31, 2016, 2015 and 2014 was $882 million, $650 million and $524 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2016	2015	2014
Medical costs payable, beginning of period	$ 14,330	$ 12,040	$ 11,575
Reported medical costs:			
Current year	117,258	104,195	94,053
Prior years	(220)	(320)	(420)
Total reported medical costs	117,038	103,875	93,633
Medical payments:			
Payments for current year	(101,696)	(90,630)	(82,750)
Payments for prior years	(13,281)	(10,955)	(10,418)
Total medical payments	(114,977)	(101,585)	(93,168)
Medical costs payable, end of period	$ 16,391	$ 14,330	$ 12,040

For the years ended December 31, 2016, 2015 and 2014 the medical cost reserve development included no individual factors that were material.

Medical costs payable included IBNR of $11.6 billion and $9.8 billion at December 31, 2016 and 2015, respectively. Substantially all of the IBNR balance as of December 31, 2016 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2016:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2015	2016
2015	$ 104,195	$ 103,973
2016		117,258
Total		$ 221,231

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2015	2016
2015	$ (90,630)	$ (103,885)
2016		(101,696)
Total		(205,581)
Net remaining outstanding liabilities prior to 2015		741
Total medical costs payable		$ 16,391

8. Commercial Paper and Long-Term Debt

Commercial paper, term loan and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2016			December 31, 2015		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value (a)	Fair Value
Commercial paper	$ 3,633	$ 3,633	$ 3,633	$ 3,987	$ 3,987	$ 3,987
Floating rate term loan due July 2016	—	—	—	1,500	1,500	1,500
5.375% notes due March 2016	—	—	—	601	605	606
1.875% notes due November 2016	—	—	—	400	400	403
5.360% notes due November 2016	—	—	—	95	95	98
Floating rate notes due January 2017	750	750	750	750	749	751
6.000% notes due June 2017	441	446	450	441	458	469
1.450% notes due July 2017	750	750	751	750	749	750
1.400% notes due October 2017	625	624	626	625	624	624
6.000% notes due November 2017	156	159	163	156	162	168
1.400% notes due December 2017	750	751	750	750	751	748
6.000% notes due February 2018	1,100	1,107	1,153	1,100	1,114	1,196
1.900% notes due July 2018	1,500	1,496	1,507	1,500	1,494	1,505
1.700% notes due February 2019	750	748	748	—	—	—
1.625% notes due March 2019	500	501	498	500	502	494
2.300% notes due December 2019	500	498	504	500	499	502
2.700% notes due July 2020	1,500	1,495	1,523	1,500	1,493	1,516
3.875% notes due October 2020	450	450	474	450	452	476
4.700% notes due February 2021	400	409	433	400	413	438
2.125% notes due March 2021	750	745	741	—	—	—
3.375% notes due November 2021	500	497	519	500	500	517
2.875% notes due December 2021	750	748	760	750	753	760
2.875% notes due March 2022	1,100	1,057	1,114	1,100	1,059	1,099
3.350% notes due July 2022	1,000	995	1,030	1,000	994	1,023
0.000% notes due November 2022	15	11	12	15	10	11
2.750% notes due February 2023	625	609	622	625	611	613
2.875% notes due March 2023	750	771	753	750	781	742
3.750% notes due July 2025	2,000	1,986	2,070	2,000	1,985	2,062
3.100% notes due March 2026	1,000	994	986	—	—	—
3.450% notes due January 2027	750	745	762	—	—	—
4.625% notes due July 2035	1,000	991	1,090	1,000	991	1,038
5.800% notes due March 2036	850	837	1,034	850	838	1,003
6.500% notes due June 2037	500	491	643	500	492	628
6.625% notes due November 2037	650	640	850	650	641	829
6.875% notes due February 2038	1,100	1,075	1,497	1,100	1,076	1,439
5.700% notes due October 2040	300	296	366	300	296	348
5.950% notes due February 2041	350	345	437	350	345	416
4.625% notes due November 2041	600	588	634	600	588	609
4.375% notes due March 2042	502	483	509	502	483	493
3.950% notes due October 2042	625	606	609	625	606	582
4.250% notes due March 2043	750	734	765	750	734	728
4.750% notes due July 2045	2,000	1,972	2,203	2,000	1,971	2,107
4.200% notes due January 2047	750	737	759	—	—	—
Total commercial paper, term loan and long-term debt	$33,022	$32,770	$34,728	$31,972	$31,801	$33,278

(a) In the first quarter of 2016, the Company adopted ASU 2015-03, retrospectively as required. See Note 2 for more information on the adoption of ASU 2015-03.

The Company's long-term debt obligations also included $200 million and $164 million of other financing obligations, of which $80 million and $47 million were current as of December 31, 2016 and 2015, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2017	$ 7,185
2018	2,622
2019	1,769
2020	1,955
2021	2,407
Thereafter	17,284

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2016, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.9%.

The Company has $3.0 billion five-year, $2.0 billion three-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in December 2021, December 2019, and December 2017, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2016, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2016, annual interest rates would have ranged from 1.6% to 2.2%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 55%. The Company was in compliance with its debt covenants as of December 31, 2016.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2016	2015	2014
Current Provision:			
Federal	$4,397	$4,155	$3,883
State and local	312	281	271
Total current provision	4,709	4,436	4,154
Deferred provision (benefit)	81	(73)	(117)
Total provision for income taxes	$4,790	$4,363	$4,037

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2016		2015		2014	
Tax provision at the U.S. federal statutory rate	$4,152	35.0%	$3,581	35.0%	$3,380	35.0%
Health insurance industry tax	645	5.4	627	6.1	469	4.8
State income taxes, net of federal benefit	205	1.7	145	1.4	154	1.6
Share-based awards — excess tax benefit	(158)	(1.3)	—	—	—	—
Non-deductible compensation	128	1.1	103	1.0	96	1.0
Other, net	(182)	(1.5)	(93)	(0.9)	(62)	(0.6)
Provision for income taxes	$4,790	40.4%	$4,363	42.6%	$4,037	41.8%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2016	2015
Deferred income tax assets:		
Accrued expenses and allowances	$ 820	$ 739
U.S. federal and state net operating loss carryforwards	147	139
Share-based compensation	126	124
Nondeductible liabilities	236	205
Medical costs payable and other current liabilities	95	71
Non-U.S. tax loss carryforwards	434	244
Net unrealized losses on investments	55	—
Other-domestic	194	214
Other-non-U.S.	175	130
Subtotal	2,282	1,866
Less: valuation allowances	(55)	(44)
Total deferred income tax assets	2,227	1,822
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(3,055)	(2,951)
Non-U.S. goodwill and intangible assets	(584)	(397)
Capitalized software	(707)	(574)
Net unrealized gains on investments	—	(34)
Depreciation and amortization	(332)	(312)
Prepaid expenses	(228)	(205)
Other-non-U.S.	(82)	(76)
Total deferred income tax liabilities	(4,988)	(4,549)
Net deferred income tax liabilities	$(2,761)	$(2,727)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $74 million expire beginning in 2021 through 2036; state net operating loss carryforwards expire beginning in 2017 through 2036. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2016, the Company had $717 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2016	2015	2014
Gross unrecognized tax benefits, beginning of period	$224	$ 92	$89
Gross increases:			
Current year tax positions	37	—	—
Prior year tax positions	24	55	4
Acquired reserves	—	89	—
Gross decreases:			
Prior year tax positions	(4)	(2)	—
Settlements	(6)	(1)	—
Statute of limitations lapses	(12)	(9)	(1)
Gross unrecognized tax benefits, end of period	$263	$224	$92

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $197 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statement of Operations. During the years ended December 31, 2016, 2015 and 2014 the Company recognized $11 million, $11 million and $6 million of interest and penalties, respectively. The Company had $70 million and $59 million of accrued interest and penalties for uncertain tax positions as of December 31, 2016 and 2015, respectively. These amounts are not included in the reconciliation above.

The Company currently files income tax returns in the United States, various states and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2015 and prior. The Company's 2016 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2010 tax year. The Brazilian federal revenue service — Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2016, the Company's regulated subsidiaries paid their parent companies dividends of $3.9 billion, including $3.3 billion of extraordinary dividends. For the year ended December 31, 2015, the Company's regulated subsidiaries paid their parent companies dividends of $4.4 billion, including $1.5 billion of extraordinary dividends. As of December 31, 2016, approximately $700 million of the Company's $10.4 billion of cash and cash equivalents was available for general corporate use.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $17.9 billion as of December 31, 2016. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $10.5 billion as of December 31, 2016.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, common equity Tier1 risk-based capital and total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2016, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2014, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2016 and 2015 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2016**	**2015**
Common share repurchases, shares	10	11
Common share repurchases, average price per share	$ 128.97	$ 112.45
Common share repurchases, aggregate cost	$ 1,280	$ 1,200
Board authorized shares remaining	51	61

Dividends

In June 2016, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to equal an annual dividend rate of $2.50 per share compared to the annual dividend rate of $2.00 per share, which the Company had paid since June 2015. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2016, the Company had 68 million shares available for future grants of share-based awards under the Plan. As of December 31, 2016, there were also 10 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2016 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	34	$ 68		
Granted	11	113		
Exercised	(8)	57		
Forfeited	(1)	103		
Outstanding at end of period	36	84	6.6	$ 2,758
Exercisable at end of period	14	56	4.0	1,458
Vested and expected to vest, end of period	35	83	6.6	2,704

Restricted Shares

Restricted share activity for the year ended December 31, 2016 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	$ 82
Granted	3	115
Vested	(3)	76
Nonvested at end of period	7	96

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2016	2015	2014
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 20	$ 22	$ 22
Total intrinsic value of stock options and SARs exercised	595	482	526
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	115	110	71
Total fair value of restricted shares vested	$274	$460	$437
Employee Stock Purchase Plan			
Number of shares purchased	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$485	$406	$364
Share-based compensation expense, net of tax effects	417	348	314
Income tax benefit realized from share-based award exercises	236	247	231

(in millions, except years)	December 31, 2016
Unrecognized compensation expense related to share awards	$ 516
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2016	2015	2014
Risk-free interest rate	1.2% - 1.4%	1.6% - 1.7%	1.7% -1.8%
Expected volatility	20.8% - 22.5%	22.3% - 24.1%	24.1% - 39.6%
Expected dividend yield	1.8%	1.4% - 1.7%	1.6% - 1.9%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.6 - 5.9	5.5 - 6.1	5.4

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2016, 2015 and 2014.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $672 million and $553 million as of December 31, 2016 and 2015, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2016, 2015 and 2014 was $608 million, $555 million and $449 million, respectively.

As of December 31, 2016, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2017	$ 453
2018	416
2019	355
2020	314
2021	273
Thereafter	499

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2016, 2015 or 2014.

As of December 31, 2016, the Company had outstanding, undrawn letters of credit with financial institutions of $28 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could

result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI had never before issued a fine in excess of $8 million, CDI advocated a fine of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a nonbinding proposed decision recommending a fine of $11.5 million. The California Insurance Commissioner rejected the administrative law judge's recommendation and on June 9, 2014, issued his own decision imposing a fine of approximately $174 million. On July 10, 2014, the Company filed a lawsuit in California state court challenging the Commissioner's decision. On September 8, 2015, in the first phase of that lawsuit, the California state court issued an order invalidating certain of the regulations the Commissioner had relied upon in issuing his decision and penalty. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the wide range of possible outcomes, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting a regulatory fine in the event of a remand, and the various remedies and levels of judicial review that remain available to the Company.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. The Company has produced documents, information and witnesses to the Department of Justice in cooperation with a current review of the Company's risk-adjustment processes, including the Company's patient chart review and related programs. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the status of the reviews, the wide range of possible outcomes and the inherent difficulty in predicting regulatory action, fines and penalties, if any, the Company's legal and factual defenses and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Guaranty Fund Assessments

Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Some states have similar laws relating to HMOs and other payers such as consumer operated and oriented plans (co-ops) established under the ACA. In 2009, the Pennsylvania Insurance Commissioner placed long term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In 2012, the court denied the liquidation petition and ordered the Insurance Commissioner to submit a rehabilitation plan. A second amended plan of rehabilitation was later withdrawn and, as of November 2016, Penn Treaty will be liquidated. As of December 31, 2016, the Company recorded the $350 million impact of its estimated share of guaranty association assessments resulting from the Penn Treaty liquidation.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide and active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.
- *OptumHealth* serves the physical, emotional and health-related financial needs of individuals, enabling population health management through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery and specialty pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 25% for 2016, 26% for 2015 and 29% for 2014, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 97%, 96% and 95% of consolidated total revenues for 2016, 2015 and 2014, respectively. Long-lived fixed assets located in the United States represented approximately 75% and 81% of the total long-lived fixed assets as of December 31, 2016 and 2015, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum: OptumHealth	Optum: OptumInsight	Optum: OptumRx	Optum: Optum Eliminations	Optum: Optum	Corporate and Eliminations	Consolidated
2016								
Revenues — external customers:								
Premiums	$ 140,455	$ 3,663	$ —	$ —	$ —	$ 3,663	$ —	$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues — external customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues — intersegment	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues	$ 148,581	$ 16,908	$ 7,333	$ 60,440	$ (1,088)	$83,593	$ (47,334)	$ 184,840
Earnings from operations	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ —	$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ (1,067)	$ 11,863
Total assets	$ 70,505	$ 18,656	$ 9,017	$ 29,066	$ —	$56,739	$ (4,434)	$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055
2015								
Revenues — external customers:								
Premiums	$ 124,011	$ 3,152	$ —	$ —	$ —	$ 3,152	$ —	$ 127,163
Products	2	31	108	17,171	—	17,310	—	17,312
Services	6,776	2,375	2,390	381	—	5,146	—	11,922
Total revenues — external customers	130,789	5,558	2,498	17,552	—	25,608	—	156,397
Total revenues — intersegment	—	8,216	3,697	30,718	(791)	41,840	(41,840)	—
Investment and other income	554	153	1	2	—	156	—	710
Total revenues	$ 131,343	$ 13,927	$ 6,196	$ 48,272	$ (791)	$67,604	$ (41,840)	$ 157,107
Earnings from operations	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ —	$ 11,021
Interest expense	—	—	—	—	—	—	(790)	(790)
Earnings before income taxes	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ (790)	$ 10,231
Total assets [a]	$ 64,212	$ 14,600	$ 8,335	$ 26,844	$ —	$49,779	$ (2,737)	$ 111,254
Purchases of property, equipment and capitalized software	653	252	572	79	—	903	—	1,556
Depreciation and amortization	718	251	492	232	—	975	—	1,693
2014								
Revenues — external customers:								
Premiums	$ 112,645	$ 2,657	$ —	$ —	$ —	$ 2,657	$ —	$ 115,302
Products	3	18	96	4,125	—	4,239	—	4,242
Services	6,516	1,300	2,224	111	—	3,635	—	10,151
Total revenues — external customers	119,164	3,975	2,320	4,236	—	10,531	—	129,695
Total revenues — intersegment	—	6,913	2,906	27,740	(489)	37,070	(37,070)	—
Investment and other income	634	144	1	—	—	145	—	779
Total revenues	$ 119,798	$ 11,032	$ 5,227	$ 31,976	$ (489)	$47,746	$ (37,070)	$ 130,474
Earnings from operations	$ 6,992	$ 1,090	$ 1,002	$ 1,190	$ —	$ 3,282	$ —	$ 10,274
Interest expense	—	—	—	—	—	—	(618)	(618)
Earnings before income taxes	$ 6,992	$ 1,090	$ 1,002	$ 1,190	$ —	$ 3,282	$ (618)	$ 9,656
Total assets [a]	$ 62,405	$ 11,148	$ 8,112	$ 5,474	$ —	$24,734	$ (839)	$ 86,300
Purchases of property, equipment and capitalized software	773	212	484	56	—	752	—	1,525
Depreciation and amortization	772	179	433	94	—	706	—	1,478

(a) In the first quarter of 2016, the Company adopted ASU 2015-03, retrospectively as required. See Note 2 for more information on the adoption of ASU 2015-03.

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2016 and 2015 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2016				
Revenues	$ 44,527	$ 46,485	$ 46,293	$ 47,535
Operating costs	41,567	43,282	42,713	44,348
Earnings from operations	2,960	3,203	3,580	3,187
Net earnings	1,627	1,760	1,978	1,708
Net earnings attributable to UnitedHealth Group common shareholders	1,611	1,754	1,968	1,684
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.69	1.84	2.07	1.77
Diluted	1.67	1.81	2.03	1.74
2015				
Revenues	$ 35,756	$ 36,263	$ 41,489	$ 43,599
Operating costs	33,116	33,368	38,471	41,131
Earnings from operations	2,640	2,895	3,018	2,468
Net earnings	1,413	1,585	1,618	1,252
Net earnings attributable to UnitedHealth Group common shareholders	1,413	1,585	1,597	1,218
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.48	1.66	1.68	1.28
Diluted	1.46	1.64	1.65	1.26

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2016. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2016.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2016

UnitedHealth Group Incorporated and Subsidiaries' (the "Company") management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2016. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2016, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2016, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2016, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2016. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2016 of the Company and our report dated February 8, 2017 expressed an unqualified opinion on those consolidated financial statements.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 8, 2017

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 8, 2017, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Edson Bueno, M.D.
Founder Amil and
Chairman UnitedHealth Group Latin America

Richard T. Burke
Non-Executive Chair
UnitedHealth Group

Robert J. Darretta
Retired Vice-Chair and
Chief Financial Officer
Johnson & Johnson

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Chief Executive Officer
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council, a company
focused on improving the governance
processes of corporate boards

Rodger A. Lawson
Executive Chair
E*TRADE Financial Corporation and
Retired President and Chief Executive Officer
Fidelity Investments — Financial Services

Glenn M. Renwick
Executive Chair
The Progressive Corporation

Kenneth I. Shine, M.D.
Professor of Medicine at the Dell Medical School
University of Texas

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE, an international health foundation

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section

16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2017 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance — Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2017 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2016, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	36	$ 84	78 [3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	36	$ 84	78

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 ESPP, as amended.

(2) Excludes 184,000 shares underlying stock options assumed by us in connection with an acquisition. These options have a weighted-average exercise price of $95 and an average remaining term of approximately 7 years. The options are administered pursuant to the terms of the plan under which the options originally were granted. No future awards will be granted under this acquired plan.

(3) Includes 10 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2016, and 68 million shares available under the 2011 Stock Incentive Plan as of December 31, 2016. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2017 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2017 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2017 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2016 and 2015.
- Consolidated Statements of Operations for the years ended December 31, 2016, 2015, and 2014.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015, and 2014.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2016, 2015, and 2014.
- Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015, and 2014.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 12, 2016)
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*10.28	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.29	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.30	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.31	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.32	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.33	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.34	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.35	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.36	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.37	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.38	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.39	Amended and Restated Employment Agreement, effective December 1, 2014, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)

*10.40	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.41	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.42	Amended and Restated Employment Agreement, dated as of February 3, 2014, between United HealthCare Services, Inc. and D. Ellen Wilson (incorporated by reference to Exhibit 10.40 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2015)
*10.43	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016, filed on February 8, 2017, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2016 and 2015, and for each of the three years in the period ended December 31, 2016, and the Company's internal control over financial reporting as of December 31, 2016, and have issued our reports thereon dated February 8, 2017; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 8, 2017

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$ 180	$ 29
Short-term notes receivable from subsidiaries	755	—
Other current assets	140	313
Total current assets	1,075	342
Equity in net assets of subsidiaries	60,593	56,316
Long-term notes receivable from subsidiaries	9,912	9,679
Other assets	248	199
Total assets	$ 71,828	$ 66,536
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 452	$ 449
Note payable to subsidiary	280	310
Commercial paper and current maturities of long-term debt	7,113	6,587
Total current liabilities	7,845	7,346
Long-term debt, less current maturities	25,657	25,215
Other liabilities	52	145
Total liabilities	33,554	32,706
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 952 and 953 issued and outstanding	10	10
Additional paid-in capital	—	29
Retained earnings	40,945	37,125
Accumulated other comprehensive loss	(2,681)	(3,334)
Total UnitedHealth Group shareholders' equity	38,274	33,830
Total liabilities and shareholders' equity	$ 71,828	$ 66,536

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2016	2015	2014
Revenues:			
Investment and other income	$ 522	$ 396	$ 293
Total revenues	522	396	293
Operating costs:			
Operating costs	(22)	(17)	1
Interest expense	995	717	554
Total operating costs	973	700	555
Loss before income taxes	(451)	(304)	(262)
Benefit for income taxes	165	111	96
Loss of parent company	(286)	(193)	(166)
Equity in undistributed income of subsidiaries	7,303	6,006	5,785
Net earnings	7,017	5,813	5,619
Other comprehensive income (loss)	653	(1,942)	(484)
Comprehensive income	$ 7,670	$ 3,871	$ 5,135

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2016	2015	2014
Operating activities			
Cash flows from operating activities	$ 4,294	$ 1,727	$ 7,445
Investing activities			
Issuance of notes to subsidiaries	(824)	(5,064)	(436)
Cash paid for acquisitions	(2,292)	(12,270)	(1,852)
Return of capital to parent company	2,143	4,375	—
Capital contributions to subsidiaries	(765)	(1,109)	(704)
Other, net	168	140	(9)
Cash flows used for investing activities	(1,570)	(13,928)	(3,001)
Financing activities			
Common stock repurchases	(1,280)	(1,200)	(4,008)
Proceeds from common stock issuances	429	402	462
Cash dividends paid	(2,261)	(1,786)	(1,362)
(Repayments of) proceeds from commercial paper, net	(382)	3,666	(794)
Proceeds from issuance of long-term debt	3,968	11,982	1,997
Repayments of long-term debt	(2,596)	(1,041)	(812)
Other, net	(451)	(352)	(190)
Cash flows (used for) from financing activities	(2,573)	11,671	(4,707)
Increase (decrease) in cash and cash equivalents	151	(530)	(263)
Cash and cash equivalents, beginning of period	29	559	822
Cash and cash equivalents, end of period	$ 180	$ 29	$ 559
Supplemental cash flow disclosures			
Cash paid for interest	$ 974	$ 573	$ 578
Cash paid for income taxes	4,557	4,294	4,028

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Intercompany Notes. In July 2015, the parent company issued $4.8 billion in intercompany notes that were used to partially fund the acquisition of Catamaran. See Note 6 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information about Catamaran.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $3.7 billion, $4.8 billion and $5.5 billion in 2016, 2015 and 2014, respectively. Additionally, $2.1 billion and $4.4 billion in cash were received as a return of capital to the parent company during 2016 and 2015, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $200 million and $164 million at December 31, 2016 and 2015, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2017	$ 7,105
2018	2,600
2019	1,750
2020	1,950
2021	2,400
Thereafter	17,217

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 8, 2017

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director and Chief Executive Officer (principal executive officer)	February 8, 2017
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 8, 2017
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 8, 2017
* **William C. Ballard, Jr.**	Director	February 8, 2017
* **Edson Bueno**	Director	February 8, 2017
* **Richard T. Burke**	Director	February 8, 2017
 Robert J. Darretta	Director	
* **Timothy P. Flynn**	Director	February 8, 2017
* **Michele J. Hooper**	Director	February 8, 2017
* **Rodger A. Lawson**	Director	February 8, 2017
* **Glenn M. Renwick**	Director	February 8, 2017
* **Kenneth I. Shine**	Director	February 8, 2017
* **Gail R. Wilensky**	Director	February 8, 2017

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

EXHIBIT INDEX**

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*10.27	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.28	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.29	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.30	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.31	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.32	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.33	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.34	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.35	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)

*10.36	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.37	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.38	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.39	Amended and Restated Employment Agreement, effective December 1, 2014, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.40	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.41	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.42	Amended and Restated Employment Agreement, dated as of February 3, 2014, between United HealthCare Services, Inc. and D. Ellen Wilson (incorporated by reference to Exhibit 10.40 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2015)
*10.43	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016, filed on February 8, 2017, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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

Form 10-K

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

For the fiscal year ended December 31, 2015

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2015 was $114,440,856,791 (based on the last reported sale price of $122.00 per share on June 30, 2015, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 29, 2016, there were 950,673,998 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2016 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and other individuals and serves the nation's active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes Amil, a health care company providing health and dental benefits and hospital and clinical services to employer groups and individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: care delivery, care management, pharmacy care services, consumer engagement, distribution, health financial services, health care information technology and operational services and support.

Through UnitedHealthcare and Optum, in 2015, we processed one half trillion dollars in gross billed charges and we managed nearly $200 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- a national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1 million physicians and other health care professionals and approximately 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, individuals and military service members in the TRICARE west region. UnitedHealthcare Employer & Individual provides access to medical services for approximately 30 million people on behalf of our customers and alliance partners. This includes more than 190,000 employer customers across all 50 states. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision. UnitedHealthcare Employer & Individual also offers a variety of insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families.

The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual's UnitedHealth Premium® program is the longest-running physician quality and efficiency designation program in the industry, making it easier for consumers to access high-quality, cost-efficient care. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers.

UnitedHealthcare Employer & Individual also distributes its products through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. UnitedHealthcare Marketplace is a shopping platform for employers seeking to offer their employees flexibility and a choice of UnitedHealthcare plans. UnitedHealthcare Employer & Individual is also participating in select multi-plan exchanges that are structured to encourage consumer choice. Direct-to-consumer sales are also supported by participation in multi-carrier health insurance marketplaces for individuals and small groups through exchanges. In 2015, UnitedHealthcare Employer & Individual participated in 23 individual and 12 small group state public exchanges and in 2016, will participate in individual public exchange offerings in 34 states. The Company is evaluating its level of participation in individual public exchange offerings for 2017. For more detail on our individual public exchange offerings, see Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet the needs of employers of all sizes, as well as the needs of individuals shopping for health benefits coverage. Cost pressures are accelerating demand for improved health care affordability and more coordinated care. UnitedHealthcare Employer & Individual is responding to this demand with new network and contracting constructs (such as performance incentives and benefit designs that direct more patients to higher-performing care providers), alternative access to affordable and convenient care (such as through telehealth appointments with registered nurses and physicians) and a new consumer-responsive service model called Advocate4Me.

UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). The market for health benefit products is shifting, with benefit and network offerings shaped, at least in part, by the requirements and effects of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation), increased employer focus on quality and employee engagement and the urgent need to align the system around value.

Employers are seeking to offer comprehensive health benefits that improve the health and wellness of their populations and as a result, lower overall health care costs, while improving employee satisfaction. By promoting a healthy workforce, employers can maximize productivity and lower overall health care costs. UnitedHealthcare Employer & Individual offers affordable products and actionable information to enable better health outcomes and to help employers attract and retain talent. UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs and consumer education. During 2015, nearly 35,000 employer-sponsored benefit plans, including nearly 400 employers in the large group self-funded market, purchased HRA or HSA products from us.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management products, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individuals) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life and disability product offerings through an integrated approach, including a network of more than 22,000 vision offices and more than 80,000 dental offices, in private and retail settings.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration and customer service.

UnitedHealthcare Military & Veterans is the provider of health care services for nearly 3 million active duty and retired military service members and their families in 21 states under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013. The DoD is moving from three to two regions for 2017. The government intends to make a decision in the spring of 2016, for contracts to begin delivering services on or about April 1, 2017. UnitedHealthcare Military & Veterans has submitted bids to offer services under the new contracts.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. Beneficiaries with special needs are served through UnitedHealthcare Medicare & Retirement Dual, Chronic and Institutional Special Needs Plans (SNPs) in many markets. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement's seniors-focused care management model enables it to operate at a medical cost level below that of traditional Medicare. This model is based on more than 20 years of expertise in chronic disease care management, underpinned by a proprietary technology platform. These capabilities help improve the health and well-being of older, disabled or otherwise vulnerable individuals. For example, through UnitedHealth Group's HouseCalls program, nurse practitioners performed approximately 1 million in-home preventative care visits in 2015 to identify, document and help close gaps in care for seniors.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 26% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2015, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and SNPs. Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement served more than 3 million people through its Medicare Advantage products as of December 31, 2015.

Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the

long-term payment rate outlook for each geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly. See Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to reach out to those members and create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. UnitedHealthcare Medicare & Retirement offers two stand-alone Medicare Part D plans: the AARP MedicareRx Preferred and the AARP MedicareRx Saver Plus plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2015, UnitedHealthcare enrolled more than 8 million people in the Medicare Part D programs, including more than 5 million individuals in the stand-alone Medicare Part D plans and more than 3 million in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover the various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2015, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 5 million beneficiaries. Health Reform Legislation provided for optional Medicaid expansion effective January 1, 2014. Currently, UnitedHealthcare Community & State serves people through Medicaid expansion programs in 13 states. For further discussion of the Medicaid expansion under Health Reform Legislation, see Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and its participation are:

- Temporary Assistance to Needy Families, primarily women and children – 21 markets;
- CHIP – 21 markets;
- Aged, Blind and Disabled (ABD) – 19 markets;
- SNP – 14 markets;
- Medicaid Expansion – 13 markets;
- Long-Term Services and Supports (LTSS) – 11 markets;
- childless adults programs for the uninsured – 3 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 6 markets; and
- MMP – 2 markets.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care.

The LTSS market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTSS population is made up of 3 million individuals who qualify for additional benefits under LTSS programs and represent a subset of the 16 million ABD Americans. Currently, 25% of the ABD population and 28% of the LTSS eligible population are served by comprehensive risk-based managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are more than 10 million individuals eligible for both Medicare and Medicaid. MMP beneficiaries typically have complex conditions with costs of care that are far higher than typical Medicare or Medicaid beneficiaries. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and improve people's health status through close coordination of care. While dual eligibles account for just 15% of the total Medicaid population, they account for approximately 35% of total Medicaid spending. As of December 31, 2015, UnitedHealthcare served nearly 350,000 people with complex conditions similar to those in an MMP population in legacy programs through Medicare Advantage dual SNPs and UnitedHealthcare Community & State served 24,000 people through MMP programs in Ohio and Texas.

UnitedHealthcare Global

UnitedHealthcare Global participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare Global's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals around the world. UnitedHealthcare Global's goal is to create business solutions that are based on local expertise, infrastructure, culture and needs. As of December 31, 2015, UnitedHealthcare Global provided medical benefits to more than 4 million people, principally in Brazil, but also residing in more than 125 other countries.

Amil. Amil provides medical and dental benefits to more than 5 million people. Amil operates hospitals and specialty, primary care and emergency services clinics across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of more than 26,000 physicians and other health care professionals, approximately 2,100 hospitals and nearly 8,000 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare Global includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians' and other care providers' practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: health plans, employers, state, federal and municipal agencies, governmental departments and nonprofit associations devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum is organized in three reportable segments which focus on eight business markets to achieve its full potential for growth and leadership in the health services sector:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, distribution and health financial services;
- OptumInsight delivers operational services and support and health care information technology services; and
- OptumRx specializes in pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of more than 78 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and, increasingly, directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by coordinating care for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, and on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and local care delivery businesses.

OptumHealth is organized into two primary operating groups: OptumCare and Optum Consumer Solutions (OCS).

OptumCare

- OptumCare partners closely with care providers to improve both the health of the populations they serve and the efficiency and cost-effectiveness of local care systems. Through networks comprised of employed, managed and contracted physicians, advanced practitioners and other providers, OptumCare assists care providers in adopting new approaches and technologies that improve collaboration and coordination among everyone involved in patient care. OptumCare also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that put patient health and outcomes first, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. OptumCare builds partnerships with care providers who share its focus on creating strong and sustainable new approaches to care delivery and works with them to develop and deliver services around the spectrum of patient and community needs.
- Mobile Care Delivery. OptumCare's mobile care delivery business provides occupational health, medical and dental readiness services, treatments and immunization programs. These solutions serve a number of government and commercial clients, including the U.S. military.

OCS.

- Population Health Management Services: OCS serves people through population health management services that meet both the preventative care and health intervention needs of consumers across the care continuum - physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OCS engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

- Distribution: This business provides sales and services through digital, phone and in-person interaction to assist individuals in selecting and understanding their benefits. OCS provides contact center support, multimodal software, data analysis and licensed sales agents that help clients acquire, retain and service large populations of health care consumers.
- Financial Services: This business provides a range of health care financial products for individuals, employers, health care professionals and payers. OCS is a leading provider of consumer health care accounts. OCS also offers electronic claims payment services to care providers through Optum Bank, a wholly-owned subsidiary, with more than 3.8 million accounts and $4.2 billion in assets under management as of December 31, 2015. During 2015, Optum Bank processed more than $100 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on modernizing the health system through technology, analytics and information that help drive higher quality and greater efficiency in the health care system. Hospital systems, physician practices, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products, advisory consulting arrangements and outsourcing contracts are delivered over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2015, was $10.4 billion, of which $5.9 billion is expected to be realized within the next 12 months. This includes $3.8 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2014, was $8.6 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospital systems), payers, governments and life sciences organizations.

Care Providers. Serving five out of six U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements and deliver health intelligence. OptumInsight brings an array of solutions to help care providers, with particular focus on clinical performance and quality improvement, population health management, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Payers. OptumInsight serves approximately 300 health plans by helping them improve operational and administrative efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals and build and manage strong provider networks. OptumInsight is also helping payer clients adapt to new market models, including health insurance exchanges, consumer-driven health care and engagement, pay-for-value contracting and population health management.

Governments. OptumInsight provides services to federal and state government clients that are tailored to them as government payers, including data and analytics technology, claims management and payment accuracy services and strategic consulting. In addition, OptumInsight provides custom system integration expertise and services to meet complex government needs, including public health insurance exchanges.

Life Sciences. OptumInsight provides services to global life sciences organizations. These companies look to OptumInsight for data analytics and expertise in core areas of health economics and outcomes research; market access and reimbursement consulting; integrated clinical and health care claims data and informatics services; epidemiology and drug safety; and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to more than 66 million people in the United States through its network of more than 67,000 retail pharmacies and multiple home delivery facilities throughout the country. In 2016, OptumRx expects to manage nearly $80 billion in pharmaceutical spending, including more than $28 billion in specialty pharmaceutical spending. OptumRx's pharmacy care services deliver a low-cost, high-quality pharmacy benefit through retail network contracting, including rebate management and clinical programs such as step therapy, formulary management, drug adherence and disease/drug therapy management programs.

The 2015 acquisition of Catamaran Corporation (Catamaran) allows OptumRx to better serve more people. OptumRx's comprehensive whole-person approach integrates demographic, medical, pharmaceutical and other clinical data and than applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individuals through enhanced services and cost trend management. These enhancements will be driven by advanced technology, augmented resources and greater efficiencies and cost containment strategies through increased scale.

OptumRx provides pharmacy care services to a substantial majority of UnitedHealthcare members. Additionally, OptumRx manages specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services, including patient support and clinical programs designed to ensure quality and deliver value for consumers. OptumRx also provides pharmacy care services to non-affiliated external clients, including a number of health plans, large national employer plans, unions and trusts and government entities. These clients rely on OptumRx for components or all of their pharmacy care services. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amount of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to risk adjustment and reinsurance data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies that are held by our Optum businesses and UnitedHealthcare Military & Veterans business, such as our TRICARE contract with the DoD. Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Health Care Reform. Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system.

Among other requirements, Health Reform Legislation expanded dependent coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain medical loss ratios (MLRs) are not satisfied, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, introduced new risk sharing programs, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

Health Reform Legislation and the related federal and state regulations are affecting how we do business and could impact our results of operations, financial position and cash flows. See also Part I, Item 1A, “Risk Factors” for a discussion of the risks related to Health Reform Legislation and related matters.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information. ICD-10, the new system of assigning codes to diagnoses and procedures associated with health care in the United States replaced ICD-9 code sets as of October 1, 2015, and health plans and providers are now required to use ICD-10 codes for such diagnoses and procedures for dates of services on or after such date. Coding informs analytics and patient care decision making, so accuracy is critical to achieving the highest quality of care and delivering the best possible outcomes for patients.

The Health Information Technology for Economic and Clinical Health Act (HITECH) significantly expanded the privacy and security provisions of HIPAA. HITECH imposes additional requirements on uses and disclosures of health information; includes new contracting requirements for HIPAA business associate agreements; extends

parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where implemented by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. In 2014, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act that requires us to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. The first report was filed with Connecticut, our lead regulator, and with New York, as required by that state's regulation, last year. It will be filed with both jurisdictions annually thereafter. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with Health Reform Legislation, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, MCO, utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related

regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distributions laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

***Guaranty Fund Assessments*.** Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies (including state insurance cooperatives) that write the same line or similar lines of business. Assessments are generally based on a formula relating to our premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets or through premiums. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty association assessments.

Pharmacy Regulation. OptumRx's businesses include home delivery and specialty pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery and specialty pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In addition to the laws and regulations in the states where our home delivery and specialty pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery and specialty pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. As certain of our home delivery and specialty pharmacies maintain certain Medicare and state Medicaid provider numbers, their participation in the programs requires them to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice

of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, disease management companies and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Anthem, Inc., Centene Corporation, Cigna Corporation, Health Net, Inc., Humana Inc., Kaiser Permanente, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and, with respect to our Brazilian operations, several established competitors in Brazil and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Health Corporation, Express Scripts, Inc. and Prime Therapeutics LLC. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including by maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors," for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2015, we employed more than 200,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 9, 2016, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	63	Chief Executive Officer
David S. Wichmann	53	President and Chief Financial Officer
Larry C. Renfro	62	Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum
Thomas E. Roos	43	Senior Vice President and Chief Accounting Officer
Marianne D. Short	64	Executive Vice President and Chief Legal Officer
D. Ellen Wilson	58	Executive Vice President, Human Capital

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. From May 1999 to November 2014, Mr. Hemsley also served as President of UnitedHealth Group.

Mr. Wichmann is President and Chief Financial Officer of UnitedHealth Group. Mr. Wichmann has served as President of UnitedHealth Group since November 2014 and Chief Financial Officer of UnitedHealth Group since January 2011. From April 2008 to November 2014, Mr. Wichmann also served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Renfro is Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum. Mr. Renfro has served as Vice Chairman of UnitedHealth Group since November 2014 and Chief Executive Officer of Optum since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President, Human Capital of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. For more detail on our reincorporation, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to stockholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have

affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise over 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, federal and state regulatory requirements obligate our commercial, Medicare Advantage and certain state-based Medicaid health plans to maintain minimum MLRs, which could make it more difficult for us to obtain price increases for our products. In addition, our OptumCare business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies is typically at a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2015 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2015 would have been reduced by approximately $210 million, excluding any offsetting impact from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also

regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies (including state insurance cooperatives) that write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty association assessments.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations, debt collection laws, banking regulations, distributor and producer licensing requirements, state corporate practice of medicine doctrines, fee-splitting rules, health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and to insurance industries and

regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation, such as Health Reform Legislation and associated exchanges. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

Health Reform Legislation could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity, ongoing implementation and continued legal challenges, Health Reform Legislation's full impact remains difficult to predict and could adversely affect us. For example, Health Reform Legislation includes specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. In addition, if we do not maintain certain minimum loss ratios, we are required to rebate ratable portions of our premiums to our customers. These changes can cause significant disruptions in local health care markets and adjustments to our business, all of which could materially and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation required the establishment of health insurance exchanges for individuals and small employers and requires insurers participating on the health insurance exchanges to offer a minimum level of benefits and includes guidelines on setting premium rates and coverage limitations. While risk adjustment applies to most individual and small group plans in the commercial markets, actual risk adjustment calculations and transfers could materially differ from our assumptions. Our participation in these exchanges involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows.

Our results of operations, financial position and cash flows could be materially and adversely affected if the number of individuals who gain coverage under Health Reform Legislation varies from our expectations, if the demand for Health Reform Legislation related products and capabilities offered by our Optum businesses is less than anticipated or if our costs are greater than anticipated. For a discussion of individual exchange-compliant products, see Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs, CHIP and our TRICARE contract with the DoD, and receive substantial revenues from these programs. Certain of our Optum businesses also provide

services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. In the event any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of Health Reform Legislation, CMS has a system that provides various quality bonus payments to plans that meet certain quality star ratings at the local plan level. The star rating system considers various measures adopted by CMS, including, among other things, quality of care, preventative services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect our membership levels, results of operations, financial position and cash flows. In addition, under Health Reform Legislation, Congress authorized CMS and the states to implement MMP managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MMP demonstration programs for dually eligible beneficiaries, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with coding and other requirements under the Medicare risk-adjustment model, our chart review programs and related processes. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use sensitive personal information and imposed additional compliance requirements on our business. While we transitioned to ICD-10 as a HIPAA-regulated entity, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment or increased medical costs for full-risk health insurance products.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business through home delivery and specialty pharmacies, which subjects it to extensive federal, state and local laws and regulations, including those of the U.S. Drug Enforcement Administration and individual state controlled substance authorities. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including potential new regulations regarding the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals and pharmacy network reimbursement methodologies.

Our pharmacy care services businesses would be materially and adversely affected by our inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our home delivery or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our home delivery or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our pharmacy care services businesses in connection with services for which our pharmacy care services businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, Brazil and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician

groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. Additionally, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits, health care usage, and in the effective navigation of the health care system we may be challenged by new technologies and market entrants that could disrupt our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, distract managements' attention and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of certain businesses, including OptumCare and Amil, depend on maintaining satisfactory physician employment relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with primary care physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various litigation actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. Success in completing acquisitions is also dependent upon efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and to realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through independent producers and consultants with whom we do not have exclusive contracts and for whose services and allegiance we must compete intensely. Our sales would be materially and adversely affected if we were unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our

industry and producers marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2015. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2015, goodwill and other intangible assets had a carrying value of $53 billion, representing 47% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management’s time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third-parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability

to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and credit ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Litigation Matters" and "Governmental Investigations, Audits and Reviews" in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 29, 2016, there were 13,501 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE and cash dividends declared for our last two fiscal years were as follows:

	High	Low	Cash Dividends Declared
2015			
First quarter	$123.76	$ 98.46	$ 0.3750
Second quarter	$124.11	$111.12	$ 0.5000
Third quarter	$126.21	$ 95.00	$ 0.5000
Fourth quarter	$125.99	$109.61	$ 0.5000
2014			
First quarter	$ 83.32	$ 69.57	$ 0.2800
Second quarter	$ 83.05	$ 73.61	$ 0.3750
Third quarter	$ 88.85	$ 78.74	$ 0.3750
Fourth quarter	$104.00	$ 80.72	$ 0.3750

DIVIDEND POLICY

In June 2015, our Board of Directors increased the Company's quarterly cash dividend to stockholders to an annual dividend rate of $2.00 per share compared to the annual dividend rate of $1.50 per share, which the Company had paid since June 2014. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During 2015, the Company repurchased 10.7 million shares at an average price of $112.45 per share, including less than one million shares at an average price of $115.01 per share for the three months ended December 31, 2015.

PERFORMANCE GRAPHS

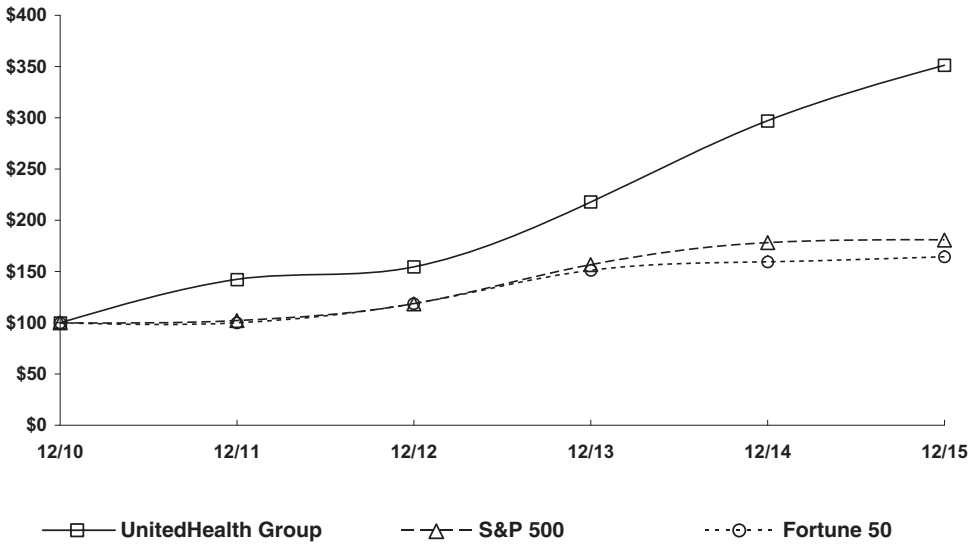
The following two performance graphs compare our total return to stockholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to stockholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group") for the five-year period ended December 31, 2015. The second graph compares our cumulative total return to stockholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2015. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2010 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50



	12/10	12/11	12/12	12/13	12/14	12/15
UnitedHealth Group	**$100.00**	**$142.19**	**$154.40**	**$217.75**	**$297.14**	**$351.39**
S&P 500 Index	**100.00**	**102.11**	**118.45**	**156.82**	**178.29**	**180.75**
Fortune 50 Group	**100.00**	**99.97**	**118.45**	**151.40**	**159.47**	**164.65**

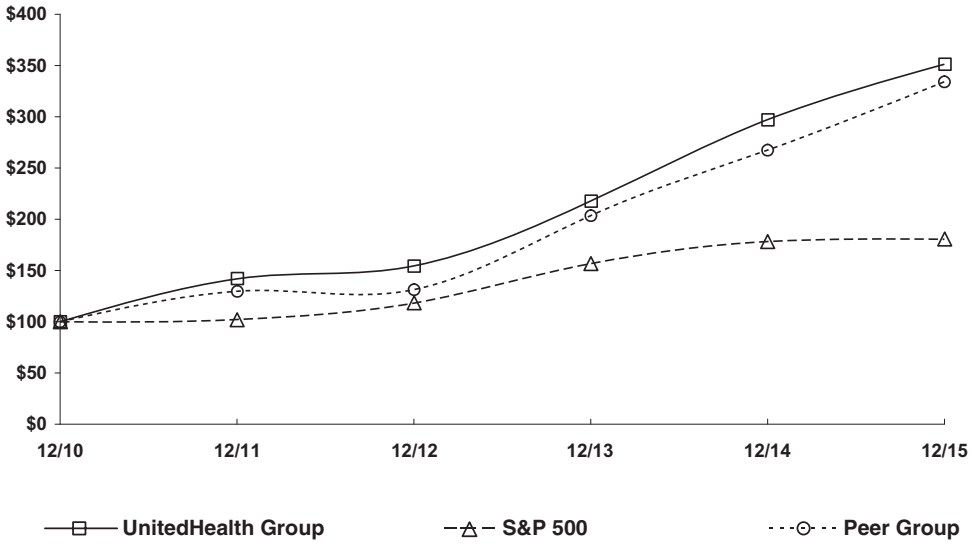
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Anthem Inc., Cigna Corporation and Humana Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and a Peer Group



	12/10	12/11	12/12	12/13	12/14	12/15
UnitedHealth Group	**$100.00**	**$142.19**	**$154.40**	**$217.75**	**$297.14**	**$351.39**
S&P 500 Index	**100.00**	**102.11**	**118.45**	**156.82**	**178.29**	**180.75**
Peer Group	**100.00**	**129.91**	**131.22**	**203.90**	**267.72**	**334.49**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Year Ended December 31, 2015 (a)	2014	2013	2012 (b)	2011
Consolidated operating results					
Revenues	$157,107	$130,474	$122,489	$110,618	$101,862
Earnings from operations	11,021	10,274	9,623	9,254	8,464
Net earnings attributable to UnitedHealth Group common stockholders	5,813	5,619	5,625	5,526	5,142
Return on equity (c)	17.7%	17.3%	17.7%	18.7%	18.9%
Basic earnings per share attributable to UnitedHealth Group common stockholders	$ 6.10	$ 5.78	$ 5.59	$ 5.38	$ 4.81
Diluted earnings per share attributable to UnitedHealth Group common stockholders	6.01	5.70	5.50	5.28	4.73
Cash dividends declared per common share	1.8750	1.4050	1.0525	0.8000	0.6125
Consolidated cash flows from (used for)					
Operating activities	$ 9,740	$ 8,051	$ 6,991	$ 7,155	$ 6,968
Investing activities	(18,395)	(2,534)	(3,089)	(8,649)	(4,172)
Financing activities	12,239	(5,293)	(4,946)	471	(2,490)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 31,703	$ 28,063	$ 28,818	$ 29,148	$ 28,172
Total assets	111,383	86,382	81,882	80,885	67,889
Total commercial paper and long-term debt	32,094	17,406	16,860	16,754	11,638
Redeemable noncontrolling interests	1,736	1,388	1,175	2,121	—
Total equity	33,725	32,454	32,149	31,178	28,292

(a) Includes the effects of the July 2015 Catamaran acquisition and related debt issuances.
(b) Includes the effects of the October 2012 Amil acquisition and related debt and equity issuances.
(c) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data; information and intelligence; and clinical care management and coordination to help meet the demands of the health system. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the United States, Brazilian and certain other international health economies. In the United States, health care spending has grown consistently for many years and comprises approximately 18% of gross domestic product. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations. Our review of regulatory considerations involves a focus on minimum MLR thresholds and the risk adjustment and reinsurance provisions that impact the small group and individual markets. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group markets. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. Health Reform Legislation included an annual, nondeductible insurance industry tax (Health Insurance

Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. Health Reform Legislation also included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program). Health plans have generally reflected the Health Insurance Industry Tax and Reinsurance Program (together, ACA Fees) in their pricing. Conversely, the industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted pricing trends. In 2015, health plans' pricing returned to a more normal year-over-year inflation after pricing for higher costs due to ACA Fees in 2014. As always, the intensity of pricing competition depends on local market conditions and competitive dynamics. A provision in the 2016 Federal Budget imposes a one year moratorium for 2017 on the collection of the Health Insurance Industry Tax. This will impact our pricing for contracts that renew during 2016 but cover all or portions of 2017.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect continued Medicaid revenue growth due to anticipated increases in the number of people we serve; we also believe that the reimbursement rate environment creates the risk of downward pressure on Medicaid net margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. Consistent with our experience in recent years, our 2015 cost trends were largely driven by unit cost pressures from health care providers. In 2016, we expect continued unit cost pressure and a modest increase in utilization. We endeavor to mitigate those increases with medical management. Our 2016 management activities include managing costs across all health care categories, including specialty pharmacy spending, as new therapies are introduced at high costs and older drugs have unexpected price increases.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider reimbursement models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2015, we served more than 14 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2015, our contracts with value-based spending total nearly $46 billion annually, up from $13 billion in 2011.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of Health Reform Legislation and other regulatory items. For additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Part I, Item 1 "Business — Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage rates have been cut over the last several years, with additional funding reductions to be phased-in through 2017. The final 2016 Medicare Advantage rates were more stable than in recent years, with an expected average increase in industry funding of approximately 1.25%. However, these rates still trail the typical industry forward medical cost trend of 3% which creates continued pressure in the Medicare Advantage program. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. These factors affected our plan benefit designs, market participation, growth prospects and earnings expectations for our Medicare Advantage plans for 2016.

The ongoing reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase the member premiums that supplement the monthly payments we receive from the government and decide on a county-by-county basis where we will offer Medicare Advantage plans.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' star ratings. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan can use to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. Beginning in 2015, quality bonus payments were paid only to plans rated 4 stars and higher. We expect that approximately 56% of our Medicare Advantage members will be in plans rated four stars or higher for payment year 2016 compared with approximately 39% of members in plans rated four stars or higher for payment year 2015. We further expect that at least 63% of our Medicare Advantage members will be in plans rated four stars or higher for payment year 2017. We continue to dedicate substantial resources to advance our quality scores and star ratings to strengthen our local market programs and further improve our performance.

Health Insurance Industry Tax and Premium Stabilization Programs. The industry-wide amount of the Health Insurance Industry Tax was $11.3 billion in 2015 and will remain at that level in 2016. A provision in the 2016 Federal Budget imposes a one year moratorium for 2017, on the collection of the Health Insurance Industry Tax. The Health Insurance Industry Tax will again be imposed for 2018 and beyond. In 2016, we expect that our share of the Health Insurance Industry Tax will increase to $1.9 billion from $1.8 billion in 2015 due to growth in our business.

The Reinsurance Program is a temporary program that will be funded on a per capita basis from all commercial lines of business, including insured and self-funded arrangements. The total three year amount of $25 billion for the Reinsurance Program is allocated as follows: $20 billion (2014 - $10 billion, 2015 - $6 billion, 2016 - $4 billion) subject to increases based on state decisions, to fund the reinsurance pool and $5 billion (2014 and 2015 - $2 billion, 2016 - $1 billion) to fund the U.S. Treasury. The actual 2014 Reinsurance Program contributions totaled approximately $9.7 billion, which was $2.3 billion short of the expected amount; all was used to fund the Reinsurance Program. While funding for the Reinsurance Program will come from all commercial lines of business, only market reform compliant individual businesses will be eligible for reinsurance recoveries. We have not recorded any receivables under the temporary risk corridor program for 2014 or 2015 due to uncertainty over the level of government funding for this program and the ultimate collectability of these funds.

For detail on the Health Insurance Industry Tax and Premium Stabilization Programs, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Individual Public Exchanges. After a measured approach to the individual public exchange market in 2014 in which we participated in only four states, we expanded significantly in 2015 to participate in 23 states. In 2016, we are expanding our individual public exchange offerings by 11 states to a total of 34 states. Recent data, however, has caused us to reconsider our long-term position in the individual public exchange market. We have seen lower consumer participation than we and others expected, lower government expectations for future consumer participation, declining performance in and accelerating failures of government-sponsored cooperatives and worsening of our own claims experience. We have recorded a premium deficiency reserve for a portion of our estimated 2016 losses in our 2015 results for in-force contracts as of January 1, 2016. We are not pursuing membership growth and have taken a comprehensive set of actions (e.g., increased prices and eliminated marketing and commissions) to contain membership growth. By mid-2016 we will determine to what extent, if any, we will continue to offer products in the individual public exchange market in 2017.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

	For the Years Ended December 31,			Increase/ (Decrease)		Increase/ (Decrease)	
(in millions, except percentages and per share data)	**2015**	**2014**	**2013**	**2015 vs. 2014**		**2014 vs. 2013**	
Revenues:							
Premiums	$127,163	$115,302	$109,557	$11,861	10%	$5,745	5%
Products	17,312	4,242	3,190	13,070	308	1,052	33
Services	11,922	10,151	8,997	1,771	17	1,154	13
Investment and other income	710	779	745	(69)	(9)	34	5
Total revenues	157,107	130,474	122,489	26,633	20	7,985	7
Operating costs (a):							
Medical costs	103,875	93,633	89,659	10,242	11	3,974	4
Operating costs	24,312	21,263	18,941	3,049	14	2,322	12
Cost of products sold	16,206	3,826	2,891	12,380	324	935	32
Depreciation and amortization	1,693	1,478	1,375	215	15	103	7
Total operating costs	146,086	120,200	112,866	25,886	22	7,334	6
Earnings from operations	11,021	10,274	9,623	747	7	651	7
Interest expense	(790)	(618)	(708)	172	28	(90)	(13)
Earnings before income taxes	10,231	9,656	8,915	575	6	741	8
Provision for income taxes	(4,363)	(4,037)	(3,242)	326	8	795	25
Net earnings	5,868	5,619	5,673	249	4	(54)	(1)
Earnings attributable to noncontrolling interests	(55)	—	(48)	55	nm	(48)	nm
Net earnings attributable to UnitedHealth Group common stockholders	$ 5,813	$ 5,619	$ 5,625	$ 194	3%	$ (6)	—%
Diluted earnings per share attributable to UnitedHealth Group common stockholders	$ 6.01	$ 5.70	$ 5.50	$ 0.31	5%	$ 0.20	4%
Medical care ratio (b)	81.7%	81.2%	81.8%	0.5%		(0.6)%	
Operating cost ratio	15.5	16.3	15.5	(0.8)		0.8	
Operating margin	7.0	7.9	7.9	(0.9)		—	
Tax rate	42.6	41.8	36.4	0.8		5.4	
Net earnings margin (c)	3.7	4.3	4.6	(0.6)		(0.3)	
Return on equity (d)	17.7%	17.3%	17.7%	0.4%		(0.4)%	

nm = not meaningful

(a) During the fourth quarter of 2015, the Company changed its presentation of certain pharmacy fulfillment costs related to its OptumRx business. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on this reclassification.
(b) Medical care ratio is calculated as medical costs divided by premium revenue.
(c) Net earnings margin attributable to UnitedHealth Group stockholders.
(d) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2015 year-over-year operating comparisons to 2014 and other 2015 significant items.

- Consolidated revenues increased by 20%, Optum revenues grew 42% and UnitedHealthcare revenues increased 10%.
- UnitedHealthcare grew to serve an additional 1.7 million people domestically. Each Optum business grew revenues by 19% or more.
- Earnings from operations increased by 7%, including an increase of 30% at Optum partially offset by a decrease of 3% at UnitedHealthcare.
- Diluted earnings per common share increased 5% to $6.01.
- Cash flow from operations were $9.7 billion an increase of 21%.
- On July 23, 2015, we acquired Catamaran through the purchase of all of its outstanding common stock for cash. See Note 3 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements" for more information.

2015 RESULTS OF OPERATIONS COMPARED TO 2014 RESULTS

Our results of operations during the year ended December 31, 2015 were affected by our acquisition of Catamaran on July 23, 2015.

Consolidated Financial Results

Revenues

The increase in revenues was primarily driven by the effect of the Catamaran acquisition and organic growth in the number of individuals served across our benefits businesses and across all of Optum's businesses.

Medical Costs

Medical costs increased primarily due to risk-based membership growth in our benefits businesses. Medical costs also included losses on individual exchange-compliant products related to 2015, and the establishment of premium deficiency reserves related to the 2016 policy year for anticipated future losses for in-force individual exchange-compliant contracts and a new state Medicaid contract.

Operating Cost Ratio

The decrease in our operating cost ratio was due to the inclusion of Catamaran and growth in government benefits programs, both of which have lower operating cost ratios and Company wide productivity gains.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2015	2014	2013	Increase/ (Decrease) 2015 vs. 2014		Increase/ (Decrease) 2014 vs. 2013	
Revenues							
UnitedHealthcare	$131,343	$119,798	$113,725	$11,545	10%	$6,073	5%
OptumHealth	13,927	11,032	9,855	2,895	26	1,177	12
OptumInsight	6,196	5,227	4,714	969	19	513	11
OptumRx	48,272	31,976	24,006	16,296	51	7,970	33
Optum eliminations	(791)	(489)	(458)	302	62	31	7
Optum	67,604	47,746	38,117	19,858	42	9,629	25
Eliminations	(41,840)	(37,070)	(29,353)	4,770	13	7,717	26
Consolidated revenues	$157,107	$130,474	$122,489	$26,633	20%	$7,985	7%
Earnings from operations							
UnitedHealthcare	$ 6,754	$ 6,992	$ 7,132	$ (238)	(3)%	$ (140)	(2)%
OptumHealth	1,240	1,090	949	150	14	141	15
OptumInsight	1,278	1,002	831	276	28	171	21
OptumRx	1,749	1,190	711	559	47	479	67
Optum	4,267	3,282	2,491	985	30	791	32
Consolidated earnings from operations	$ 11,021	$ 10,274	$ 9,623	$ 747	7%	$ 651	7%
Operating margin							
UnitedHealthcare	5.1%	5.8%	6.3%	(0.7)%		(0.5)%	
OptumHealth	8.9	9.9	9.6	(1.0)%		0.3	
OptumInsight	20.6	19.2	17.6	1.4%		1.6	
OptumRx	3.6	3.7	3.0	(0.1)%		0.7	
Optum	6.3	6.9	6.5	(0.6)%		0.4	
Consolidated operating margin	7.0%	7.9%	7.9%	(0.9)%		—%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2015	2014	2013	Increase/ (Decrease) 2015 vs. 2014		Increase/ (Decrease) 2014 vs. 2013	
UnitedHealthcare Employer & Individual	$ 47,194	$ 43,017	$ 44,847	$ 4,177	10%	$(1,830)	(4)%
UnitedHealthcare Medicare & Retirement	49,735	46,258	44,225	3,477	8	2,033	5
UnitedHealthcare Community & State	28,911	23,586	18,268	5,325	23	5,318	29
UnitedHealthcare Global	5,503	6,937	6,385	(1,434)	(21)	552	9
Total UnitedHealthcare revenues	$131,343	$119,798	$113,725	$11,545	10%	$ 6,073	5%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2015	2014	2013	Increase/ (Decrease) 2015 vs. 2014		Increase/ (Decrease) 2014 vs. 2013	
Commercial risk-based	8,285	7,505	8,185	780	10%	(680)	(8)%
Commercial fee-based, including TRICARE	21,445	21,245	21,975	200	1	(730)	(3)
Total commercial	29,730	28,750	30,160	980	3	(1,410)	(5)
Medicare Advantage	3,235	3,005	2,990	230	8	15	1
Medicaid	5,305	5,055	4,035	250	5	1,020	25
Medicare Supplement (Standardized)	4,035	3,750	3,455	285	8	295	9
Total public and senior	12,575	11,810	10,480	765	6	1,330	13
Total UnitedHealthcare — domestic medical	42,305	40,560	40,640	1,745	4	(80)	—
International	4,090	4,425	4,805	(335)	(8)	(380)	(8)
Total UnitedHealthcare — medical	46,395	44,985	45,445	1,410	3%	(460)	(1)%
Supplemental Data:							
Medicare Part D stand-alone	5,060	5,165	4,950	(105)	(2)%	215	4%

The increase in commercial risk-based enrollment was the result of strong participation in UnitedHealthcare's individual public exchange products and favorable annual renewal activity and new business wins in the employer group segment. Medicare Advantage participation increased year-over-year primarily due to growth in people served through employer-sponsored group Medicare Advantage plans. Medicaid growth was driven by the combination of health reform related Medicaid expansion, states launching new programs to complement established programs and growth in established programs, partially offset by a decrease of 175,000 people in one market where an additional offering was introduced by the state in the first quarter of 2015. Medicare Supplement growth reflected strong customer retention and new sales. The number of people served internationally decreased year-over-year primarily due to pricing and underwriting disciplines in Brazil in response to regulatory actions and declining employment levels in Brazil.

UnitedHealthcare's revenue growth during the year ended December 31, 2015 was due to growth in the number of individuals served across its businesses and price increases reflecting underlying medical cost trends.

UnitedHealthcare's operating earnings for the year ended December 31, 2015 decreased as the combined individual exchange-compliant losses and premium deficiency reserves totaling $815 million more than offset strong growth across the business, improved medical cost management and increased productivity.

Optum

Total revenues and operating earnings increased for the year ended December 31, 2015 as each reporting segment increased revenues and earnings from operations by double-digit percentages as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth during the year ended December 31, 2015 primarily due to growth in its care delivery businesses and the impact of acquisitions in patient care centers and population health management services. The operating margins for the year ended December 31, 2015 decreased from the prior year primarily due to investments made to develop future growth opportunities.

OptumInsight

Revenue, earnings from operations and operating margins at OptumInsight for the year ended December 31, 2015 increased primarily due to expansion and growth in care provider revenue management services and payer services.

OptumRx

Revenue and earnings from operations for the year ended December 31, 2015 increased due to the mid-year acquisition of Catamaran as well as strong organic growth. Operating margins for the year ended December 31, 2015 decreased slightly due to the inclusion of lower margin Catamaran business. For more information about Catamaran, see Note 3 in Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements."

2014 RESULTS OF OPERATIONS COMPARED TO 2013 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during the year ended December 31, 2014 were primarily driven by growth in the number of individuals served in our public and senior markets businesses and growth across all of Optum's businesses.

Medical Costs and Medical Care Ratio

Medical costs during the year ended December 31, 2014 increased due to risk-based membership growth in our public and senior markets businesses. To the extent possible, we included the reform fees and related tax impacts in our pricing; since the ACA Fees are included in operating costs, this decreased our medical care ratio in 2014. This decrease from ACA Fees was partially offset by the impact of lower levels of favorable medical cost reserve development.

Operating Cost Ratio

The increase in our operating cost ratio during the year ended December 31, 2014 was due to the introduction of ACA Fees and services business growth and acquisitions, partially offset by productivity and operating performance gains.

Income Tax Rate

The increase in our income tax rate resulted primarily from the nondeductible Health Insurance Industry Tax.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth during the year ended December 31, 2014 was due to growth in the number of individuals served in our public and senior markets businesses; revenues to recover ACA Fees, which resulted in $1.5 billion of additional annual premiums in 2014; and commercial price increases reflecting underlying medical cost trends. These increases were partially offset by decreased commercial risk-based enrollment and a reduced level of Medicare Advantage funding.

UnitedHealthcare's operating earnings for the year ended December 31, 2014 were pressured year-over-year by ACA Fees, Medicare Advantage funding reductions, increased spending on specialty medications to treat

hepatitis C and reduced levels of favorable medical cost reserve development. Partially offsetting these factors were growth in our public and senior markets businesses, reduced levels of per-member inpatient hospital utilization and revenue true-ups.

Optum

Total revenues increased for the year ended December 31, 2014 primarily due to pharmacy growth at OptumRx and growth at OptumHealth.

The increases in Optum's earnings from operations and operating margins for the year ended December 31, 2014 were driven by revenue growth and increased productivity, partially offset by investments at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth during 2014 primarily due to acquisitions and growth in care delivery and subacute care services.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to revenue growth and cost efficiencies, offset in part by investments to develop future growth opportunities.

OptumInsight

Revenue, earnings from operations and operating margins at OptumInsight for the year ended December 31, 2014 increased primarily due to the growth and expansion in revenue management services and government exchange services, partially offset by a reduction in hospital compliance services and investments for future growth.

OptumRx

Increased OptumRx revenue for the year ended December 31, 2014 was due to growth in people served in UnitedHealthcare's public and senior markets, the insourcing of UnitedHealthcare's commercial pharmacy benefit programs, growth from external clients and an increase in specialty pharmaceutical revenues.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to growth in scale that resulted in greater productivity and better absorption of our fixed costs and improved performance in both drug purchasing and home delivery pharmacy fulfillment.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In 2015, our U.S. regulated subsidiaries paid their parent companies dividends of $4.4 billion. For the year ended December 31, 2014, our U.S. regulated subsidiaries paid their parent companies dividends of $4.6 billion. See Note 11 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our stockholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

	For the Years Ended December 31,			Increase/ (Decrease)	Increase/ (Decrease)
(in millions)	**2015**	**2014**	**2013**	**2015 vs. 2014**	**2014 vs. 2013**
Sources of cash:					
Cash provided by operating activities	$ 9,740	$ 8,051	$ 6,991	$ 1,689	$ 1,060
Issuances of long-term debt and commercial paper, net of repayments	14,607	391	152	14,216	239
Proceeds from common stock issuances	402	462	598	(60)	(136)
Sales and maturities of investments, net of purchases	—	799	—	(799)	799
Customer funds administered	768	—	31	768	(31)
Other	—	115	191	(115)	(76)
Total sources of cash	25,517	9,818	7,963		
Uses of cash:					
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed	(16,282)	(1,923)	(1,836)	(14,359)	(87)
Cash dividends paid	(1,786)	(1,362)	(1,056)	(424)	(306)
Common stock repurchases	(1,200)	(4,008)	(3,170)	2,808	(838)
Purchases of property, equipment and capitalized software	(1,556)	(1,525)	(1,307)	(31)	(218)
Purchases of investments, net of sales and maturities	(531)	—	(1,611)	(531)	1,611
Customer funds administered	—	(638)	—	638	(638)
Other	(578)	(138)	(27)	(440)	(111)
Total uses of cash	(21,933)	(9,594)	(9,007)		
Effect of exchange rate changes on cash and cash equivalents	(156)	(5)	(86)	(151)	81
Net increase (decrease) in cash and cash equivalents	$ 3,428	$ 219	$ (1,130)	$ 3,209	$ 1,349

2015 Cash Flows Compared to 2014 Cash Flows

Cash flows provided by operating activities in 2015 increased primarily due to growth in risk-based products, which increased medical costs payable and an increase in CMS risk share payables, which increased other policy

liabilities. These increases were partially offset by an increase in pharmacy rebates, which increased other receivables, the increase in the payment of the 2015 Health Insurance Industry Tax and the payment of Reinsurance Program fees in 2015.

Other significant changes in sources or uses of cash year-over-year included increased cash paid for acquisitions and net debt issuances and decreased share repurchases, all due to the Catamaran acquisition.

2014 Cash Flows Compared to 2013 Cash Flows

Cash flows provided by operating activities in 2014 increased primarily due to an increased level of accounts payable and other liabilities, including the collection of Reinsurance Program fees in advance of remittance in 2015, partially offset by an increase in government receivables.

Other significant changes in sources or uses of cash year-over-year included: (a) a change in investment activity from net purchases in 2013 to net sales in 2014; (b) an increase in Part D subsidy receivables causing a change in customer funds administered; and (c) increased levels of cash used to repurchase common stock.

Financial Condition

As of December 31, 2015, our cash, cash equivalent and available-for-sale investment balances of $31.2 billion included $10.9 billion of cash and cash equivalents (of which $286 million was available for general corporate use), $18.6 billion of debt securities and $1.6 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 5 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.4 years and a weighted-average credit rating of “AA” as of December 31, 2015. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 9 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-stockholders’ equity ratio of not more than 55%. As of December 31, 2015, our debt to debt-plus-stockholders’ equity ratio, as defined and calculated under the credit facilities was approximately 47%.

Long-Term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for

share repurchases. In July 2015, we issued debt to fund the acquisition of Catamaran. For more information on this debt issuance, see Note 9 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements."

Credit Ratings. Our credit ratings as of December 31, 2015 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Negative	A+	Negative	A-	Negative	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. We expect continued moderated share repurchase activity through 2016 following the acquisition of Catamaran. For more information on our share repurchase program, see Note 11 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2015, our Board increased our quarterly cash dividend to stockholders to an annual dividend rate of $2.00 per share. For more information on our dividend, see Note 11 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2015, under our various contractual obligations and commitments:

(in millions)	2016	2017 to 2018	2019 to 2020	Thereafter	Total
Debt (a)	$7,651	$ 7,938	$ 4,564	$ 26,569	$46,722
Operating leases	417	695	497	471	2,080
Purchase obligations (b)	365	230	54	28	677
Future policy benefits (c)	133	277	283	1,936	2,629
Unrecognized tax benefits (d)	4	—	—	207	211
Other liabilities recorded on the Consolidated Balance Sheet (e)	185	4	—	1,477	1,666
Other obligations (f)	52	64	20	16	152
Redeemable noncontrolling interests (g)	55	1,453	228	—	1,736
Total contractual obligations	$8,862	$ 10,661	$ 5,646	$ 30,704	$55,873

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 9 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2015.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies

sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter."

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."

(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

(g) Includes commitments for redeemable shares of our subsidiaries.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2015, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

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 processing backlogs, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes and business mix changes related to products, customers and geography. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the 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. As of December 31, 2015, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times 365 days.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates and include the changes in estimates in medical costs in the period in which the change is identified. Therefore, 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). Medical costs in 2015, 2014 and 2013 included favorable medical cost development related to prior years of $320 million, $420 million and $680 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2015:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 370
(0.50)	246
(0.25)	123
0.25	(122)
0.50	(244)
0.75	(365)

Medical Cost PMPM Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and by reviewing a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2015:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 727
2	485
1	242
(1)	(242)
(2)	(485)
(3)	(727)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2015, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2015; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2015 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2015 net earnings would have increased or decreased by $83 million.

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us to CMS.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. We completed our annual impairment tests for goodwill as of October 1, 2015. All of our reporting units had fair values substantially in excess of their carrying values. During 2015, we changed our

annual quantitative goodwill impairment testing date from January 1 to October 1 of each year. The change in the goodwill impairment test date better aligns the impairment testing procedures with the timing of our long-term planning process, which is a significant input to the testing. This change in testing date did not delay, accelerate, or avoid a goodwill impairment charge. Impairment tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends above and the discussion in the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future.

Intangible Assets. Our recorded separately-identifiable intangible assets were acquired in business combinations and were initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis.

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset’s (or asset group’s) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets,

changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2015.

Investments

Our investments are principally classified as available-for-sale and are recorded at fair value. We continually monitor the difference between the cost and fair value of our investments.

Other-Than-Temporary Impairment Assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. In December 2015, the Federal Reserve (Fed) announced that it would increase short-term interest rates to a range between 25 and 50 basis points. Fed officials emphasized that they intend to raise rates gradually, if necessary. We estimate a 25 basis point rise in short-term interest rates impacts the fair-value of our investments by $200 million. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

The judgments and estimates related to other-than-temporary impairment may ultimately prove to be inaccurate due to many factors, including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2015, we had a reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.” for more information. As of December 31, 2015, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real.

As of December 31, 2015, we had $12.9 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2015, $12.9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2015, $17.1 billion of our investments were fixed-rate debt securities and $21.9 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2015 and 2014 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2015			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities (c)
2%	$ 258	$ 257	$ (1,388)	$ (3,233)
1	129	128	(702)	(1,746)
(1)	(80)	(55)	677	2,085
(2)	nm	nm	1,132	4,442

	December 31, 2014			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 187	$ 245	$ (1,364)	$ (1,846)
1	94	122	(683)	(1,014)
(1)	(54)	(21)	628	1,242
(2)	nm	nm	982	2,770

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2015 and 2014, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2015 and 2014, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

(c) The year over year change in the fair value of financial liabilities was driven by the issuance of debt to fund the Catamaran acquisition. For more information on our debt issuances, see Note 9 of Notes to the Consolidated Financial Statements included in Part II, Item 8 of this report.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2015, a hypothetical 10% and 25% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $300 million and $660 million, respectively. We manage exposure to foreign currency earnings risk by conducting our international business operations primarily in their functional currencies.

As of December 31, 2015, we had $1.6 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates. Valuations in venture capital funds are subject to conditions affecting health care and technology stocks and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2015. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and subsidiaries as of December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2015, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2015, based on the criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 9, 2016, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 9, 2016

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2015	December 31, 2014
Assets		
Current assets:		
Cash and cash equivalents	$ 10,923	$ 7,495
Short-term investments	1,988	1,741
Accounts receivable, net of allowances of $333 and $260	6,523	4,252
Other current receivables, net of allowances of $138 and $156	6,801	5,498
Assets under management	2,998	2,962
Deferred income taxes	860	556
Prepaid expenses and other current assets	1,546	1,052
Total current assets	31,639	23,556
Long-term investments	18,792	18,827
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $3,173 and $2,954	4,861	4,418
Goodwill	44,453	32,940
Other intangible assets, net of accumulated amortization of $3,128 and $2,685	8,391	3,669
Other assets	3,247	2,972
Total assets	$ 111,383	$ 86,382
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 14,330	$ 12,040
Accounts payable and accrued liabilities	11,994	9,247
Other policy liabilities	7,798	5,965
Commercial paper and current maturities of long-term debt	6,634	1,399
Unearned revenues	2,142	1,972
Total current liabilities	42,898	30,623
Long-term debt, less current maturities	25,460	16,007
Future policy benefits	2,496	2,488
Deferred income taxes	3,587	2,065
Other liabilities	1,481	1,357
Total liabilities	75,922	52,540
Commitments and contingencies (Note 13)		
Redeemable noncontrolling interests	1,736	1,388
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 953 and 954 issued and outstanding	10	10
Additional paid-in capital	29	—
Retained earnings	37,125	33,836
Accumulated other comprehensive loss	(3,334)	(1,392)
Nonredeemable noncontrolling interest	(105)	—
Total equity	33,725	32,454
Total liabilities, redeemable noncontrolling interests and equity	$ 111,383	$ 86,382

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2015	2014	2013
Revenues:			
Premiums	$127,163	$115,302	$109,557
Products	17,312	4,242	3,190
Services	11,922	10,151	8,997
Investment and other income	710	779	745
Total revenues	157,107	130,474	122,489
Operating costs:			
Medical costs	103,875	93,633	89,659
Operating costs	24,312	21,263	18,941
Cost of products sold	16,206	3,826	2,891
Depreciation and amortization	1,693	1,478	1,375
Total operating costs	146,086	120,200	112,866
Earnings from operations	11,021	10,274	9,623
Interest expense	(790)	(618)	(708)
Earnings before income taxes	10,231	9,656	8,915
Provision for income taxes	(4,363)	(4,037)	(3,242)
Net earnings	5,868	5,619	5,673
Earnings attributable to noncontrolling interests	(55)	—	(48)
Net earnings attributable to UnitedHealth Group common stockholders	$ 5,813	$ 5,619	$ 5,625
Earnings per share attributable to UnitedHealth Group common stockholders:			
Basic	$ 6.10	$ 5.78	$ 5.59
Diluted	$ 6.01	$ 5.70	$ 5.50
Basic weighted-average number of common shares outstanding	953	972	1,006
Dilutive effect of common share equivalents	14	14	17
Diluted weighted-average number of common shares outstanding	967	986	1,023
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	6	8
Cash dividends declared per common share	$ 1.8750	$ 1.4050	$ 1.0525

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2015	2014	2013
Net earnings	$ 5,868	$ 5,619	$ 5,673
Other comprehensive loss:			
Gross unrealized (losses) gains on investment securities during the period	(123)	476	(543)
Income tax effect	44	(173)	196
Total unrealized (losses) gains, net of tax	(79)	303	(347)
Gross reclassification adjustment for net realized gains included in net earnings	(141)	(211)	(181)
Income tax effect	53	77	66
Total reclassification adjustment, net of tax	(88)	(134)	(115)
Total foreign currency translation losses	(1,775)	(653)	(884)
Other comprehensive loss	(1,942)	(484)	(1,346)
Comprehensive income	3,926	5,135	4,327
Comprehensive income attributable to noncontrolling interests	(55)	—	(48)
Comprehensive income attributable to UnitedHealth Group common stockholders	$ 3,871	$ 5,135	$ 4,279

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interest	Total Equity
Balance at January 1, 2013	1,019	$ 10	$ 66	$ 30,664	$ 516	$ (78)	$ —	$31,178
Net earnings				5,625			—	5,625
Other comprehensive loss					(462)	(884)		(1,346)
Issuances of common stock, and related tax effects	17	—	431					431
Share-based compensation, and related tax benefits			406					406
Common stock repurchases	(48)	—	(984)	(2,186)				(3,170)
Acquisition of redeemable noncontrolling interests and related tax effects			81					81
Cash dividends paid on common stock				(1,056)				(1,056)
Balance at December 31, 2013	988	10	—	33,047	54	(962)	—	32,149
Net earnings				5,619			—	5,619
Other comprehensive income (loss)					169	(653)		(484)
Issuances of common stock, and related tax effects	15	—	146					146
Share-based compensation, and related tax benefits			394					394
Common stock repurchases	(49)	—	(540)	(3,468)				(4,008)
Cash dividends paid on common stock				(1,362)				(1,362)
Balance at December 31, 2014	954	10	—	33,836	223	(1,615)	—	32,454
Net earnings				5,813			26	5,839
Other comprehensive loss					(167)	(1,775)		(1,942)
Issuances of common stock, and related tax effects	10	—	127					127
Share-based compensation, and related tax benefits			589					589
Common stock repurchases	(11)	—	(462)	(738)				(1,200)
Cash dividends paid on common stock				(1,786)				(1,786)
Redeemable noncontrolling interests fair value and other adjustments			(225)					(225)
Acquisition of nonredeemable noncontrolling interest							9	9
Distributions to nonredeemable noncontrolling interest							(140)	(140)
Balance at December 31, 2015	953	$ 10	$ 29	$ 37,125	$ 56	$ (3,390)	$ (105)	$33,725

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2015	2014	2013
Operating activities			
Net earnings	$ 5,868	$ 5,619	$ 5,673
Noncash items:			
Depreciation and amortization	1,693	1,478	1,375
Deferred income taxes	(73)	(117)	1
Share-based compensation	406	364	331
Other, net	(235)	(298)	(83)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(591)	(911)	(317)
Other assets	(1,430)	(590)	(838)
Medical costs payable	2,585	484	509
Accounts payable and other liabilities	643	1,642	459
Other policy liabilities	637	(5)	(221)
Unearned revenues	237	385	102
Cash flows from operating activities	9,740	8,051	6,991
Investing activities			
Purchases of investments	(9,939)	(9,928)	(12,176)
Sales of investments	6,054	7,701	5,706
Maturities of investments	3,354	3,026	4,859
Cash paid for acquisitions, net of cash assumed	(16,164)	(1,923)	(362)
Purchases of property, equipment and capitalized software	(1,556)	(1,525)	(1,307)
Other, net	(144)	115	191
Cash flows used for investing activities	(18,395)	(2,534)	(3,089)
Financing activities			
Acquisition of redeemable noncontrolling interest shares	(118)	—	(1,474)
Common stock repurchases	(1,200)	(4,008)	(3,170)
Cash dividends paid	(1,786)	(1,362)	(1,056)
Proceeds from common stock issuances	402	462	598
Repayments of long-term debt	(1,041)	(812)	(1,609)
Proceeds from (repayments of) commercial paper, net	3,666	(794)	(474)
Proceeds from issuance of long-term debt	11,982	1,997	2,235
Customer funds administered	768	(638)	31
Other, net	(434)	(138)	(27)
Cash flows from (used for) financing activities	12,239	(5,293)	(4,946)
Effect of exchange rate changes on cash and cash equivalents	(156)	(5)	(86)
Increase (decrease) in cash and cash equivalents	3,428	219	(1,130)
Cash and cash equivalents, beginning of period	7,495	7,276	8,406
Cash and cash equivalents, end of period	$ 10,923	$ 7,495	$ 7,276
Supplemental cash flow disclosures			
Cash paid for interest	$ 639	$ 644	$ 724
Cash paid for income taxes	4,401	4,024	2,785

See Notes to the Consolidated Financial Statements

UnitedHealth Group

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables and valuations of certain investments. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Reclassification

During the fourth quarter of 2015, the Company changed its accounting policy for the presentation of certain pharmacy fulfillment costs related to its OptumRx business. These costs are now included in medical costs and cost of products sold, whereas they were previously included in operating costs. Prior periods have been reclassified to conform to the current period presentation. The reclassification increased medical expenses by $376 million and $369 million, decreased operating costs by $418 million and $421 million and increased cost of products sold by $42 million and $52 million for the years ended December 31, 2014 and 2013, respectively. The reclassification had no impact on total operating costs, earnings from operations, net earnings, earnings per share or total equity.

Reincorporation

On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. The reincorporation was approved by the Company's stockholders at its 2015 Annual Meeting of Shareholders held on June 1, 2015. Upon reincorporation, the affairs of UnitedHealth Group Incorporated became subject to the Delaware General Corporation Law, a new certificate of incorporation and new bylaws, and each previously outstanding share of UnitedHealth Group Incorporated's common stock as a Minnesota corporation (UNH Minnesota) converted into an outstanding share of common stock of UnitedHealth Group Incorporated as a Delaware corporation after the reincorporation (UNH Delaware). The reincorporation was a tax-free reorganization under the U.S. Internal Revenue Code and did not affect the Company's business operations.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. Additionally, the Company's market reform compliant individual and small group plans in the commercial markets are subject to risk adjustment provisions as discussed in "Premium Stabilization Programs" below.

Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the Centers for Medicare & Medicaid Services' (CMS) risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans are subject to review by the government, including audit by regulators. See Note 13 for additional information regarding these audits.

For the Company's OptumRx pharmacy care services business, revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the

Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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 processing backlogs, care provider contract rate changes, medical care utilization and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Medical costs also include the direct cost of patient care.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its mail and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the

issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and records rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates from two to five months after billing. As of December 31, 2015 and 2014, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $2.6 billion and $1.5 billion, respectively.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivable" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to premium revenues in the Consolidated Statements of Operations and other policy liabilities or other current receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Health Reform Legislation mandated a consumer discount on brand name prescription drugs for Medicare Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as premium revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in unearned revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in medical costs and operating costs, respectively, in the Consolidated Statements of Operations.

The final 2015 risk-share amount is expected to be settled during the second half of 2016, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2015			December 31, 2014		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$ 1,703	$ 423	$ —	$ 1,801	$ 719	$ 20
Other policy liabilities	—	58	496	—	302	—

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. First, the Company estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

During 2015, the Company changed its annual quantitative goodwill impairment testing date from January 1 to October 1 of each year. The change in the goodwill impairment test date better aligns the impairment testing procedures with the timing of the Company's long-term planning process, which is a significant input to the testing. This change in testing date did not delay, accelerate, or avoid a goodwill impairment charge.

There was no impairment of goodwill during the year ended December 31, 2015.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2015.

Accounts Payable and Accrued Liabilities

The Company had checks outstanding of $1.6 billion and $1.4 billion as of December 31, 2015 and 2014, respectively, which were classified as accounts payable and accrued liabilities and the change in this balance has been reflected within other financing activities in the Consolidated Statements of Cash Flows.

As of both December 31, 2015 and 2014, accounts payable and accrued liabilities included accrued payroll liabilities of $1.5 billion.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program, health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Changes in the RSF are reported in medical costs in the Consolidated Statement of Operations. As of December 31, 2015 and 2014, the balance in the RSF was $1.6 billion and $1.5 billion, respectively.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. The Consolidated Balance Sheets include the following amounts associated with Golden Rule as of December 31, 2015 and 2014:

(in millions)	2015	2014
Other current receivables	$ 133	$ 127
Other assets	1,610	1,669
Other policy liabilities	(133)	(127)
Future policy benefits	(1,610)	(1,669)

The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. As of December 31, 2015, the reinsurer was rated by A.M. Best as "A+."

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests activity for the years ended December 31, 2015 and 2014:

(in millions)	2015	2014
Redeemable noncontrolling interests, beginning of period	$1,388	$1,175
Net earnings	29	—
Acquisitions	196	203
Redemptions	(116)	—
Distributions	(19)	(40)
Fair value and other adjustments	258	50
Redeemable noncontrolling interests, end of period	$1,736	$1,388

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably; primarily over two to five years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably primarily over four to six years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP) eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Company's Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common stockholders by dividing net earnings attributable to UnitedHealth Group common stockholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common stockholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP, (collectively, common stock equivalents) using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise, any unrecognized compensation cost and any related excess tax benefit. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

Health Reform Legislation includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance

Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method of allocation over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets. In September 2015, the Company paid its full year 2015 Health Insurance Industry Tax of $1.8 billion. There was no liability or asset related to the Health Insurance Industry Tax recorded as of both December 31, 2015 and 2014 as the Health Insurance Industry Tax was paid in September of both years and the asset was fully expensed by each year end.

Premium Stabilization Programs

Health Reform Legislation has included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program).

The risk-adjustment provisions apply to market reform compliant individual and small group plans in the commercial markets. Under the program, each covered member is assigned a risk score based upon demographic information and applicable diagnostic codes from the current year paid claims, in order to determine an average risk score for each plan in a particular state and market risk pool. Generally, a plan with a risk score that is less than the state's average risk score will pay into the pool, while a plan with a risk score that is greater than the state's average will receive money from the pool. The temporary risk corridors provisions are intended to limit the gains and losses of individual and small group qualified health plans. Plans are required to calculate the U.S. Department of Health and Human Services (HHS) risk corridor ratio of allowable costs to the defined target amount. Qualified health plans with ratios below 97% are required to make payments to HHS, while plans with ratios greater than 103% expect to receive funds from HHS. The Reinsurance Program is a transitional three year program through 2016 that is funded on a per capita basis from all commercial lines of business, including insured and self-funded arrangements.

For the Premium Stabilization Programs, the Company records a receivable or payable as an adjustment to premium revenue based on year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final adjustments or recoverable amounts to the Premium Stabilization Programs are determined by HHS in the year following the policy year.

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09) as modified by ASU No. 2015-14, "Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 is effective for annual and interim reporting periods beginning after December 15, 2017. Early adoption at the original effective date, for interim and annual periods beginning after December 15, 2016, will be permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

In November 2015, the FASB issued ASU No. 2015-17, "Balance Sheet Classification of Deferred Taxes (Topic 740)" (ASU 2015-17). ASU 2015-17 requires entities to present deferred tax assets and deferred tax liabilities as noncurrent on a classified balance sheet. ASU -2015-17 is effective for annual and interim reporting periods after

December 15, 2016 and companies are permitted to apply ASU 2015-17 either prospectively or retrospectively. Early adoption of ASU 2015-17 is permitted. The Company plans to early adopt ASU 2015-17 on a prospective basis in the first quarter of 2016.

The Company has determined that there have been no other recently issued or adopted accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Business Combination

On July 23, 2015, the Company acquired all of the outstanding common shares of Catamaran Corporation (Catamaran) and funded Catamaran's payoff of its outstanding debt and credit facility for a total of $14.3 billion in cash. This combination diversifies OptumRx's customer and business mix, while enhancing OptumRx's technology capabilities and flexible service offerings. Catamaran offers pharmacy benefits management services similar to OptumRx to a broad client portfolio, including health plans and employers serving 35 million people, and provides health care information technology solutions to the pharmacy benefits management industry.

The Company paid for the acquisition primarily with the proceeds of new indebtedness. Debt issuances included $10.5 billion of senior unsecured notes, approximately $2.4 billion of commercial paper and a $1.5 billion term loan. The total consideration exceeded the estimated fair value of the net tangible assets acquired by $15.6 billion, of which $5.4 billion has been allocated to finite-lived intangible assets and $10.2 billion to goodwill. The goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) for Catamaran at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 299
Accounts receivable and other current assets	2,005
Rebates receivable	602
Property, equipment and other long-term assets	215
Accounts payable and other current liabilities	(2,525)
Deferred income taxes and other long-term liabilities	(1,923)
Total net tangible liabilities	$(1,327)

Since the Catamaran acquisition closed during the third quarter of 2015, the preliminary purchase price allocation is subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized.

The acquisition date fair values and weighted-average useful lives assigned to Catamaran's finite-lived intangible assets were:

(in millions, except years)	Fair Value	Weighted-Average Useful Life
Customer-related	$5,278	19 years
Trademarks and technology	159	4 years
Total acquired finite-lived intangible assets	$5,437	19 years

The results of operations and financial condition of Catamaran have been included in the Company's consolidated results and the results of the OptumRx segment as of July 23, 2015. Through December 31, 2015, the Catamaran business has generated $12.4 billion in revenue and had an immaterial impact on net earnings.

Unaudited pro forma revenue for the years ended December 31, 2015 and 2014 as if the acquisition of Catamaran had occurred on January 1, 2014 were $172 billion and $152 billion, respectively. The pro forma effects of this acquisition on net earnings were immaterial for both years.

4. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2015				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,982	$ 1	$ (6)	$ 1,977
State and municipal obligations	6,022	149	(3)	6,168
Corporate obligations	7,446	41	(81)	7,406
U.S. agency mortgage-backed securities	2,127	13	(16)	2,124
Non-U.S. agency mortgage-backed securities	962	5	(11)	956
Total debt securities — available-for-sale	18,539	209	(117)	18,631
Equity securities — available-for-sale	1,638	58	(57)	1,639
Debt securities — held-to-maturity:				
U.S. government and agency obligations	163	1	—	164
State and municipal obligations	8	—	—	8
Corporate obligations	339	—	—	339
Total debt securities — held-to-maturity	510	1	—	511
Total investments	$ 20,687	$ 268	$ (174)	$20,781
December 31, 2014				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,614	$ 7	$ (1)	$ 1,620
State and municipal obligations	6,456	217	(5)	6,668
Corporate obligations	7,241	112	(26)	7,327
U.S. agency mortgage-backed securities	2,022	39	(5)	2,056
Non-U.S. agency mortgage-backed securities	872	12	(4)	880
Total debt securities — available-for-sale	18,205	387	(41)	18,551
Equity securities — available-for-sale	1,511	36	(25)	1,522
Debt securities — held-to-maturity:				
U.S. government and agency obligations	178	2	—	180
State and municipal obligations	19	—	—	19
Corporate obligations	298	—	—	298
Total debt securities — held-to-maturity	495	2	—	497
Total investments	$ 20,211	$ 425	$ (66)	$20,570

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2015.

The amortized cost and fair value of debt securities as of December 31, 2015, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 2,103	$ 2,105	$ 121	$121
Due after one year through five years	6,830	6,843	188	188
Due after five years through ten years	4,752	4,793	118	118
Due after ten years	1,765	1,810	83	84
U.S. agency mortgage-backed securities	2,127	2,124	—	—
Non-U.S. agency mortgage-backed securities	962	956	—	—
Total debt securities	$ 18,539	$18,631	$ 510	$511

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2015						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$1,473	$ (6)	$ —	$ —	$1,473	$ (6)
State and municipal obligations	650	(3)	—	—	650	(3)
Corporate obligations	4,629	(63)	339	(18)	4,968	(81)
U.S. agency mortgage-backed securities	1,304	(12)	116	(4)	1,420	(16)
Non-U.S. agency mortgage-backed securities	593	(7)	127	(4)	720	(11)
Total debt securities — available-for-sale	$8,649	$ (91)	$ 582	$ (26)	$9,231	$ (117)
Equity securities — available-for-sale	$ 112	$ (11)	$ 89	$ (46)	$ 201	$ (57)
December 31, 2014						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 420	$ (1)	$ —	$ —	$ 420	$ (1)
State and municipal obligations	711	(4)	99	(1)	810	(5)
Corporate obligations	2,595	(17)	464	(9)	3,059	(26)
U.S. agency mortgage-backed securities	—	—	272	(5)	272	(5)
Non-U.S. agency mortgage-backed securities	254	(2)	114	(2)	368	(4)
Total debt securities — available-for-sale	$3,980	$ (24)	$ 949	$ (17)	$4,929	$ (41)
Equity securities — available-for-sale	$ 107	$ (6)	$ 88	$ (19)	$ 195	$ (25)

The Company's unrealized losses from all securities as of December 31, 2015 were generated from approximately 11,000 positions out of a total of 24,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of December 31, 2015, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, venture capital funds and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

	For the Years Ended December 31,		
(in millions)	2015	2014	2013
Total OTTI	$ (22)	$ (26)	$ (8)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(22)	(26)	(8)
Gross realized losses from sales	(28)	(47)	(9)
Gross realized gains from sales	191	284	198
Net realized gains (included in investment and other income on the Consolidated Statements of Operations)	141	211	181
Income tax effect (included in provision for income taxes on the Consolidated Statements of Operations)	(53)	(77)	(66)
Realized gains, net of taxes	$ 88	$ 134	$ 115

5. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2015 or 2014.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2015 or 2014.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Other Assets. The fair values of the Company's other assets are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-Related Investments. AARP Program-related investments consist of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Interest Rate Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information, including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-Related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2015				
Cash and cash equivalents	$ 10,906	$ 17	$ —	$10,923
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,779	198	—	1,977
State and municipal obligations	—	6,168	—	6,168
Corporate obligations	5	7,308	93	7,406
U.S. agency mortgage-backed securities	—	2,124	—	2,124
Non-U.S. agency mortgage-backed securities	—	951	5	956
Total debt securities — available-for-sale	1,784	16,749	98	18,631
Equity securities — available-for-sale	1,223	14	402	1,639
Interest rate swap assets	—	93	—	93
Total assets at fair value	$ 13,913	$ 16,873	$ 500	$31,286
Percentage of total assets at fair value	44%	54%	2%	100%
Interest rate swap liabilities	$ —	$ 11	$ —	$ 11
December 31, 2014				
Cash and cash equivalents	$ 7,472	$ 23	$ —	$ 7,495
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,427	193	—	1,620
State and municipal obligations	—	6,668	—	6,668
Corporate obligations	2	7,257	68	7,327
U.S. agency mortgage-backed securities	—	2,056	—	2,056
Non-U.S. agency mortgage-backed securities	—	874	6	880
Total debt securities — available-for-sale	1,429	17,048	74	18,551
Equity securities — available-for-sale	1,200	12	310	1,522
Interest rate swap assets	—	62	—	62
Total assets at fair value	$ 10,101	$ 17,145	$ 384	$27,630
Percentage of total assets at fair value	37%	62%	1%	100%
Interest rate swap liabilities	$ —	$ 55	$ —	$ 55

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2015					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 164	$ —	$ —	$ 164	$ 163
State and municipal obligations	—	—	8	8	8
Corporate obligations	91	10	238	339	339
Total debt securities — held-to-maturity	$ 255	$ 10	$ 246	$ 511	$ 510
Other assets	$ —	$ 493	$ —	$ 493	$ 500
Long-term debt and other financing obligations	$ —	$ 29,455	$ —	$29,455	$28,107
December 31, 2014					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 180	$ —	$ —	$ 180	$ 178
State and municipal obligations	—	—	19	19	19
Corporate obligations	46	10	242	298	298
Total debt securities — held-to-maturity	$ 226	$ 10	$ 261	$ 497	$ 495
Other assets	$ —	$ 478	$ —	$ 478	$ 484
Long-term debt and other financing obligations	$ —	$ 18,863	$ —	$18,863	$17,085

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2015			December 31, 2014			December 31, 2013		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 74	$ 310	$384	$ 42	$ 269	$ 311	$ 17	$ 224	$241
Purchases	27	106	133	32	105	137	38	71	109
Sales	(4)	(24)	(28)	(1)	(180)	(181)	(10)	(25)	(35)
Net unrealized gains (losses) in other comprehensive income	2	5	7	1	6	7	(2)	(7)	(9)
Net realized (losses) gains in investment and other income	(1)	5	4	—	110	110	(1)	6	5
Balance at end of period	$ 98	$ 402	$500	$ 74	$ 310	$ 384	$ 42	$ 269	$311

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
December 31, 2015					
Equity securities — available-for-sale:					
Venture capital portfolios	$ 358	Market approach — comparable companies	Revenue multiple	1.0	5.0
			EBITDA multiple	9.0	10.0
	44	Market approach — recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$ 402				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $98 million of available-for-sale debt securities as of December 31, 2015, which were not significant.

The Company elected to measure the entirety of the AARP Program assets under management at fair value pursuant to the fair value option. See Note 2 for further detail on the AARP Program. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
December 31, 2015			
Cash and cash equivalents	$ 274	$ —	$ 274
Debt securities:			
U.S. government and agency obligations	482	140	622
State and municipal obligations	—	103	103
Corporate obligations	—	1,244	1,244
U.S. agency mortgage-backed securities	—	398	398
Non-U.S. agency mortgage-backed securities	—	195	195
Total debt securities	482	2,080	2,562
Other investments	76	86	162
Total assets at fair value	$ 832	$ 2,166	$ 2,998
December 31, 2014			
Cash and cash equivalents	$ 415	$ —	$ 415
Debt securities:			
U.S. government and agency obligations	409	245	654
State and municipal obligations	—	95	95
Corporate obligations	—	1,200	1,200
U.S. agency mortgage-backed securities	—	340	340
Non-U.S. agency mortgage-backed securities	—	177	177
Total debt securities	409	2,057	2,466
Equity securities — available-for-sale	—	81	81
Total assets at fair value	$ 824	$ 2,138	$ 2,962
Other liabilities	$ 5	$ 13	$ 18

6. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2015	December 31, 2014
Land and improvements	$ 237	$ 310
Buildings and improvements	2,420	2,295
Computer equipment	1,945	1,693
Furniture and fixtures	790	675
Less accumulated depreciation	(2,163)	(1,982)
Property and equipment, net	3,229	2,991
Capitalized software	2,642	2,399
Less accumulated amortization	(1,010)	(972)
Capitalized software, net	1,632	1,427
Total property, equipment and capitalized software, net	$ 4,861	$ 4,418

Depreciation expense for property and equipment for 2015, 2014 and 2013 was $613 million, $532 million and $445 million, respectively. Amortization expense for capitalized software for 2015, 2014 and 2013 was $430 million, $422 million and $411 million, respectively.

7. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2014	$ 24,251	$ 2,860	$ 3,653	$ 840	$ 31,604
Acquisitions	266	978	591	—	1,835
Foreign currency effects and adjustments, net	(487)	(4)	(8)	—	(499)
Balance at December 31, 2014	24,030	3,834	4,236	840	32,940
Acquisitions	128	1,817	89	10,732	12,766
Foreign currency effects and adjustments, net	(1,233)	9	(29)	—	(1,253)
Balance at December 31, 2015	$ 22,925	$ 5,660	$ 4,296	$ 11,572	$ 44,453

The increase in the Company's goodwill is primarily due to the acquisition of Catamaran. For more detail on the Catamaran acquisition, see Note 3 of the Notes to the Consolidated Financial Statements.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2015			December 31, 2014		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$10,270	$ (2,796)	$ 7,474	$ 5,021	$ (2,399)	$ 2,622
Trademarks and technology	682	(249)	433	527	(202)	325
Trademarks — indefinite-lived	358	—	358	539	—	539
Other	209	(83)	126	267	(84)	183
Total	$11,519	$ (3,128)	$ 8,391	$ 6,354	$ (2,685)	$ 3,669

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2015		2014	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$5,518	19 years	$314	14 years
Trademarks and technology	194	4 years	148	6 years
Other	—		2	14 years
Total acquired finite-lived intangible assets	$5,712	19 years	$464	11 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2016	$808
2017	772
2018	668
2019	612
2020	543

Amortization expense relating to intangible assets for December 31, 2015, 2014 and 2013 was $650 million, $524 million and $519 million, respectively.

8. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2015	2014	2013
Medical costs payable, beginning of period	$ 12,040	$ 11,575	$ 11,004
Reported medical costs:			
Current year	104,195	94,053	90,339
Prior years	(320)	(420)	(680)
Total reported medical costs	103,875	93,633	89,659
Claim payments:			
Payments for current year	(90,630)	(82,750)	(79,358)
Payments for prior year	(10,955)	(10,418)	(9,730)
Total claim payments	(101,585)	(93,168)	(89,088)
Medical costs payable, end of period	$ 14,330	$ 12,040	$ 11,575

For the years ended December 31, 2015 and 2014, the favorable medical cost reserve development was due to a number of individual factors that were not material. The net favorable development for the year ended December 31, 2013 was primarily driven by lower than expected health system utilization levels.

9. Commercial Paper and Long-Term Debt

Commercial paper, term loan and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2015 Par Value	December 31, 2015 Carrying Value	December 31, 2015 Fair Value	December 31, 2014 Par Value	December 31, 2014 Carrying Value	December 31, 2014 Fair Value
Commercial paper	$ 3,987	$ 3,987	$ 3,987	$ 321	$ 321	$ 321
Floating rate term loan due July 2016 (c)	1,500	1,500	1,500	—	—	—
4.875% notes due March 2015 (a)	—	—	—	416	419	419
0.850% notes due October 2015 (a), (b)	—	—	—	625	625	627
5.375% notes due March 2016 (a), (b)	601	605	606	601	623	634
1.875% notes due November 2016 (a), (b)	400	400	403	400	397	406
5.360% notes due November 2016	95	95	98	95	95	103
Floating rate notes due January 2017 (c)	750	750	751	—	—	—
6.000% notes due June 2017 (a), (b)	441	458	469	441	466	489
1.450% notes due July 2017 (c)	750	750	750	—	—	—
1.400% notes due October 2017 (a), (b)	625	625	624	625	616	624
6.000% notes due November 2017 (a), (b)	156	163	168	156	164	175
1.400% notes due December 2017 (a), (b)	750	753	748	750	745	749
6.000% notes due February 2018 (a), (b)	1,100	1,115	1,196	1,100	1,106	1,238
1.900% notes due July 2018 (c)	1,500	1,498	1,505	—	—	—
1.625% notes due March 2019 (a), (b)	500	503	494	500	496	493
2.300% notes due December 2019 (a)	500	501	502	500	496	502
2.700% notes due July 2020 (c)	1,500	1,499	1,516	—	—	—
3.875% notes due October 2020 (a)	450	454	476	450	450	477
4.700% notes due February 2021 (a)	400	414	438	400	413	450
3.375% notes due November 2021 (a)	500	501	517	500	496	519
2.875% notes due December 2021 (a)	750	756	760	750	748	759
2.875% notes due March 2022 (a)	1,100	1,061	1,099	1,100	1,042	1,104
3.350% notes due July 2022 (c)	1,000	999	1,023	—	—	—
0.000% notes due November 2022	15	10	11	15	10	11
2.750% notes due February 2023 (a)	625	614	613	625	604	613
2.875% notes due March 2023 (a)	750	784	742	750	777	745
3.750% notes due July 2025 (c)	2,000	1,995	2,062	—	—	—
4.625% notes due July 2035 (c)	1,000	1,000	1,038	—	—	—
5.800% notes due March 2036	850	845	1,003	850	845	1,052
6.500% notes due June 2037	500	495	628	500	495	670
6.625% notes due November 2037	650	646	829	650	646	888
6.875% notes due February 2038	1,100	1,085	1,439	1,100	1,085	1,544
5.700% notes due October 2040	300	298	348	300	298	378
5.950% notes due February 2041	350	348	416	350	348	455
4.625% notes due November 2041	600	593	609	600	593	646
4.375% notes due March 2042	502	486	493	502	486	536
3.950% notes due October 2042	625	612	582	625	611	621
4.250% notes due March 2043	750	740	728	750	740	786
4.750% notes due July 2045 (c)	2,000	1,992	2,107	—	—	—
Total commercial paper, term loan and long-term debt	$31,972	$31,930	$33,278	$17,347	$17,256	$19,034

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

(b) The Company terminated the interest rate swap contracts on these hedged instruments during the year ended December 31, 2015. See below for more information on this termination.

(c) Debt issued to fund the Catamaran acquisition. For more detail on Catamaran, see Note 3 of Notes to the Consolidated Financial Statements.

The Company's long-term debt obligations also included $164 million and $150 million of other financing obligations, of which $47 million and $34 million were current as of December 31, 2015 and 2014, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2016	$ 6,630
2017	3,491
2018	2,607
2019	1,024
2020	1,952
Thereafter	16,432

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2015, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.7%.

The Company has $3.0 billion five-year, $2.0 billion three-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in December 2020, December 2018, and November 2016, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2015, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2015, annual interest rates would have ranged from 1.2% to 1.7%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-stockholders' equity ratio of not more than 55%. The Company was in compliance with its debt covenants as of December 31, 2015.

Interest Rate Swap Contracts

The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its variable rate financial assets. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are considered to be highly effective hedges and all changes in the fair values of the swaps are recorded as adjustments to the carrying value of the related debt with no net impact recorded on the Consolidated Statements of Operations. Both the hedge fair value changes and the offsetting debt adjustments are recorded in interest expense on the Consolidated Statements of Operations. The following table summarizes the location and fair value of the interest rate swap fair value hedges on the Company's Consolidated Balance Sheet:

Type of Fair Value Hedge	Notional Amount (in billions)	Fair Value (in millions)	Balance Sheet Location
December 31, 2015			
Interest rate swap contracts	$ 5.1	$ 93	Other assets
		11	Other liabilities
December 31, 2014			
Interest rate swap contracts	$ 10.7	$ 62	Other assets
		55	Other liabilities

During 2015, the Company terminated $5.2 billion notional amount of its interest rate swap fair value hedges. The resulting gain was not material.

The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Consolidated Statements of Operations:

	For the Years Ended December 31,		
(in millions)	2015	2014	2013
Hedge — interest rate swap gain (loss) recognized in interest expense	$ 75	$ 170	$ (166)
Hedged item — long-term debt (loss) gain recognized in interest expense	(75)	(170)	166
Net impact on the Company's Consolidated Statements of Operations	$ —	$ —	$ —

10. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2015	2014	2013
Current Provision:			
Federal	$4,155	$3,883	$3,004
State and local	281	271	237
Total current provision	4,436	4,154	3,241
Deferred (benefit) provision	(73)	(117)	1
Total provision for income taxes	$4,363	$4,037	$3,242

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2015		2014		2013	
Tax provision at the U.S. federal statutory rate	$3,581	35.0%	$3,380	35.0%	$3,120	35.0%
Health insurance industry tax	627	6.1	469	4.8	—	—
State income taxes, net of federal benefit	145	1.4	154	1.6	126	1.4
Tax-exempt investment income	(44)	(0.4)	(49)	(0.5)	(53)	(0.6)
Non-deductible compensation	103	1.0	96	1.0	39	0.5
Other, net	(49)	(0.5)	(13)	(0.1)	10	0.1
Provision for income taxes	$4,363	42.6%	$4,037	41.8%	$3,242	36.4%

The higher tax rates for 2015 and 2014 were primarily due to the increase in the nondeductible Health Insurance Industry Tax.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2015	2014
Deferred income tax assets:		
Accrued expenses and allowances	$ 739	$ 313
U.S. federal and state net operating loss carryforwards	139	172
Share-based compensation	124	141
Nondeductible liabilities	205	222
Medical costs payable and other policy liabilities	71	120
Non-U.S. tax loss carryforwards	244	257
Unearned revenues	94	90
Unrecognized tax benefits	69	38
Other-domestic	51	36
Other-non-U.S.	130	141
Subtotal	1,866	1,530
Less: valuation allowances	(44)	(119)
Total deferred income tax assets	1,822	1,411
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,951)	(1,275)
Non-U.S. goodwill and intangible assets	(397)	(496)
Capitalized software	(574)	(506)
Net unrealized gains on investments	(34)	(129)
Depreciation and amortization	(312)	(272)
Prepaid expenses	(205)	(140)
Other-non-U.S.	(76)	(102)
Total deferred income tax liabilities	(4,549)	(2,920)
Net deferred income tax liabilities	$(2,727)	$(1,509)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $122 million expire beginning in 2021 through 2035; state net operating loss carryforwards expire beginning in 2016 through 2035. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2015, the Company had $459 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2015	2014	2013
Gross unrecognized tax benefits, beginning of period	$ 92	$89	$81
Gross increases:			
Current year tax positions	—	—	8
Prior year tax positions	55	4	5
Acquired reserves	89	—	—
Gross decreases:			
Prior year tax positions	(2)	—	—
Settlements	(1)	—	—
Statute of limitations lapses	(9)	(1)	(5)
Gross unrecognized tax benefits, end of period	$224	$92	$89

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $137 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statement of Operations. During 2015, 2014, and 2013, the Company recognized $11 million, $6 million and $4 million of interest and penalties, respectively. The Company had $59 million and $33 million of accrued interest and penalties for uncertain tax positions as of December 31, 2015 and 2014, respectively. These amounts are not included in the reconciliation above.

The Company currently files income tax returns in the United States, various states and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2014 and prior. The Company's 2015 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2008 tax year. The Brazilian federal revenue service — Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed.

11. Stockholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2015, the Company's regulated subsidiaries paid their parent companies dividends of $4.4 billion, including $1.5 billion of extraordinary dividends. For the year ended December 31,

2014, the Company's regulated subsidiaries paid their parent companies dividends of $4.6 billion, including $1.5 billion of extraordinary dividends. As of December 31, 2015, $286 million of the Company's $10.9 billion of cash and cash equivalents was available for general corporate use.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $15.3 billion as of December 31, 2015. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $8.6 billion as of December 31, 2015.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital and total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2015, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to stockholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2014, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock. During 2015, the Company repurchased 10.7 million shares at an average price of $112.45 per share and an aggregate cost of $1.2 billion. As of December 31, 2015, the Company had Board authorization to purchase up to 61 million shares of its common stock.

Dividends

In June 2015, the Company's Board of Directors increased the Company's quarterly cash dividend to stockholders to equal an annual dividend rate of $2.00 per share compared to the annual dividend rate of $1.50 per share, which the Company had paid since June 2014. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2015	$1.8750	$ 1,786
2014	1.4050	1,362
2013	1.0525	1,056

12. Share-Based Compensation

In June 2015, the Company's stockholders approved an amendment to the 2011 Stock Incentive Plan (Plan). The approved amendment increased the number of shares authorized for issuance under the Plan by 70 million and removed certain limits in the Plan. The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2015, the Company had 85 million shares available for future grants of share-based awards under the Plan. As of December 31, 2015, there were also 12 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2015 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	33	$ 53		
Granted	9	110		
Exercised	(7)	53		
Forfeited	(1)	80		
Outstanding at end of period	34	68	6.0	$ 1,666
Exercisable at end of period	16	47	3.4	1,133
Vested and expected to vest, end of period	33	67	5.9	1,646

Restricted Shares

Restricted share activity for the year ended December 31, 2015 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	9	$ 61
Granted	3	110
Vested	(5)	62
Nonvested at end of period	7	82

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2015	2014	2013
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 22	$ 22	$ 19
Total intrinsic value of stock options and SARs exercised	482	526	592
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	110	71	58
Total fair value of restricted shares vested	$460	$437	$ 31
Employee Stock Purchase Plan			
Number of shares purchased	2	2	3
Share-Based Compensation Items			
Share-based compensation expense, before tax	$406	$364	$331
Share-based compensation expense, net of tax effects	348	314	239
Income tax benefit realized from share-based award exercises	247	231	206

(in millions, except years)	December 31, 2015
Unrecognized compensation expense related to share awards	$ 469
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2015	2014	2013
Risk-free interest rate	1.6% - 1.7%	1.7% - 1.8%	1.0% - 1.6%
Expected volatility	22.3% - 24.1%	24.1% - 39.6%	41.0% - 43.0%
Expected dividend yield	1.4% - 1.7%	1.6% - 1.9%	1.4% - 1.6%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.5 - 6.1	5.4	5.3

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2015, 2014 and 2013.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $553 million and $496 million as of December 31, 2015 and 2014, respectively.

13. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for 2015, 2014 and 2013 was $555 million, $449 million and $438 million, respectively.

As of December 31, 2015, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2016	$ 417
2017	370
2018	325
2019	267
2020	230
Thereafter	471

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2015, 2014 and 2013.

As of December 31, 2015, the Company had outstanding, undrawn letters of credit with financial institutions of $30 million and surety bonds outstanding with insurance companies of $1.1 billion, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI had never before issued a fine in excess of $8 million, CDI advocated a fine of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a nonbinding proposed decision recommending a fine of $11.5 million. The California Insurance Commissioner rejected the administrative law judge's recommendation and on June 9, 2014, issued his own decision imposing a fine of approximately $174 million. On July 10, 2014, the Company filed a lawsuit in California state court challenging the Commissioner's decision. On September 8, 2015, in the first phase of that lawsuit, the California state court issued an order invalidating certain of the regulations the Commissioner had relied upon in issuing his decision and penalty. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the wide range of possible outcomes, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting a regulatory fine in the event of a remand, and the various remedies and levels of judicial review that remain available to the Company.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the Brazilian federal revenue service (the

Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model. The Company has produced documents, information and witnesses to the Department of Justice in cooperation with a current review of the Company's risk-adjustment processes, including the Company's patient chart review and related programs. CMS has selected certain of our local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to our health plans.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the status of the reviews, the wide range of possible outcomes and inherent difficulty in predicting regulatory action, fines and penalties, if any, the Company's legal and factual defenses and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Guaranty Fund Assessments

Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies (including state health insurance cooperatives) that write the same line or similar lines of business. In 2009, the Pennsylvania Insurance Commissioner placed long term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In 2012, the court denied the liquidation petition and ordered the Insurance Commissioner to submit a rehabilitation plan. The court held a hearing in July 2015 to begin its consideration of the latest proposed rehabilitation plan. The hearing is scheduled to continue in the spring of 2016.

If the current proposed rehabilitation plan, which contemplates the partial liquidation of Penn Treaty, is approved by the court, the Company's insurance entities and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through state guaranty association assessments. The Company continues to vigorously challenge the proposed rehabilitation plan. The Company is currently unable to estimate losses or ranges of losses because the Company cannot predict when or to what extent Penn Treaty will ultimately be liquidated, the amount of the insolvency, the amount and timing of any associated guaranty fund assessments or the availability and amount of any premium tax and other potential offsets.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit

plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide and active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.

- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling population health management and local care delivery through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and relationship management and sales distribution platform services and financial services.
- *OptumInsight* is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers pharmacy care services and programs, including retail pharmacy network management services, home delivery and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 26% for 2015, and 29% for both 2014 and 2013, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 95% and 95% of consolidated total revenues for 2015, 2014 and 2013, respectively. Long-lived fixed assets located in the United States represented approximately 81% and 73% of the total long-lived fixed assets as of December 31, 2015 and 2014, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum: OptumHealth	Optum: OptumInsight	Optum: OptumRx	Optum: Optum Eliminations	Optum: Optum	Corporate and Eliminations	Consolidated
2015								
Revenues — external customers:								
Premiums	$ 124,011	$ 3,152	$ —	$ —	$ —	$ 3,152	$ —	$ 127,163
Products	2	31	108	17,171	—	17,310	—	17,312
Services	6,776	2,375	2,390	381	—	5,146	—	11,922
Total revenues — external customers	130,789	5,558	2,498	17,552	—	25,608	—	156,397
Total revenues — intersegment	—	8,216	3,697	30,718	(791)	41,840	(41,840)	—
Investment and other income	554	153	1	2	—	156	—	710
Total revenues	$ 131,343	$ 13,927	$ 6,196	$ 48,272	$ (791)	$67,604	$ (41,840)	$ 157,107
Earnings from operations	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ —	$ 11,021
Interest expense	—	—	—	—	—	—	(790)	(790)
Earnings before income taxes	$ 6,754	$ 1,240	$ 1,278	$ 1,749	$ —	$ 4,267	$ (790)	$ 10,231
Total assets	$ 64,212	$ 14,600	$ 8,335	$ 26,844	$ —	$49,779	$ (2,608)	$ 111,383
Purchases of property, equipment and capitalized software	653	252	572	79	—	903	—	1,556
Depreciation and amortization	718	251	492	232	—	975	—	1,693
2014								
Revenues — external customers:								
Premiums	$ 112,645	$ 2,657	$ —	$ —	$ —	$ 2,657	$ —	$ 115,302
Products	3	18	96	4,125	—	4,239	—	4,242
Services	6,516	1,300	2,224	111	—	3,635	—	10,151
Total revenues — external customers	119,164	3,975	2,320	4,236	—	10,531	—	129,695
Total revenues — intersegment	—	6,913	2,906	27,740	(489)	37,070	(37,070)	—
Investment and other income	634	144	1	—	—	145	—	779
Total revenues	$ 119,798	$ 11,032	$ 5,227	$ 31,976	$ (489)	$47,746	$ (37,070)	$ 130,474
Earnings from operations	$ 6,992	$ 1,090	$ 1,002	$ 1,190	$ —	$ 3,282	$ —	$ 10,274
Interest expense	—	—	—	—	—	—	(618)	(618)
Earnings before income taxes	$ 6,992	$ 1,090	$ 1,002	$ 1,190	$ —	$ 3,282	$ (618)	$ 9,656
Total assets	$ 62,405	$ 11,148	$ 8,112	$ 5,474	$ —	$24,734	$ (757)	$ 86,382
Purchases of property, equipment and capitalized software	773	212	484	56	—	752	—	1,525
Depreciation and amortization	772	179	433	94	—	706	—	1,478
2013								
Revenues — external customers:								
Premiums	$ 107,024	$ 2,533	$ —	$ —	$ —	$ 2,533	$ —	$ 109,557
Products	8	19	92	3,071	—	3,182	—	3,190
Services	6,076	819	2,006	96	—	2,921	—	8,997
Total revenues — external customers	113,108	3,371	2,098	3,167	—	8,636	—	121,744
Total revenues — intersegment	—	6,357	2,615	20,839	(458)	29,353	(29,353)	—
Investment and other income	617	127	1	—	—	128	—	745
Total revenues	$ 113,725	$ 9,855	$ 4,714	$ 24,006	$ (458)	$38,117	$ (29,353)	$ 122,489
Earnings from operations	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ —	$ 9,623
Interest expense	—	—	—	—	—	—	(708)	(708)
Earnings before income taxes	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ (708)	$ 8,915
Total assets	$ 61,942	$ 9,244	$ 6,880	$ 4,483	$ —	$20,607	$ (667)	$ 81,882
Purchases of property, equipment and capitalized software	670	185	363	89	—	637	—	1,307
Depreciation and amortization	766	158	359	92	—	609	—	1,375

15. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2015 and 2014 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2015				
Revenues	$35,756	$36,263	$ 41,489	$ 43,599
Operating costs	33,116	33,368	38,471	41,131
Earnings from operations	2,640	2,895	3,018	2,468
Net earnings	1,413	1,585	1,618	1,252
Net earnings attributable to UnitedHealth Group common stockholders	1,413	1,585	1,597	1,218
Net earnings per share attributable to UnitedHealth Group common stockholders:				
Basic	1.48	1.66	1.68	1.28
Diluted	1.46	1.64	1.65	1.26
2014				
Revenues	$31,708	$32,574	$ 32,759	$ 33,433
Operating costs	29,654	30,022	29,856	30,668
Earnings from operations	2,054	2,552	2,903	2,765
Net earnings	1,099	1,408	1,602	1,510
Net earnings attributable to UnitedHealth Group common stockholders	1,099	1,408	1,602	1,510
Net earnings per share attributable to UnitedHealth Group common stockholders:				
Basic	1.12	1.44	1.65	1.58
Diluted	1.10	1.42	1.63	1.55

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2015. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2015.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2015

UnitedHealth Group Incorporated and Subsidiaries' (the "Company") management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2015. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Management's assessment of the effectiveness of our internal control over financial reporting excluded an assessment of the effectiveness of our internal control over financial reporting of the Catamaran Corporation (Catamaran) acquisition. Such exclusion was in accordance with Securities and Exchange Commission guidance that an assessment of a recently acquired business may be omitted in management's report on internal control over financial reporting in the year of acquisition. We acquired Catamaran during July 2015. Catamaran represented 16% of our consolidated total assets and 8% of our consolidated total revenues as of and for the year ended December 31, 2015. Based on our assessment and the COSO criteria, we believe that, as of December 31, 2015, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2015, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2015, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Report of Management on Internal Control over Financial Reporting as of December 31, 2015, management excluded from its assessment the internal control over financial reporting at Catamaran Corporation (Catamaran), which was acquired during July 2015 and whose financial statements collectively constitute 16% of consolidated total assets and 8% of consolidated total revenues as of and for the year ended December 31, 2015. Accordingly, our audit did not include the internal control over financial reporting at Catamaran. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2015. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2015 of the Company and our report dated February 9, 2016 expressed an unqualified opinion on those consolidated financial statements.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 9, 2016

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 9, 2016, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP
(formerly Greenebaum Doll & McDonald PLLC)

Edson Bueno, M.D.
Founder and Chief Executive Officer
Amil

Richard T. Burke
Non-Executive Chairman
UnitedHealth Group

Robert J. Darretta
Retired Vice-Chairman and
Chief Financial Officer
Johnson & Johnson

Stephen J. Hemsley
Chief Executive Officer
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council, a company
focused on improving the governance
processes of corporate boards

Rodger A. Lawson
Chairman
E*TRADE Financial Corporation and
Retired President and Chief Executive Officer
Fidelity Investments — Financial Services

Glenn M. Renwick
Chairman, President and Chief Executive Officer
The Progressive Corporation

Kenneth I. Shine, M.D.
Professor of Medicine at the Dell Medical School
University of Texas

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE, an international health foundation

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2016 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance — Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2016 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2015, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by stockholders [1]	33	$ 68	97 [3]
Equity compensation plans not approved by stockholders [2]	—	—	—
Total [2]	33	$ 68	97

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 ESPP, as amended.

(2) Excludes 263,000 shares underlying stock options assumed by us in connection with an acquisition. These options have a weighted-average exercise price of $95 and an average remaining term of approximately 8.6 years. The options are administered pursuant to the terms of the plan under which the options originally were granted. No future awards will be granted under this acquired plan.

(3) Includes 12 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2015, and 85 million shares available under the 2011 Stock Incentive Plan as of December 31, 2015. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2016 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2016 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2016 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2015 and 2014.
- Consolidated Statements of Operations for the years ended December 31, 2015, 2014, and 2013.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2015, 2014, and 2013.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2015, 2014, and 2013.
- Consolidated Statements of Cash Flows for the years ended December 31, 2015, 2014, and 2013.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

2.1	Arrangement Agreement, dated as of March 29, 2015, among UnitedHealth Group Incorporated, 1031387 B.C. Unlimited Liability Company and Catamaran Corporation (incorporated by reference to Exhibit 2.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on March 30, 2015)
3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A filed on July 1, 2015)

4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2015 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on June 5, 2015)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 toUnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)

*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Summary of Non-Management Director Compensation, effective as of January 1, 2016

*10.25	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.26	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.27	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.28	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.29	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.30	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.31	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.32	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.33	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.34	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.35	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.36	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.37	Amended and Restated Employment Agreement, effective December 1, 2014, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)

*10.38	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.39	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.40	Amended and Restated Employment Agreement, dated as of February 3, 2014, between United HealthCare Services, Inc. and D. Ellen Wilson
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2015, filed on February 9, 2016, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2015 and 2014, and for each of the three years in the period ended December 31, 2015, and the Company's internal control over financial reporting as of December 31, 2015, and have issued our reports thereon dated February 9, 2016; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 9, 2016

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2015	December 31, 2014
Assets		
Current assets:		
Cash and cash equivalents	$ 29	$ 559
Short-term notes receivable from subsidiaries	—	27
Deferred income taxes and other current assets	313	271
Total current assets	342	857
Equity in net assets of subsidiaries	56,316	44,643
Long-term notes receivable from subsidiaries	9,679	4,635
Other assets	328	278
Total assets	$ 66,665	$ 50,413
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 449	$ 332
Note payable to subsidiary	310	215
Commercial paper and current maturities of long-term debt	6,587	1,365
Total current liabilities	7,346	1,912
Long-term debt, less current maturities	25,344	15,891
Deferred income taxes and other liabilities	145	156
Total liabilities	32,835	17,959
Commitments and contingencies (Note 5)		
Stockholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 953 and 954 issued and outstanding	10	10
Additional paid-in capital	29	—
Retained earnings	37,125	33,836
Accumulated other comprehensive loss	(3,334)	(1,392)
Total UnitedHealth Group stockholders' equity	33,830	32,454
Total liabilities and stockholders' equity	$ 66,665	$ 50,413

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2015	2014	2013
Revenues:			
Investment and other income	$ 396	$ 293	$ 252
Total revenues	396	293	252
Operating costs:			
Operating costs	(17)	1	(9)
Interest expense	717	554	618
Total operating costs	700	555	609
Loss before income taxes	(304)	(262)	(357)
Benefit for income taxes	111	96	130
Loss of parent company	(193)	(166)	(227)
Equity in undistributed income of subsidiaries	6,006	5,785	5,852
Net earnings	5,813	5,619	5,625
Other comprehensive loss	(1,942)	(484)	(1,346)
Comprehensive income	$ 3,871	$ 5,135	$ 4,279

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2015	2014	2013
Operating activities			
Cash flows from operating activities	$ 1,727	$ 7,445	$ 5,099
Investing activities			
Issuance of notes to subsidiaries	(5,064)	(436)	(1,517)
Cash paid for acquisitions	(12,270)	(1,852)	(274)
Return of capital to parent company	4,375	—	—
Capital contributions to subsidiaries	(1,109)	(704)	(942)
Other, net	140	(9)	275
Cash flows used for investing activities	(13,928)	(3,001)	(2,458)
Financing activities			
Common stock repurchases	(1,200)	(4,008)	(3,170)
Proceeds from common stock issuances	402	462	598
Cash dividends paid	(1,786)	(1,362)	(1,056)
Proceeds from (repayments of) commercial paper, net	3,666	(794)	(474)
Proceeds from issuance of long-term debt	11,982	1,997	2,235
Repayments of long-term debt	(1,041)	(812)	(943)
Other, net	(352)	(190)	(34)
Cash flows from (used for) financing activities	11,671	(4,707)	(2,844)
Decrease in cash and cash equivalents	(530)	(263)	(203)
Cash and cash equivalents, beginning of period	559	822	1,025
Cash and cash equivalents, end of period	$ 29	$ 559	$ 822
Supplemental cash flow disclosures			
Cash paid for interest	$ 573	$ 578	$ 618
Cash paid for income taxes	4,294	4,028	2,765

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Intercompany Notes. In July 2015, the parent company issued $4.8 billion in intercompany notes that were used to partially fund the Catamaran acquisition. See Note 3 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information about Catamaran.

In 2013, the parent company issued intercompany notes of $1.5 billion that were used primarily to fund the purchase of Amil's remaining public shares.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $4.8 billion, $5.5 billion and $5.3 billion in 2015, 2014 and 2013, respectively. Additionally, in 2015, $4.4 billion in cash was received as a return of capital to the parent company.

3. Business Combination

For information on the Catamaran acquisition, see Note 3 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

4. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 9 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $164 million and $150 million at December 31, 2015 and 2014, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2016	$ 6,583
2017	3,472
2018	2,600
2019	1,000
2020	1,950
Thereafter	16,367

5. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 9, 2016

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director and Chief Executive Officer (principal executive officer)	February 9, 2016
/s/ DAVID S. WICHMANN **David S. Wichmann**	President and Chief Financial Officer (principal financial officer)	February 9, 2016
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 9, 2016
* **William C. Ballard, Jr.**	Director	February 9, 2016
* **Edson Bueno**	Director	February 9, 2016
* **Richard T. Burke**	Director	February 9, 2016
* **Robert J. Darretta**	Director	February 9, 2016
* **Michele J. Hooper**	Director	February 9, 2016
* **Rodger A. Lawson**	Director	February 9, 2016
* **Glenn M. Renwick**	Director	February 9, 2016
* **Kenneth I. Shine**	Director	February 9, 2016
* **Gail R. Wilensky**	Director	February 9, 2016

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

EXHIBIT INDEX**

2.1	Arrangement Agreement, dated as of March 29, 2015, among UnitedHealth Group Incorporated, 1031387 B.C. Unlimited Liability Company and Catamaran Corporation (incorporated by reference to Exhibit 2.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on March 30, 2015)
3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A filed on July 1, 2015)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2015 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on June 5, 2015)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)

*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)

*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Summary of Non-Management Director Compensation, effective as of January 1, 2016
*10.25	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.26	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.27	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.28	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.29	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.30	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.31	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.32	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.33	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.34	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.35	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)

*10.36	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.37	Amended and Restated Employment Agreement, effective December 1, 2014, between United HealthCare Services, Inc. and Larry Renfro (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.38	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.39	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.40	Amended and Restated Employment Agreement, dated as of February 3, 2014, between United HealthCare Services, Inc. and D. Ellen Wilson
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2015, filed on February 9, 2016, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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

Form 10-K

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

For the fiscal year ended December 31, 2014

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®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Minnesota	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2014 was $78,282,268,950 (based on the last reported sale price of $81.75 per share on June 30, 2014, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 30, 2015, there were 953,695,161 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2015 Annual Meeting of Stockholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers, students and other individuals and serves the nation's active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global (formerly UnitedHealthcare International) includes Amil, a health care company providing health and dental benefits and hospital and clinical services to individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: local care delivery, care management, consumer engagement, distribution services, health financial services, operational services and support, health care information technology and pharmacy services.

Through UnitedHealthcare and Optum, in 2014, we managed over $165 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

UnitedHealthcare

UnitedHealthcare's market position is built on:

- national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx pharmacy benefit products and services, certain OptumHealth care management and local care delivery services and OptumInsight health information and technology solutions, consulting and other services.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include a total of over 850,000 physicians and other health care professionals and approximately 6,100 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, individuals and military service members in the TRICARE west region. UnitedHealthcare Employer & Individual provides nearly 29 million Americans access to health care as of December 31, 2014. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

UnitedHealthcare Employer & Individual also offers a variety of insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers.

In recent years, UnitedHealthcare Employer & Individual has diversified its model more extensively, distributing through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. In 2014, UnitedHealthcare Employer & Individual launched UnitedHealthcare Marketplace, a new shopping platform for employers seeking to offer their employees flexibility and a choice of UnitedHealthcare plans. UnitedHealthcare Employer & Individual is also participating in select multi-plan exchanges that they believe are structured to encourage consumer choice. Direct-to-consumer sales are also supported by participation in multi-carrier health insurance marketplaces for individuals and small groups through exchanges. In 2014, UnitedHealthcare Employer & Individual participated in 13 state public health care exchanges, including four individual and nine small group exchanges. In 2015, we are participating in 23 individual and 12 small group state public exchanges.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provide the flexibility to meet the needs of employers of all sizes, as well as individuals shopping for health benefits coverage. UnitedHealthcare Employer & Individual has seen increased demand for consumer driven health plans and new network approaches with lower costs, as well as more convenient care options for consumers. UnitedHealthcare Employer & Individual emphasizes local markets and leverages its national scale to adapt products to meet specific local market needs.

UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). The market for health benefit products is shifting, with benefit and network offerings shaped, at least in part, by the requirements and effects of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation), employer focus on quality and employee engagement, and the urgent need to align the system around value.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products and Tools. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs and consumer education. During 2014, more than 32,000 employer-sponsored benefit plans, including more than 300 employers in the large group self-funded market, purchased HRA or HSA products from us. UnitedHealthcare Employer & Individual's consumer engagement tools support members with access to benefit, cost and quality information through online and mobile applications, such as Advocate4Me, myHealthcare Cost Estimator and Health4Me. Using innovative tools and technology, UnitedHealthcare and Optum's applications are helping people address a broad range of health related issues, including benefits and claims questions, finding the right doctor, proactive support for appointments and issue resolution, health education, clinical program enrollment and treatment decision support.

Value Based Products. UnitedHealthcare Employer & Individual's suite of consumer incentive products increases individual awareness of personal health and care quality and cost for heightened consumer responsibility and behavior change. These products include: Small Business Wellness, which is a packaged

wellness and incentives product that offers gym reimbursement and encourages completion of important wellness activities. For mid-sized clients, SimplyEngaged is a scalable activity-based reward program that ties incentives to completion of health improvement activities, while SimplyEngaged Plus provides richer incentives for achieving health goals. For large, self-funded customers, the UnitedHealthcare Healthy Rewards program offers a flexible incentive design to help employers choose the right activities and include appropriate biometric outcomes that best fit the needs of their employee population. UnitedHealth Personal Rewards leverages a tailored approach to incentives by combining personalized scorecards with financial incentives for improving biometric scores, compliance with key health treatments and preventive care.

Essential Benefits Products. UnitedHealthcare Employer & Individual's portfolio of lower cost products provides value to consumers through innovative plan designs and unique network programs like UnitedHealth Premium®, which guide people to physicians recognized for providing high-quality, cost-efficient care to their patients. This approach to essential benefits is designed to deliver sustainable health care costs for employers, enabling them to continue to offer their employees coverage at more affordable prices. For example, UnitedHealthcare Employer & Individual's tiered benefit plans offer enhanced benefits in the form of greater coinsurance coverage and/or lower copays for people using UnitedHealth Premium® designated care providers.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management programs, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, improving health and decreasing medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts and individuals), and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, and disability product offerings through an integrated approach including a network of more than 58,000 vision professionals in private and retail settings, and nearly 75,000 dental offices.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans is the provider of health care services for nearly 3 million active duty and retired military service members and their families in 21 states

(West Region) under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013, and includes a transition period and five one-year renewals at the government's option.

UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration and customer service.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. It has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a spectrum of risk-based Medicare products that may be purchased by individuals or on a group basis, including Medicare Advantage plans, Medicare Prescription Drug Benefit (Medicare Part D) and Medicare Supplement products that extend and enhance traditional fee-for-service coverage. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 29% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2014, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS and in some cases consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement had approximately 3 million people enrolled in its Medicare Advantage products as of December 31, 2014.

Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the long-term payment rate outlook for each geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly. See Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage

products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to reach out to those members and create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. UnitedHealthcare Medicare & Retirement offers two stand-alone Medicare Part D plans: the AARP MedicareRx Preferred and the AARP MedicareRx Saver Plus plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2014, UnitedHealthcare enrolled approximately 8 million people in the Medicare Part D programs, including more than 5 million individuals in the stand-alone Medicare Part D plans and approximately 3 million in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers plans in all 50 states, the District of Columbia, and most U.S. territories. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover the various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2014, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 5 million beneficiaries. Health Reform Legislation provided for optional Medicaid expansion effective January 1, 2014. For 2015, 13 of our state customers have elected to expand Medicaid, an increase of one state since 2014. For further discussion of the Medicaid expansion under Health Reform Legislation, see Part II, Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and our participation are:

- Temporary Assistance to Needy Families, primarily women and children – 21 markets;
- CHIP – 21 markets;

- Aged, Blind and Disabled (ABD) – 16 markets;
- SNP – 14 markets;
- Medicaid Expansion – 13 markets;
- Long-Term Services and Supports (LTSS) – 12 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 6 markets
- childless adults programs for the uninsured – 4 markets; and
- MMP – 1 market.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. They often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care.

The LTSS market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTSS population is made up of over 4 million individuals who qualify for additional benefits under LTSS programs who represent a subset of the more than 16 million ABD Americans. Currently, only one-quarter of the ABD population and approximately 20% of the LTSS eligible population are served by managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are more than 9 million individuals eligible for both Medicare and Medicaid. This group has historically been referred to as dually eligible or MMP. MMP beneficiaries typically have complex conditions with costs of care that are far higher than typical Medicare or Medicaid beneficiaries. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and improve people's health status through close coordination of care.

Total annual expenditures for MMPs are estimated at more than $390 billion, or approximately 13% of the total health care costs in the United States. As of December 31, 2014, UnitedHealthcare served more than 315,000 people with complex conditions similar to those in an MMP population in legacy programs through Medicare Advantage dual SNPs. As of December 31, 2014, UnitedHealthcare Community & State had been awarded new MMP business taking effect in 2015 in Ohio and Texas.

UnitedHealthcare Global

UnitedHealthcare Global participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare Global's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals

around the world. UnitedHealthcare Global's goal is to create business solutions that are based on local infrastructure, culture and needs, and that blend local expertise with experiences from the U.S. health care industry. As of December 31, 2014, UnitedHealthcare Global provided medical benefits to more than 4 million people, principally in Brazil, but also residing in more than 125 other countries.

Amil. Amil provides health and dental benefits to nearly 7 million people. Amil operates more than 30 acute hospitals and approximately 50 specialty, primary care and emergency services clinics across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of nearly 27,000 physicians and other health care professionals, approximately 2,100 hospitals and more than 7,600 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare Global includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, physicians' practices, hospitals and clinical facilities seeking to modernize the health system and support the best possible patient care and experience.
- Those who pay for care: insurers, employers and government agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently.
- Those who innovate for care: life sciences and research focused organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Using advanced data analytics and technology, Optum helps improve overall health system performance by optimizing care quality, reducing costs and improving the consumer experience and care provider performance. Optum is organized in three reportable segments:

- OptumHealth focuses on care delivery, care management, consumer engagement, distribution and health financial services;
- OptumInsight delivers operational services and support and health information technology services; and
- OptumRx specializes in pharmacy services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and financial needs of more than 63 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and, increasingly, directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth works to optimize the care delivery system through the creation of high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by focusing on caring for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, and on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and local care delivery businesses.

OptumHealth is organized into two major operating groups: Collaborative Care and Consumer Solutions Group (CSG).

Collaborative Care. Collaborative Care's major product offerings include local care delivery, complex population management and mobile care delivery.

- Local Care Delivery. Local care delivery serves patients through a collaborative network of care providers aligned around total population health management and outcomes-based reimbursement. Within its local care delivery systems, OptumHealth works directly with medical groups and Independent Practice Associations to deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. OptumHealth is directly affiliated with clinics and physicians who provided care to more than 2 million patients in 2014.
- Complex Population Management. Complex population management services focus on improving care for patients with very challenging medical conditions by providing the optimal care in the most appropriate setting. Complex population management is focused on building and executing integrated solutions for payers, governmental agencies, accountable care organizations and provider groups for the highest cost patient segment of the health care system with focus on optimizing patient outcomes, quality and cost effectiveness. In addition, complex population management provides hospice services in 17 markets in the United States.
- Mobile Care Delivery. OptumHealth's mobile care delivery business provides occupational health, medical and dental readiness services, treatments and immunization programs. These solutions serve a number of government and commercial clients including the U.S. military.

CSG. CSG includes population health management services, specialty networks, distribution and financial services products.

- Population Health Management Services: OptumHealth serves nearly 38 million people through population health management services, including care management, complex conditions (e.g., cancer, neonatal and maternity), health and wellness and advocacy decision support solutions.

- Specialty Networks. Within specialty networks, OptumHealth serves more than 57 million people by offering them access to proprietary networks of provider specialists in the areas of behavioral health management (e.g., mental health, substance abuse), chiropractic, physical therapy, transplant, infertility, kidney and end stage renal disease.
- Distribution: This business provides health exchange capabilities to help payers, market aggregators and employers meet the needs of the consumers they serve. OptumHealth provides call center support, multi-modal communications software, data analysis and trained nurses that help clients acquire, retain and service large populations of health care consumers.
- Financial Services: This business serves the health financial needs of individuals, employers, health care professionals and payers. OptumHealth is a leading provider of consumer health care accounts. OptumHealth also offers electronic payment solutions to manage compliance and improve the administrative efficiency of electronic claim payments. As of December 31, 2014, Financial Services and its wholly owned subsidiary, Optum Bank, had $2.8 billion in customer assets under management and during 2014 processed $85 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides technology, operational and consulting services to participants in the health care industry. Hospital systems, physician practices, commercial health plans, government agencies, life sciences companies and other organizations that constitute the health care system use OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance, achieve efficiency and modernize their core operating systems to meet the changing needs of the health system landscape.

Many of OptumInsight's software and information products, advisory consulting arrangements and outsourcing contracts are delivered over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. OptumInsight's aggregate backlog at December 31, 2014, was $8.6 billion, of which $4.8 billion is expected to be realized within the next 12 months. This includes $2.9 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2013, adjusted for the January 1, 2014 business realignment discussed in Note 13 of Notes to Consolidated Financial Statements included in Part II, Item 8, "Financial Statements," was $7.5 billion including $2.7 billion related to intersegment agreements. The increase in 2014 backlog was attributable to a revenue management services acquisition and general business growth, partially offset by services performed on existing contracts. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospitals), payers, governments and life sciences organizations.

Care Providers. Serving four out of five U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements and deliver health intelligence. OptumInsight's offerings in clinical workflow software, revenue management tools and services, health IT and analytics help hospitals and physician practices improve patient outcomes, strengthen financial performance and meet quality measurement and compliance requirements, as well as transition to new collaborative and value based business models.

Payers. OptumInsight serves approximately 300 health plans by helping them improve operational and administrative efficiency, meet clinical performance and compliance goals, develop strong provider networks, manage risk and drive growth. OptumInsight also helps payer clients adapt to new market models, including health insurance exchanges, consumer driven health care and engagement, pay-for-value contracting and population health management.

Governments. OptumInsight provides services to government agencies across 36 states and the District of Columbia. Services include financial management and program integrity services, policy and compliance consulting, data and analytics technology, systems integration and expertise to improve medical quality, access and costs.

Life Sciences. OptumInsight's Life Sciences business provides services to more than 200 global life sciences organizations. OptumInsight's services use real-world evidence to support market access and positioning of products, provide insights into patient reported outcomes and optimize and manage risk.

OptumRx

OptumRx provides a full spectrum of pharmacy benefit management (PBM) services to more than 30 million Americans nationwide, managing more than $40 billion in pharmaceutical spending annually and processing nearly 600 million adjusted retail, home delivery and specialty drug prescriptions annually. OptumRx's PBM services deliver a low cost, high-quality pharmacy benefit through retail network contracting services, home delivery and specialty pharmacy services, manufacturer rebate contracting and management and a variety of clinical programs such as step therapy, formulary management, drug adherence and disease and drug therapy management programs. As of December 31, 2014, OptumRx's network included more than 67,000 retail pharmacies and two home delivery pharmacy facilities in California and Kansas.

The home delivery and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component of its business, providing patients with convenient access to maintenance medications, offering a broad range of complex drug therapies and patient management services for individuals with chronic health conditions and enabling OptumRx to help consumers achieve optimal health, while maximizing cost savings.

OptumRx provides PBM services to a substantial majority of UnitedHealthcare members. Additionally, OptumRx manages specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services including patient support and clinical programs designed to ensure quality and deliver value for consumers. This is crucial in managing overall drug spend, as biologics and other specialty medications are the fastest growing pharmacy expenditures. OptumRx also provides PBM services to non-affiliated external clients, including public and private sector employer groups, insurance companies, Taft-Hartley Trust Funds, TPAs, managed care organizations (MCOs), Medicare-contracted plans, Medicaid plans and other sponsors of health benefit plans and individuals throughout the United States. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses, and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amount of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to risk adjustment and reinsurance data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies that are held by our Optum businesses and UnitedHealthcare Military & Veterans business, such as our TRICARE West Region contract with the DoD.

Certain of our businesses, such as UnitedHealthcare's eyeglass manufacturing activities and Optum's high acuity clinical workflow software, hearing aid products and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration (FDA). Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Health Care Reform. Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system.

Among other requirements, Health Reform Legislation expanded dependent coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain medical loss ratios (MLRs) are not satisfied, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, introduced new risk sharing programs, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

Health Reform Legislation and the related federal and state regulations are affecting how we do business and could impact our results of operations, financial position and cash flows. The full impact of Health Reform Legislation remains difficult to predict and is not yet fully known. See also Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" for a discussion of the risks related to Health Reform Legislation and related matters.

Privacy, Security, and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to

HIPAA contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States is anticipated to be replaced by ICD-10 code sets on October 1, 2015, and health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures for dates of services on or after such date.

The Health Information Technology for Economic and Clinical Health Act (HITECH) significantly expanded the privacy and security provisions of HIPAA. HITECH imposes additional requirements on uses and disclosures of health information; includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a third-party, and generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where implemented by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. In 2014, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment Model Act that requires us to maintain a risk management framework and file a self-assessment report with state insurance regulators. The first report will be filed with Connecticut, our lead regulator, in 2015, and annually thereafter. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with Health Reform Legislation, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports

that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, MCO, utilization review (UR), TPA, or care provider-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distributions laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or similar lines of business. Assessments are generally based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets. Any such assessment could expose our insurance entities and other insurers to the risk of paying a portion of an insolvent insurance company's claims through state guaranty association assessments in future periods.

Pharmacy Regulation. OptumRx's home delivery pharmacies must be licensed as pharmacies in the states in which they are located. Our home delivery pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In addition to the laws and regulations in the states where our home delivery pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. As our home delivery pharmacies maintain certain Medicare and state Medicaid provider numbers, their participation in the programs requires them to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our PBM businesses.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, tax, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary from jurisdiction to jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and to insurance industries and regulation by Brazilian regulators including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Anthem, Inc., Cigna Corporation, Health Net, Inc., Humana Inc., Kaiser Permanente, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association,

and, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including by maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors," for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2014, we employed approximately 170,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 10, 2015, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	62	Chief Executive Officer
David S. Wichmann	52	President and Chief Financial Officer
Eric S. Rangen	58	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	61	Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum
Marianne D. Short	63	Executive Vice President and Chief Legal Officer
D. Ellen Wilson	57	Executive Vice President, Human Capital

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. From May 1999 to November 2014, Mr. Hemsley also served as President of UnitedHealth Group.

Mr. Wichmann is President and Chief Financial Officer of UnitedHealth Group. Mr. Wichmann has served as President of UnitedHealth Group since November 2014 and Chief Financial Officer of UnitedHealth Group since January 2011. From April 2008 to November 2014, Mr. Wichmann also served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006.

Mr. Renfro is Vice Chairman of UnitedHealth Group and Chief Executive Officer of Optum. Mr. Renfro has served as Vice Chairman of UnitedHealth Group since November 2014 and Chief Executive Officer of Optum since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President, Human Capital of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking

statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or 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 our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, Health Reform Legislation established minimum MLRs for certain health plans and authorized HHS to maintain an annual price increase review process for commercial health plans, which could make it more difficult for us to increase the prices of our products. In addition, our OptumHealth Local Care Delivery business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer’s premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies is typically at a fixed monthly rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly drugs, treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2014 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2014 would have been reduced by approximately $190 million, excluding any offsetting impact from premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims, and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or similar lines of business. Any such assessment could expose our insurance entities to the risk of paying a portion of an insolvent insurance company's claims through state guaranty association assessments in future periods.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, FDA regulations, state telemedicine regulations, debt collection laws, banking regulations, distributor and producer licensing requirements, state corporate practice of medicine doctrines, fee-splitting rules, health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products, increase prices for certain regulated products, and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Some of our businesses operate internationally and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory

environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, capital (including minimum solvency margin and reserve requirements), management control, labor relations, fraud and corruption present compliance requirements and uncertainties for us that are different from those faced by U.S.-based businesses. We have acquired and may in the future acquire or commence additional businesses based outside of the United States, which may subject us to foreign and U.S.-based laws specific to the products and services we acquire or develop outside of the United States. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and insurance industries, which vary from comparable U.S. laws and regulations, and to regulation by Brazilian regulators, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation, such as Health Reform Legislation and associated exchanges. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

Health Reform Legislation could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity, ongoing implementation and continued legal challenges, Health Reform Legislation's full impact remains difficult to predict and could adversely affect us. For example, Health Reform Legislation includes specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. In addition, if we do not maintain certain minimum loss ratios, we are required to rebate ratable portions of our premiums to our customers. These changes can cause significant disruptions in local health care markets and adjustments to our business, all of which could materially and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation required the establishment of health insurance exchanges for individuals and small employers and requires insurers participating on the health insurance exchanges to offer a minimum level of benefits and includes guidelines on setting premium rates and coverage limitations. While risk adjustment applies to most individual and small group plans in the commercial markets, actual risk adjustment calculations and transfers could materially differ from our assumptions. Our participation in these exchanges involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows. In addition, pending legal challenges to the availability of tax subsidies to participants in federal exchange marketplaces could significantly disrupt the health insurance market and negatively affect our business.

Our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under Health Reform Legislation than we expect, if we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for Health Reform Legislation related products and capabilities offered by our Optum businesses is less than anticipated.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs, CHIP and our TRICARE West Region contract with the DoD, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. For 2014, CMS asked plans to submit additional information indicating whether or not medical conditions were diagnosed in a clinical setting. CMS has indicated that it will publish further guidance on the treatment of risk adjustment data in early 2015. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of Health Reform Legislation, CMS has a system that provides various quality bonus payments to plans that meet certain quality star ratings at the local plan level. The star rating system considers various measures adopted by CMS, including, among other things, quality of care, preventative services, chronic illness management and customer satisfaction. Beginning in 2015, plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could

materially and adversely affect our results of operations, financial position and cash flows. In addition, under Health Reform Legislation, Congress authorized CMS and the states to implement MMP managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MMP demonstration programs for dually eligible beneficiaries, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the “error rate” identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service “error rate” adjuster that will be used in determining the payment adjustment. Depending on the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been and may in the future become involved in routine, regular, and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with coding and other requirements under the Medicare risk-adjustment model. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to

HIPAA imposed further restrictions on our ability to collect, disclose and use sensitive personal information and imposed additional compliance requirements on our business. While we have prepared for the transition to ICD-10 as a HIPAA-regulated entity, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business as a home delivery pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM businesses would be materially and adversely affected by our inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our home delivery or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our home

delivery or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, Brazil and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. Additionally, new direct to consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits, health care usage, and in the effective navigation of the health care system we may be challenged by new technologies and market entrants that could disrupt our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other service providers at competitive prices. Any failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, distract managements' attention and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations; practice management companies (which are companies that aggregate physician practices for administrative efficiency); and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of certain businesses, including OptumHealth Local Care Delivery and Amil, depend on maintaining satisfactory physician employment relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with primary care physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various litigation actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. Success in completing acquisitions is also dependent upon efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and to realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation, and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through independent producers and consultants with whom we do not have exclusive contracts and for whose services and allegiance we must compete intensely. Our sales would be materially and adversely affected if we were unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans and our non-employer individual plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance

companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2014. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and shareholders' equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and credit ratings could be materially and adversely affected.

As of December 31, 2014, goodwill and other intangible assets had a carrying value of $36.6 billion, representing 42% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of

the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third-parties. Some of the data we process, store and transmit may be outside of the U.S. due to our information technology systems and international business operations. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss

or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position, and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency’s opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Litigation Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 30, 2015, there were 13,946 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE and cash dividends declared for our last two fiscal years were as follows:

	High	Low	Cash Dividends Declared
2014			
First quarter	$ 83.32	$69.57	$0.2800
Second quarter	$ 83.05	$73.61	$0.3750
Third quarter	$ 88.85	$78.74	$0.3750
Fourth quarter	$104.00	$80.72	$0.3750
2013			
First quarter	$ 58.26	$51.36	$0.2125
Second quarter	$ 66.19	$57.01	$0.2800
Third quarter	$ 75.88	$64.65	$0.2800
Fourth quarter	$ 75.54	$66.72	$0.2800

DIVIDEND POLICY

In June 2014, our Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.50 per share, paid quarterly. Since June 2013, we had paid an annual cash dividend of $1.12 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2014

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
October 31, 2014	3	$ 87	3	79
November 30, 2014	4	96	4	75
December 31, 2014	3	100	3	71
Total	10	$ 94	10	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2014, the Board renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs). There is no established expiration date for the program.

PERFORMANCE GRAPHS

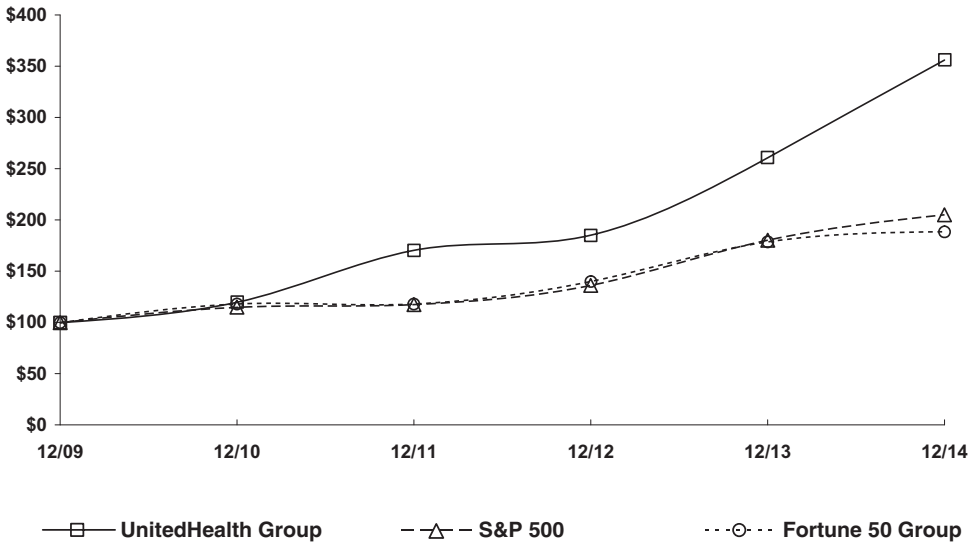
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group") for the five-year period ended December 31, 2014. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2014. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2009 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/09	12/10	12/11	12/12	12/13	12/14
UnitedHealth Group	**$100.00**	**$119.89**	**$170.47**	**$185.11**	**$261.07**	**$356.25**
S&P 500 Index	**100.00**	**115.06**	**117.49**	**136.30**	**180.44**	**205.14**
Fortune 50 Group	**100.00**	**118.15**	**118.12**	**139.95**	**178.88**	**188.42**

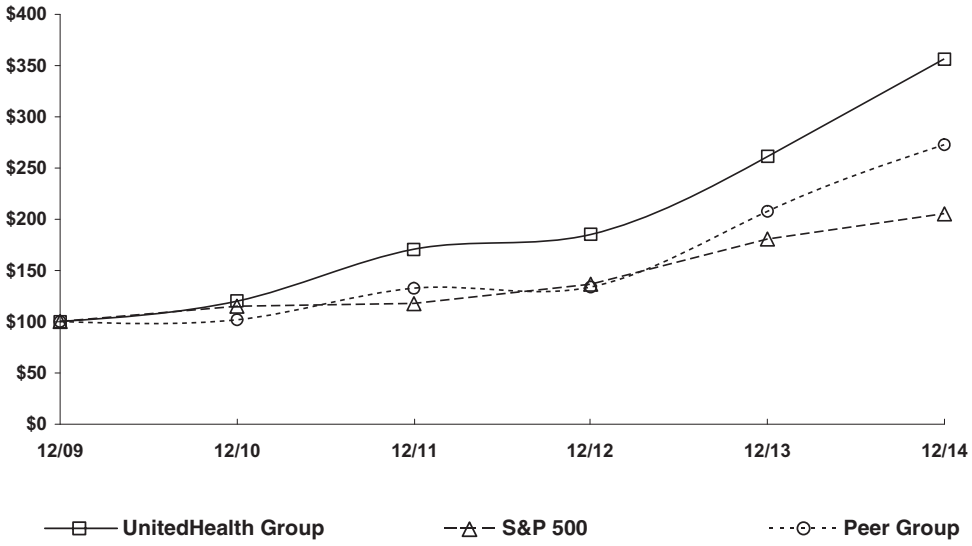
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Anthem Inc., Cigna Corporation and Humana Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Peer Group



	12/09	12/10	12/11	12/12	12/13	12/14
UnitedHealth Group	$100.00	$119.89	$170.47	$185.11	$261.07	$356.25
S&P 500 Index	100.00	115.06	117.49	136.30	180.44	205.14
Peer Group	100.00	101.88	132.34	133.68	207.73	272.75

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Year Ended December 31, 2014	2013	2012 (a)	2011	2010
Consolidated operating results					
Revenues	$130,474	$122,489	$110,618	$101,862	$94,155
Earnings from operations	10,274	9,623	9,254	8,464	7,864
Net earnings attributable to UnitedHealth Group common shareholders	5,619	5,625	5,526	5,142	4,634
Return on equity (b)	17.3%	17.7%	18.7%	18.9%	18.7%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 5.78	$ 5.59	$ 5.38	$ 4.81	$ 4.14
Diluted earnings per share attributable to UnitedHealth Group common shareholders	5.70	5.50	5.28	4.73	4.10
Cash dividends declared per common share	1.4050	1.0525	0.8000	0.6125	0.4050
Consolidated cash flows from (used for)					
Operating activities	$ 8,051	$ 6,991	$ 7,155	$ 6,968	$ 6,273
Investing activities	(2,534)	(3,089)	(8,649)	(4,172)	(5,339)
Financing activities	(5,293)	(4,946)	471	(2,490)	(1,611)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 28,063	$ 28,818	$ 29,148	$ 28,172	$25,902
Total assets	86,382	81,882	80,885	67,889	63,063
Total commercial paper and long-term debt	17,406	16,860	16,754	11,638	11,142
Redeemable noncontrolling interests	1,388	1,175	2,121	—	—
Shareholders' equity	32,454	32,149	31,178	28,292	25,825
Debt to debt-plus-equity ratio	34.9%	34.4%	35.0%	29.1%	30.1%

(a) Includes the effects of the October 2012 Amil acquisition and related debt and equity issuances.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Business Trends

Our businesses participate in the U.S., Brazilian and certain other international health economies. In the U.S., health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, including enacted health reform legislation in the United States, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering all relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations. Our review of regulatory considerations involves a focus on minimum MLR thresholds and the new risk adjustment, risk corridor and reinsurance provisions that impact the small group and individual markets. We will continue to balance growth and profitability across all of these dimensions. Overall, we continue to be under pressure from ongoing market competition in commercial products and from government payment rates.

The intensity of commercial pricing competition depends on local market conditions and competitive dynamics. Health plans have generally reflected the Industry Tax and Reinsurance Programs (together, ACA Fees) in their pricing. Conversely, the industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted pricing trends. Having reflected the additional cost step-ups in 2014 related to the ACA Fees, we anticipate health plans' pricing returning to a more normal inflation rate in 2015.

Annual commercial premium rate increases are subject to federal and state review and approval procedures. While our rates and rate filings are developed using methods consistent with the standards of actuarial practice, we have experienced regulatory challenges to proposed premium rate increases in certain states, including California and New York.

The Medicare Advantage rate structure is changing and funding has been cut in recent years, with additional reductions to take effect in 2015, as discussed below in "Regulatory Trends and Uncertainties." We are taking actions to respond to these funding reductions, but the reductions adversely affected after-tax earnings for our Medicare business during 2014, and we expect our 2015 Medicare MLR to be slightly higher than in 2014.

We expect continued Medicaid revenue increases due to anticipated growth in our offerings; we also believe that the reimbursement rate environment creates the risk of downward pressure on Medicaid net margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We advocate for actuarially sound rates that are commensurate with our medical cost trends and remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends are primarily related to unit costs, utilization and prescription drug costs. Consistent with our experience in recent years, our 2014 cost trends were largely driven by continued unit cost pressure from health care providers. Although the weak economic environment combined with our medical cost management strategies has had a favorable impact on utilization trends in recent years, the impacts of Health Reform Legislation, namely mandated essential health benefits and limits on out-of-pocket maximums, are exerting upward pressure on medical cost trends. The primary drivers of prescription drug trends continue to be unit cost pressure on brand name drugs and a shift towards expensive new specialty medications, including new hepatitis C therapies.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. Delivery system modernization and payment reform are critical and the alignment of incentives between key constituents remains an important theme.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2014, we served nearly 3 million people through the most progressive of these arrangements, including full-risk, shared-risk and bundled episode-of-care payment approaches. As of December 31, 2014, our contracts with value based spending total nearly $37 billion annually, up significantly from recent years.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of Health Reform Legislation and other regulatory items. For additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage rates have been cut over the last several years, with additional funding reductions to be phased-in through 2017 as a result of (a) changes to CMS Medicare Advantage benchmark rates; (b) Health Reform Legislation; and (c) the Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, which reduced Medicare Advantage and Medicare Part D payments (Sequestration). The CMS final notice of 2015 Medicare Advantage benchmark rates and payment policies includes additional significant reductions for 2015. These industry level reductions, including the impact of the Industry Tax described below, resulted in revenue reductions and incremental assessments totaling more than 6% of revenue in 2014 and more than an additional 3% in 2015, against a typical industry forward medical cost trend of 3%. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. These factors affected our plan benefit designs, market participation, growth prospects and expectation of earnings for our Medicare Advantage plans for 2015.

Health Reform Legislation directed HHS to establish a program to reward high-quality Medicare Advantage plans beginning in 2012. Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' star ratings. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. The historical expanded star bonus program, which paid bonuses to qualifying plans rated 3 stars or higher expired after 2014. In 2015, quality bonus payments will be paid only to plans rated 4 stars and higher. For the 2015 star bonus payment year, more than 37% of our Medicare Advantage members are enrolled in plans rated 4 stars or higher. We currently expect a similar percentage of members to be enrolled in such plans for the 2016 payment year. We are dedicating substantial resources to advance our quality scores and star ratings to strengthen our local market programs and further improve our performance for the 2017 and 2018 payment years.

The ongoing reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase member premiums over the monthly payments we receive from the government, and decide on a county-by-county basis where we will offer Medicare Advantage plans. For 2015, we have added premiums in certain markets; one-third of our members that had previously purchased $0 premium products will be impacted. We may experience some reduction in membership in the plans with the greatest premiums additions, but we expect overall growth in Medicare Advantage membership in 2015.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Industry Tax and Premium Stabilization Programs. Health Reform Legislation includes an Industry Tax levied proportionally across the health insurance industry for risk-based products, which began January 1, 2014. The industry-wide amount of the annual tax was $8 billion in 2014 and increases to $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will equal the annual tax for the preceding year increased by the rate of premium growth for the preceding year. In 2015, we expect that our share of the Industry Tax will be $1.8 billion compared to $1.3 billion in 2014.

With the introduction of state health insurance exchanges and other significant market reforms in the individual and small group markets in 2014, Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs encompass: a Reinsurance Program; a temporary risk corridors

program; and a permanent risk adjustment program. The Reinsurance Program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. The total three year amount of $25 billion for the Reinsurance Program will be allocated as follows: $20 billion (2014 - $10 billion, 2015 - $6 billion, 2016 - $4 billion) subject to increases based on state decisions, to fund the reinsurance pool and $5 billion (2014 and 2015 - $2 billion, 2016 - $1 billion) to fund the U.S. Treasury. While funding for the Reinsurance Program will come from all commercial lines of business, only market reform compliant individual businesses will be eligible for reinsurance recoveries.

For detail on the Industry Tax and Premium Stabilization Programs, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Exchanges and Coverage Expansion. Across markets, we and our competitors are adapting product, network and marketing strategies to anticipate new or expanding distribution channels including public exchanges, private exchanges and off exchange purchasing. Effective in 2014, states have either created their own public exchange, entered a partnership exchange or relied on the federally facilitated exchange for individuals and small employers. The exchanges have created new market dynamics that have impacted and could further impact our existing businesses, depending on the ultimate member migration patterns for each market. In 2014, commercial fully insured membership expanded industry-wide with more than 7 million consumers served through the individual public exchanges alone. Self-insured enrollment remained relatively stable, but there has been an increased interest in post-reform alternatives such as private exchange solutions. Our level of participation in public exchanges is determined on a state-by-state basis. Each state is evaluated based on factors such as growth opportunities, our current local presence, our competitive positioning, our ability to honor our commitments to our local customers and consumers, and the regulatory environment. In 2014, we participated in 13 state public exchanges, including four individual and nine small group exchanges. In 2015, we are participating in 23 individual exchanges and in 12 small group exchanges.

Health Reform Legislation also provided for optional expanded Medicaid coverage that became effective in January 2014. We participate in programs in 24 states and the District of Columbia, and of these, 12 states opted to expand Medicaid for 2014. For 2015, 13 of our state customers have elected to expand Medicaid. The Congressional Budget Office forecasts that due to Medicaid expansion, a total of 13 million people will have obtained coverage through Medicaid by the end of 2016, and we are actively seeking to build market share serving the needs of these Medicaid expansion beneficiaries and their state sponsors.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Revenues:							
Premiums	$115,302	$109,557	$ 99,728	$5,745	5%	$ 9,829	10%
Services	10,151	8,997	7,437	1,154	13	1,560	21
Products	4,242	3,190	2,773	1,052	33	417	15
Investment and other income	779	745	680	34	5	65	10
Total revenues	130,474	122,489	110,618	7,985	7	11,871	11
Operating costs:							
Medical costs	93,257	89,290	80,226	3,967	4	9,064	11
Operating costs	21,681	19,362	17,306	2,319	12	2,056	12
Cost of products sold	3,784	2,839	2,523	945	33	316	13
Depreciation and amortization	1,478	1,375	1,309	103	7	66	5
Total operating costs	120,200	112,866	101,364	7,334	6	11,502	11
Earnings from operations	10,274	9,623	9,254	651	7	369	4
Interest expense	(618)	(708)	(632)	(90)	(13)	76	12
Earnings before income taxes	9,656	8,915	8,622	741	8	293	3
Provision for income taxes	(4,037)	(3,242)	(3,096)	795	25	146	5
Net earnings	5,619	5,673	5,526	(54)	(1)	147	3
Earnings attributable to noncontrolling interests	—	(48)	—	(48)	nm	48	nm
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,619	$ 5,625	$ 5,526	$ (6)	—%	$ 99	2%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 5.70	$ 5.50	$ 5.28	$ 0.20	4%	$ 0.22	4%
Medical care ratio (a)	80.9%	81.5%	80.4%	(0.6)%		1.1%	
Operating cost ratio	16.6	15.8	15.6	0.8		0.2	
Operating margin	7.9	7.9	8.4	—		(0.5)	
Tax rate	41.8	36.4	35.9	5.4		0.5	
Net earnings margin	4.3	4.6	5.0	(0.3)		(0.4)	
Return on equity (b)	17.3%	17.7%	18.7%	(0.4)%		(1.0)%	

nm = not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2014 year-over-year operating comparisons to 2013 and other 2014 significant items.

- Consolidated revenues increased by 7%, Optum revenues grew 25% and UnitedHealthcare revenues increased 5%.
- ACA Fees favorably affected our 2014 medical care ratio (110 bps), and unfavorably impacted our operating cost ratio (120 bps) and effective income tax rate (510 bps).
- Earnings from operations increased by 7%, including an increase of 32% at Optum partially offset by a decrease of 2% at UnitedHealthcare.
- Diluted earnings per share to UnitedHealth Group shareholders increased 4% to $5.70 and included the negative year-over-year impact of approximately $1.00 per share in ACA Fees, ACA Medicare rate cuts and other ACA impacts.
- As of December 31, 2014, there was $738 million of cash available for general corporate use and 2014 cash flows from operations were $8.1 billion.

2014 RESULTS OF OPERATIONS COMPARED TO 2013 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during the year ended December 31, 2014 were primarily driven by growth in the number of individuals served in our public and senior markets businesses and growth across all of Optum's businesses.

Medical Costs and Medical Care Ratio

Medical costs during the year ended December 31, 2014 increased due to risk-based membership growth in our public and senior markets businesses. To the extent possible, we included the reform fees and related tax impacts in our pricing; since the ACA Fees are included in operating costs, this decreased our medical care ratio in 2014. This decrease from ACA fees was partially offset by the impact of lower levels of favorable medical cost reserve development.

Operating Cost Ratio

The increase in our operating cost ratio during the year ended December 31, 2014 was due to the introduction of ACA Fees and services business growth and acquisitions, partially offset by productivity and operating performance gains.

Income Tax Rate

The increase in our income tax rate resulted primarily from the nondeductible Industry Tax.

See Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" and "Industry Tax and Premium Stabilization Programs" in the "Executive Overview" above for more information on the Industry Tax and ACA Fees.

Reportable Segments

Prior period segment financial information has been recast to conform to the 2014 presentation. See Notes 2 and 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Revenues							
UnitedHealthcare	$119,798	$113,725	$103,332	$6,073	5%	$10,393	10%
OptumHealth	11,032	9,855	8,147	1,177	12	1,708	21
OptumInsight	5,227	4,714	4,257	513	11	457	11
OptumRx	31,976	24,006	18,359	7,970	33	5,647	31
Optum eliminations	(489)	(458)	(364)	31	7	94	26
Optum	47,746	38,117	30,399	9,629	25	7,718	25
Eliminations	(37,070)	(29,353)	(23,113)	7,717	26	6,240	27
Consolidated revenues	$130,474	$122,489	$110,618	$7,985	7%	$11,871	11%
Earnings from operations							
UnitedHealthcare	$ 6,992	$ 7,132	$ 7,687	$ (140)	(2)%	$ (555)	(7)%
OptumHealth	1,090	949	538	141	15	411	76
OptumInsight	1,002	831	656	171	21	175	27
OptumRx	1,190	711	373	479	67	338	91
Optum	3,282	2,491	1,567	791	32	924	59
Consolidated earnings from operations	$ 10,274	$ 9,623	$ 9,254	$ 651	7%	$ 369	4%
Operating margin							
UnitedHealthcare	5.8%	6.3%	7.4%	(0.5)%		(1.1)%	
OptumHealth	9.9	9.6	6.6	0.3		3.0	
OptumInsight	19.2	17.6	15.4	1.6		2.2	
OptumRx	3.7	3.0	2.0	0.7		1.0	
Optum	6.9	6.5	5.2	0.4		1.3	
Consolidated operating margin	7.9%	7.9%	8.4%	—%		(0.5)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
UnitedHealthcare Employer & Individual	$ 43,017	$ 44,847	$ 46,509	$(1,830)	(4)%	$ (1,662)	(4)%
UnitedHealthcare Medicare & Retirement	46,258	44,225	39,257	2,033	5	4,968	13
UnitedHealthcare Community & State	23,586	18,268	16,422	5,318	29	1,846	11
UnitedHealthcare Global	6,937	6,385	1,144	552	9	5,241	nm
Total UnitedHealthcare revenues	$119,798	$113,725	$103,332	$ 6,073	5%	$10,393	10%

nm = not meaningful

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013		Increase/ (Decrease) 2013 vs. 2012	
Commercial risk-based	7,505	8,185	9,340	(680)	(8)%	(1,155)	(12)%
Commercial fee-based	18,350	19,055	17,585	(705)	(4)	1,470	8
Commercial fee-based TRICARE	2,895	2,920	—	(25)	(1)	2,920	nm
Total commercial	28,750	30,160	26,925	(1,410)	(5)	3,235	12
Medicare Advantage	3,005	2,990	2,565	15	1	425	17
Medicaid	5,055	4,035	3,830	1,020	25	205	5
Medicare Supplement (Standardized)	3,750	3,455	3,180	295	9	275	9
Total public and senior	11,810	10,480	9,575	1,330	13	905	9
International	4,425	4,805	4,425	(380)	(8)	380	9
Total UnitedHealthcare — medical	44,985	45,445	40,925	(460)	(1)%	4,520	11%
Supplemental Data:							
Medicare Part D stand-alone	5,165	4,950	4,225	215	4%	725	17%

nm = not meaningful

The decrease in commercial risk-based enrollment was a result of disciplined pricing in a continued competitive environment and a decrease in individual policy customers due to customers moving to public exchanges. The decrease in number of people served under commercial fee-based arrangements was primarily attributable to the loss of a large state employer account. Medicare Advantage participation increased slightly year-over-year despite the significant funding reductions, which caused us to exit certain markets in January 2014, reduce product offerings, adjust networks and reduce benefits for 2014. Approximately 60% of the Medicaid growth was driven by Medicaid expansion under the ACA with the remaining growth resulting from the combination of states launching new programs to complement established programs and growth in those traditional programs. Medicare Supplement growth reflected strong customer retention and new sales. The number of people served internationally decreased year-over-year primarily due to price increases in Brazil in response to the increasing costs of mandated health care benefits. In our Medicare Part D stand-alone business, the number of people served increased primarily as a result of new product introductions and strong customer retention.

UnitedHealthcare's revenue growth during the year ended December 31, 2014 was due to growth in the number of individuals served in our public and senior markets businesses; revenues to recover ACA Fees, which resulted in $1.5 billion of additional annual premiums in 2014; and commercial price increases reflecting underlying medical cost trends. These increases were partially offset by decreased commercial risk-based enrollment and a reduced level of Medicare Advantage funding.

UnitedHealthcare's operating earnings for the year ended December 31, 2014 were pressured year-over-year by ACA Fees, Medicare Advantage funding reductions, increased spending on specialty medications to treat hepatitis C and reduced levels of favorable medical cost reserve development. Partially offsetting these factors were growth in our public and senior markets businesses, reduced levels of per-member inpatient hospital utilization and revenue true-ups.

Optum

Total revenues increased for the year ended December 31, 2014 primarily due to pharmacy growth at OptumRx and growth at OptumHealth.

The increases in Optum's earnings from operations and operating margins for the year ended December 31, 2014 were driven by revenue growth and increased productivity, partially offset by investments at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth during 2014 primarily due to acquisitions and growth in local care delivery and subacute care services.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to revenue growth and cost efficiencies, offset in part by investments to develop future growth opportunities.

OptumInsight

Revenue, earnings from operations and operating margins at OptumInsight for the year ended December 31, 2014 increased primarily due to the growth and expansion in revenue management services and government exchange services, partially offset by a reduction in hospital compliance services and investments for future growth.

OptumRx

Increased OptumRx revenue for the year ended December 31, 2014 was due to growth in people served in UnitedHealthcare's public and senior markets, the insourcing of UnitedHealthcare's commercial pharmacy benefit programs, which was completed on January 1, 2014, growth from external clients and an increase in specialty pharmaceutical revenues.

Earnings from operations and operating margins for the year ended December 31, 2014 increased primarily due to growth in scale that resulted in greater productivity and better absorption of our fixed costs, and improved performance in both drug purchasing and home delivery pharmacy fulfillment.

2013 RESULTS OF OPERATIONS COMPARED TO 2012 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during 2013 were primarily driven by the full year effect of 2012 acquisitions, including Amil, growth in the number of individuals served through benefit products and overall organic growth in each of Optum's major businesses. The revenue impact of these factors was partially offset by the reduction in Medicare Advantage rates. Also offsetting the revenue increase was the first quarter conversion of a large fully-insured commercial customer from a risk-based to a fee-based arrangement affecting 1.1 million members. While this conversion reduced our full-year 2013 consolidated revenues by $2.3 billion, the impact to earnings from operations and cash flows was negligible.

Medical Costs and Medical Care Ratio

Medical costs during 2013 increased due to risk-based membership growth in our international and public and senior markets businesses, partially offset by the funding conversion of the large client discussed above. The year-over-year medical care ratio increased primarily due to funding reductions for Medicare Advantage products, changes in business mix favoring governmental benefit programs, and reduced levels of favorable medical cost reserve development.

Operating Costs

The increase in our operating costs during 2013 was due to business growth, including an increase in fee-based benefits and fee-based service revenues and a greater mix of international business, which carry comparatively higher operating costs, partially offset by our ongoing cost containment efforts.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth in 2013 was primarily attributable to the impact of 2012 acquisitions and the growth in the number of individuals served. The effect of these factors was partially offset by the government funding reductions described previously and the customer funding conversion discussed above.

UnitedHealthcare's earnings from operations and operating margins in 2013 decreased compared to the prior year as operating margins were pressured by the funding reductions that decreased revenues and by decreased levels of favorable reserve development.

Optum

Total revenues increased in 2013 primarily due to broad-based growth across Optum's services portfolio with growth in each of Optum's major businesses led by pharmacy growth from the insourcing of UnitedHealthcare commercial customers and external clients.

Optum's earnings from operations and operating margin in 2013 increased significantly compared to 2012, reflecting progress on Optum's plan to accelerate growth and improve productivity by strengthening integration and business alignment.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth in 2013 were primarily due to market expansion, including growth related to 2012 acquisitions in local care delivery, and organic growth.

Earnings from operations and operating margins in 2013 increased primarily due to revenue growth and an improved cost structure across the business, including local care delivery, population health and wellness solutions, and health-related financial services offerings.

OptumInsight

Revenues at OptumInsight in 2013 increased primarily due to the impact of a 2012 acquisition and growth in services to commercial payers.

The increases in earnings from operations and operating margins in 2013 reflected increased revenues, changes in product mix and continuing improvements in business alignment and efficiency.

OptumRx

The increase in OptumRx revenues in 2013 were due to the insourcing of UnitedHealthcare's commercial pharmacy benefit programs and growth in both UnitedHealthcare's Medicare Part D members and external clients. Over the course of 2013, we completed our transition of 12 million migrating and new members to the OptumRx platform from a third-party.

Earnings from operations and operating margins in 2013 increased primarily due to strong revenue growth, pricing disciplines, and greater use of generic medications.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In 2014, our U.S. regulated subsidiaries paid their parent companies dividends of $4.6 billion. For the twelve months ended December 31, 2013, our U.S. regulated subsidiaries paid their parent companies dividends of $3.2 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2014	2013	2012	Increase/ (Decrease) 2014 vs. 2013	Increase/ (Decrease) 2013 vs. 2012
Sources of cash:					
Cash provided by operating activities	$ 8,051	$ 6,991	$ 7,155	$1,060	$ (164)
Sales and maturities of investments, net of purchases	799	—	—	799	—
Customer funds administered	—	31	—	(31)	31
Proceeds from common stock issuances	462	598	1,078	(136)	(480)
Issuances of long-term debt and commercial paper, net of repayments	391	152	4,567	239	(4,415)
Other	37	45	—	(8)	45
Total sources of cash	9,740	7,817	12,800		
Uses of cash:					
Common stock repurchases	(4,008)	(3,170)	(3,084)	(838)	(86)
Purchases of property, equipment and capitalized software, net	(1,447)	(1,161)	(1,070)	(286)	(91)
Cash dividends paid	(1,362)	(1,056)	(820)	(306)	(236)
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed	(1,923)	(1,836)	(6,599)	(87)	4,763
Purchases of investments, net of sales and maturities	—	(1,611)	(1,299)	1,611	(312)
Customer funds administered	(638)	—	(324)	(638)	324
Other	(138)	(27)	(627)	(111)	600
Total uses of cash	(9,516)	(8,861)	(13,823)		
Effect of exchange rate changes on cash and cash equivalents	(5)	(86)	—	81	(86)
Net increase (decrease) in cash and cash equivalents	$ 219	$(1,130)	$ (1,023)	$1,349	$ (107)

2014 Cash Flows Compared to 2013 Cash Flows

Cash flows provided by operating activities in 2014 increased primarily due to an increased level of accounts payable and other liabilities including the collection of Reinsurance Program fees in advance of remittance in 2015, partially offset by an increase in government receivables.

Other significant changes in sources or uses of cash year-over-year included: (a) a change in investment activity from net purchases in 2013 to net sales in 2014; (b) an increase in Part D subsidy receivables causing a change in customer funds administered; and (c) increased levels of cash used to repurchase common stock.

2013 Cash Flows Compared to 2012 Cash Flows

Cash flows provided by operating activities in 2013 decreased due to the net effects of changes in operating assets and liabilities, including: (a) an increase in pharmacy rebates receivables stemming from the increased membership at OptumRx, the effects of which were partially offset by (b) increases in medical costs payable due to the growth in the number of individuals served in our public and senior markets and international businesses.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) decreased investments in acquisitions and noncontrolling interest shares (the activity in 2013 primarily related to the acquisition of the remaining publicly traded shares of Amil during the second quarter of 2013 for $1.5 billion);

(b) a decrease in net proceeds from commercial paper and long-term debt, as proceeds from 2013 debt issuances were fully offset by scheduled maturities and the redemption of all of our outstanding subsidiary debt (in 2012, the increased cash flows from common stock issuances and proceeds from issuances of commercial paper and long-term debt primarily related to the Amil acquisition); and (c) increased net purchases of investments.

Financial Condition

As of December 31, 2014, our cash, cash equivalent and available-for-sale investment balances of $27.6 billion included $7.5 billion of cash and cash equivalents (of which $738 million was available for general corporate use), $18.6 billion of debt securities and $1.5 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. The use of different market assumptions or valuation methodologies, especially those used in valuing our $384 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair values of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.4 years and a weighted-average credit rating of “AA” as of December 31, 2014. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Our bank credit facilities contain various covenants, including covenants requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, which reasonably approximates the actual covenant ratio, was 34.9% as of December 31, 2014.

Long-Term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

In December 2014, we issued $2.0 billion in senior unsecured notes, which included: $750 million of 1.4% fixed-rate notes due December 15, 2017, $500 million of 2.3% fixed-rate notes due December 15, 2019 and $750 million of 2.875% fixed-rate notes due December 15, 2021.

Credit Ratings. Our credit ratings as of December 31, 2014 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	bbb+	Positive
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. In June 2014, our Board renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock. As of December 31, 2014, we had Board authorization to purchase up to an additional 71 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2014, our Board of Directors increased our quarterly cash dividend to shareholders to an annual dividend rate of $1.50 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2014, under our various contractual obligations and commitments:

(in millions)	2015	2016 to 2017	2018 to 2019	Thereafter	Total
Debt (a)	$2,103	$4,398	$3,193	$17,997	$27,691
Operating leases	491	715	533	464	2,203
Purchase obligations (b)	176	173	17	6	372
Future policy benefits (c)	127	282	289	1,917	2,615
Unrecognized tax benefits (d)	2	—	—	83	85
Other liabilities recorded on the Consolidated Balance Sheet (e)	207	36	—	1,321	1,564
Other obligations (f)	143	126	44	33	346
Redeemable noncontrolling interests (g)	83	767	538	—	1,388
Total contractual obligations	$3,332	$6,497	$4,614	$21,821	$36,264

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2014.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter."
(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."
(f) Includes remaining capital commitments for venture capital funds and other funding commitments.
(g) Includes commitments for redeemable shares of our subsidiaries, primarily the shares owned by Amil's remaining non-public shareholders.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications, and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2014, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

In May 2014, the Financial Accounting Standards Board issued ASU No. 2014-09 "Revenue from Contracts with Customers (Topic 606)." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard using either the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. We are currently evaluating the effect of the new revenue recognition guidance.

We have determined that there have been no other recently issued, but not yet adopted, accounting standards that will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

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 processing backlogs, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90

days from the 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. As of December 31, 2014, our days outstanding in medical payables was 47 days, calculated as total medical payables divided by total medical costs times 365 days.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates and include the changes in estimates in medical costs in the period in which the change is identified. Therefore, 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). Medical costs in 2014, 2013 and 2012 included favorable medical cost development related to prior years of $420 million, $680 million and $860 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2014:

Completion Factors Increase (Decrease) in Factors	**Increase (Decrease) In Medical Costs Payable**
	(in millions)
(0.75)%	$ 318
(0.50)	212
(0.25)	106
0.25	(105)
0.50	(209)
0.75	(313)

Medical Cost PMPM Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design, and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product

growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates including: our ability and practices to manage medical costs, changes in level and mix of services utilized, mix of benefits offered including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2014:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 635
2	423
1	212
(1)	(212)
(2)	(423)
(3)	(635)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2014, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2014; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2014 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2014 net earnings would have increased or decreased by $67 million.

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us to CMS.

U.S. commercial health plans with MLRs on fully insured products, as calculated under the definitions in Health Reform Legislation, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals) are required to rebate ratable portions of their premiums to their customers

annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because we are able to reasonably estimate the ultimate premiums of these contracts. Each period, we estimate premium rebates based on the expected financial performance of the applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Impairment tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends above and the discussion in the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, “Business — Government Regulation.” For additional discussions regarding how the enactment or implementation of health care reforms and other factors could affect our business and the related long-term forecasts, see Part I, Item 1A, “Risk Factors” and “Regulatory Trends and Uncertainties” above.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2015. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible Assets. Our recorded separately-identifiable intangible assets were acquired in business combinations and represent future expected benefits but they lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). These intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis. Both finite-lived and indefinite-lived intangible assets are evaluated for impairment between annual periods if an event occurs or circumstances change that may indicate impairment. Our most significant intangible assets are customer-related intangibles, which represent 71% of our total intangible asset balance of $3.7 billion as of December 31, 2014.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and earnings growth, retention rates, perpetuity growth rates and discount rates. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset (or asset group) using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that an impairment exists, the amount by which the carrying value exceeds its estimated fair value would be recorded as an impairment.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we assess qualitative factors to determine whether the existence of events and circumstances indicates that it is more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value. If, after assessing the totality of events and circumstances, we conclude that it is not more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value, no impairment exists and no further testing is performed. If we

conclude otherwise, we would perform a quantitative analysis by comparing its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not materially impaired in 2014.

Investments

As of December 31, 2014, we had investments with a carrying value of $20.6 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from net earnings and report net unrealized gains or losses, net of income tax effects, as other comprehensive income and 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, 2014, our available-for-sale investments had gross unrealized gains of $423 million and gross unrealized losses of $66 million.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell the security before recovery of the entire amortized cost basis or maturity of the security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, and recognized in net earnings, and all other causes, and recognized in other comprehensive income.

For equity securities, we recognize unrealized losses in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the loss in net earnings.

The most significant judgments and estimates related to investments are related to determination of their fair values and the other-than-temporary impairment assessment.

Fair Values. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses of the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- prices received from the pricing service to prices reported by a secondary pricing service, our custodian, our investment consultant and third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-Than-Temporary Impairment Assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of

impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. We do not expect that trend to change in the near term. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

Our unrealized losses of $66 million and $234 million at December 31, 2014 and 2013, respectively, were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments for 2014, 2013 and 2012 were $26 million, $8 million and $6 million, respectively. Our available-for-sale debt portfolio had a weighted-average credit rating of “AA” as of December 31, 2014. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A “Quantitative and Qualitative Disclosures About Market Risk” a 1% increase in market interest rates would have the effect of decreasing the fair value of our investment portfolio by $683 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements.

Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes. We have established a valuation allowance against certain deferred tax assets for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized.

An uncertain tax position is recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax positions due to changes in tax law resulting from legislation, regulation or as concluded through the various jurisdictions’ tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2014 earnings before income taxes would have caused the provision for income taxes and net earnings to change by $97 million.

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 where appropriate. Our estimates are developed in consultation with legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of costs resulting from legal and regulatory matters are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, in many cases, we are unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Similarly, the assessment of the likelihood of assertion of unasserted claims involves significant judgment.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures in each reporting period. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for a discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2014, we had an aggregate $1.8 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and record the reinsurance receivable only to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as “A+.” As of December 31, 2014, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and (c) changes in equity prices that impact the value of our equity investments.

As of December 31, 2014, we had $9.4 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2014, $12.6 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2014, $17.2 billion of our investments were fixed-rate debt securities and $7.7 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2014 and 2013 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2014			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$187	$245	$(1,364)	$(1,846)
1	94	122	(683)	(1,014)
(1)	(54)	(21)	628	1,242
(2)	nm	nm	982	2,770

	December 31, 2013			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$175	$189	$(1,474)	$(1,786)
1	87	95	(756)	(974)
(1)	(52)	(17)	704	1,167
(2)	nm	nm	1,224	2,505

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2014 and 2013, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2014 and 2013, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2014, a hypothetical 10% and 20% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $430 million and $790 million, respectively. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies.

As of December 31, 2014, we had $1.5 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates. Valuations in venture capital funds are subject to conditions affecting health care and technology stocks, and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014 and 2013, and the related consolidated statements of operations, comprehensive income, changes in shareholders' equity and cash flows for each of the three years in the period ended December 31, 2014. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2014, based on the criteria established in Internal Control-Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 10, 2015, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 7,495	$ 7,276
Short-term investments	1,741	1,937
Accounts receivable, net of allowances of $260 and $196	4,252	3,052
Other current receivables, net of allowances of $156 and $169	5,498	3,998
Assets under management	2,962	2,757
Deferred income taxes	556	430
Prepaid expenses and other current assets	1,052	930
Total current assets	23,556	20,380
Long-term investments	18,827	19,605
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,954 and $2,675	4,418	4,010
Goodwill	32,940	31,604
Other intangible assets, net of accumulated amortization of $2,685 and $2,283	3,669	3,844
Other assets	2,972	2,439
Total assets	$86,382	$81,882
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$12,040	$11,575
Accounts payable and accrued liabilities	9,247	7,458
Other policy liabilities	5,965	5,279
Commercial paper and current maturities of long-term debt	1,399	1,969
Unearned revenues	1,972	1,600
Total current liabilities	30,623	27,881
Long-term debt, less current maturities	16,007	14,891
Future policy benefits	2,488	2,465
Deferred income taxes	2,065	1,796
Other liabilities	1,357	1,525
Total liabilities	52,540	48,558
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,388	1,175
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 954 and 988 issued and outstanding	10	10
Retained earnings	33,836	33,047
Accumulated other comprehensive loss	(1,392)	(908)
Total shareholders' equity	32,454	32,149
Total liabilities and shareholders' equity	$86,382	$81,882

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2014	2013	2012
Revenues:			
Premiums	$115,302	$109,557	$ 99,728
Services	10,151	8,997	7,437
Products	4,242	3,190	2,773
Investment and other income	779	745	680
Total revenues	130,474	122,489	110,618
Operating costs:			
Medical costs	93,257	89,290	80,226
Operating costs	21,681	19,362	17,306
Cost of products sold	3,784	2,839	2,523
Depreciation and amortization	1,478	1,375	1,309
Total operating costs	120,200	112,866	101,364
Earnings from operations	10,274	9,623	9,254
Interest expense	(618)	(708)	(632)
Earnings before income taxes	9,656	8,915	8,622
Provision for income taxes	(4,037)	(3,242)	(3,096)
Net earnings	5,619	5,673	5,526
Earnings attributable to noncontrolling interests	—	(48)	—
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,619	$ 5,625	$ 5,526
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 5.78	$ 5.59	$ 5.38
Diluted	$ 5.70	$ 5.50	$ 5.28
Basic weighted-average number of common shares outstanding	972	1,006	1,027
Dilutive effect of common share equivalents	14	17	19
Diluted weighted-average number of common shares outstanding	986	1,023	1,046
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	8	17
Cash dividends declared per common share	$ 1.4050	$ 1.0525	$ 0.8000

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2014	2013	2012
Net earnings	$5,619	$ 5,673	$5,526
Other comprehensive loss:			
Gross unrealized gains (losses) on investment securities during the period	476	(543)	217
Income tax effect	(173)	196	(78)
Total unrealized gains (losses), net of tax	303	(347)	139
Gross reclassification adjustment for net realized gains included in net earnings	(211)	(181)	(156)
Income tax effect	77	66	57
Total reclassification adjustment, net of tax	(134)	(115)	(99)
Total foreign currency translation losses	(653)	(884)	(63)
Other comprehensive loss	(484)	(1,346)	(23)
Comprehensive income	5,135	4,327	5,503
Comprehensive income attributable to noncontrolling interests	—	(48)	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$5,135	$ 4,279	$5,503

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation Losses	Total Shareholders' Equity
Balance at January 1, 2012	1,039	$10	$ —	$27,821	$ 476	$ (15)	$28,292
Net earnings attributable to UnitedHealth Group common shareholders				5,526			5,526
Other comprehensive income (loss)					40	(63)	(23)
Issuances of common shares, and related tax effects	37	—	704				704
Share-based compensation, and related tax benefits			594				594
Common share repurchases	(57)	—	(1,221)	(1,863)			(3,084)
Acquisition of noncontrolling interests			(11)				(11)
Cash dividends paid on common shares				(820)			(820)
Balance at December 31, 2012	1,019	10	66	30,664	516	(78)	31,178
Net earnings attributable to UnitedHealth Group common shareholders				5,625			5,625
Other comprehensive loss					(462)	(884)	(1,346)
Issuances of common shares, and related tax effects	17	—	431				431
Share - based compensation, and related tax benefits			406				406
Common share repurchases	(48)	—	(984)	(2,186)			(3,170)
Acquisition of noncontrolling interests and related tax effects			81				81
Cash dividends paid on common shares				(1,056)			(1,056)
Balance at December 31, 2013	988	10	—	33,047	54	(962)	32,149
Net earnings attributable to UnitedHealth Group common shareholders				5,619			5,619
Other comprehensive income (loss)					169	(653)	(484)
Issuances of common shares, and related tax effects	15	—	146				146
Share-based compensation, and related tax benefits			394				394
Common share repurchases	(49)	—	(540)	(3,468)			(4,008)
Cash dividends paid on common shares				(1,362)			(1,362)
Balance at December 31, 2014	954	$10	$ —	$33,836	$ 223	$(1,615)	$32,454

See Notes to the Consolidated Financial Statements

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UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2014	2013	2012
Operating activities			
Net earnings	$ 5,619	$ 5,673	$ 5,526
Noncash items:			
Depreciation and amortization	1,478	1,375	1,309
Deferred income taxes	(117)	1	308
Share-based compensation	364	331	421
Other, net	(298)	(83)	(231)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(911)	(317)	(130)
Other assets	(590)	(838)	(295)
Medical costs payable	484	509	101
Accounts payable and other liabilities	1,642	459	199
Other policy liabilities	(5)	(221)	(81)
Unearned revenues	385	102	28
Cash flows from operating activities	8,051	6,991	7,155
Investing activities			
Purchases of investments	(9,928)	(12,176)	(9,903)
Sales of investments	7,701	5,706	3,794
Maturities of investments	3,026	4,859	4,810
Cash paid for acquisitions, net of cash assumed	(1,923)	(362)	(6,280)
Purchases of property, equipment and capitalized software	(1,525)	(1,307)	(1,070)
Proceeds from disposal of property, equipment and capitalized software	78	146	—
Other, net	37	45	—
Cash flows used for investing activities	(2,534)	(3,089)	(8,649)
Financing activities			
Acquisition of noncontrolling interest shares	—	(1,474)	(319)
Common stock repurchases	(4,008)	(3,170)	(3,084)
Cash dividends paid	(1,362)	(1,056)	(820)
Proceeds from common stock issuances	462	598	1,078
Repayments of long-term debt	(812)	(1,609)	(986)
(Repayments of) proceeds from commercial paper, net	(794)	(474)	1,587
Proceeds from issuance of long-term debt	1,997	2,235	3,966
Customer funds administered	(638)	31	(324)
Other, net	(138)	(27)	(627)
Cash flows (used for) from financing activities	(5,293)	(4,946)	471
Effect of exchange rate changes on cash and cash equivalents	(5)	(86)	—
Increase (decrease) in cash and cash equivalents	219	(1,130)	(1,023)
Cash and cash equivalents, beginning of period	7,276	8,406	9,429
Cash and cash equivalents, end of period	$ 7,495	$ 7,276	$ 8,406
Supplemental cash flow disclosures			
Cash paid for interest	$ 644	$ 724	$ 600
Cash paid for income taxes	4,024	2,785	2,666

See Notes to the Consolidated Financial Statements

UnitedHealth Group

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, are now included in OptumInsight's results of operations. The Company's reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 13 for segment financial information.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of certain investments, and estimates and judgments related to income taxes and contingent liabilities. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, and beginning in 2014, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums

annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the Centers for Medicare & Medicaid Services' (CMS) risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

For the Company's OptumRx pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies or home delivery and specialty pharmacy facilities, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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 processing backlogs, care provider contract rate changes, medical care utilization

and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Medical costs also include the direct cost of patient care rendered through OptumHealth.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of shareholders' equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends either to sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in investment and other income. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.
- For equity securities, the Company recognizes unrealized losses in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the loss in investment and other income.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program), and to AARP members and non-members under separate

Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2020 for the AARP Program and give the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings until December 31, 2020, subject to certain limited exclusions.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the RSF and were $86 million, $101 million and $109 million in 2014, 2013 and 2012, respectively.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. The Company generally receives rebates from two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivable" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.

- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to premium revenues in the Consolidated Statements of Operations and other policy liabilities or other current receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Health Reform Legislation mandated a consumer discount on brand name prescription drugs for Medicare Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as premium revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in unearned revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as customer funds administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in medical costs and operating costs, respectively, in the Consolidated Statements of Operations.

The final 2014 risk-share amount is expected to be settled during the second half of 2015, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2014			December 31, 2013		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$1,801	$719	$20	$881	$425	$ —
Other policy liabilities	—	302	—	—	152	214

As of January 1, 2015, certain changes were made to the Medicare Part D individual coverage levels by CMS, including:

- The initial coverage limit increased to $2,960 from $2,850 in 2014.
- The catastrophic coverage begins at $6,680 as compared to $6,455 in 2014.
- The annual out-of-pocket maximum increased to $4,700 from $4,550 in 2014.
- The discount on prescription drugs within the coverage gap increased to 55% from 52.5% in 2014 for brand name drugs and increased to 35% from 28% in 2014 for generic drugs.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. First, the Company estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

As of December 31, 2014, no reporting unit had a fair value less than its carrying value and the Company concluded that there was no need for any impairment of goodwill.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There were no material impairments of intangible assets during the year ended December 31, 2014.

Accounts Payable and Accrued Liabilities

The Company had checks outstanding of $1.4 billion and $1.3 billion issued from zero balance accounts as of December 31, 2014 and 2013, respectively, which were classified as accounts payable and accrued liabilities and the change in this balance has been reflected within other financing activities in the Consolidated Statements of Cash Flows.

As of December 31, 2014 and 2013, accounts payable and accrued liabilities included accrued payroll liabilities of $1.5 billion and $1.2 billion, respectively.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program (described below), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Underwriting gains or losses related to the AARP Program are directly 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. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF; losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. Changes in the RSF are reported in medical costs in the Consolidated Statement of Operations. As of December 31, 2014 and 2013, the balance in the RSF was $1.5 billion and $1.3 billion, respectively.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2014, the Company had an aggregate $1.8 billion reinsurance receivable, of which $127 million was recorded in Other Current Receivables and $1.7 billion was recorded in other assets in the Consolidated Balance Sheets. As of December 31, 2013, the Company had an aggregate $1.8 billion reinsurance receivable, of which $136 million was recorded in other current receivables and $1.7 billion was recorded in other assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. As of December 31, 2014, the reinsurer was rated by A.M. Best as "A+."

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Redeemable Noncontrolling Interests

Noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The redeemable noncontrolling interests are primarily related to non-public shareholders of Amil. The following table provides details of the Company's redeemable noncontrolling interests activity for the years ended December 31, 2014 and 2013:

(in millions)	2014	2013
Redeemable noncontrolling interests, beginning of period	$1,175	$ 2,121
Net earnings	—	48
Acquisitions	203	360
Redemptions	—	(1,417)
Distributions	(40)	—
Fair value and other adjustments	50	63
Redeemable noncontrolling interests, end of period	$1,388	$ 1,175

During 2013, the Company increased its ownership of Amil to 90% by acquiring all of Amil's remaining publicly-traded shares.

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably; primarily over three to four years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP) eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Company's Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP, (collectively, common stock equivalents) using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise, any unrecognized compensation cost and any related excess tax benefit. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Industry Tax

Health Reform Legislation includes an annual, nondeductible insurance industry tax (Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products that began on January 1, 2014.

The Company estimates its liability for the Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method of allocation over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets. In September 2014, the Company paid its 2014 Industry Tax liability of $1.3 billion.

Premium Stabilization Programs

Since the beginning of 2014, Health Reform Legislation has included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program).

The risk-adjustment provisions of Health Reform Legislation are permanent regulations and apply to market reform compliant individual and small group plans in the commercial markets. Under the program, each covered member is assigned a risk score based upon demographic information and applicable diagnostic codes from the current year paid claims, in order to determine an average risk score for each plan in a particular state and market risk pool. Generally, a plan with a risk score that is less than the state's average risk score will pay into the pool, while a plan with a risk score that is greater than the state's average will receive money from the pool.

The risk corridors provisions of Health Reform Legislation will be in place for three years and are intended to limit the gains and losses of individual and small group qualified health plans. Plans are required to calculate the U.S. Department of Health and Human Services (HHS) risk corridor ratio of allowable costs (defined as medical claims plus quality improvement costs adjusted for the impact of reinsurance recoveries and the risk adjustment program) to the defined target amount (defined as actual premiums less defined allowable administrative costs inclusive of taxes and profits). Qualified health plans with ratios below 97% are required to make payments to HHS, while plans with ratios greater than 103% expect to receive funds from HHS.

The Reinsurance Program is a temporary three year program that is funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. Only issuers of market reform compliant individual plans are eligible for reinsurance recoveries from the risk pools.

None of the Premium Stabilization Programs had a material impact on the Consolidated Financial Statements in 2014.

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board issued Accounting Standard Update (ASU) No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09). ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2014				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,614	$ 7	$ (1)	$ 1,620
State and municipal obligations	6,456	217	(5)	6,668
Corporate obligations	7,241	112	(26)	7,327
U.S. agency mortgage-backed securities	2,022	39	(5)	2,056
Non-U.S. agency mortgage-backed securities	872	12	(4)	880
Total debt securities — available-for-sale	18,205	387	(41)	18,551
Equity securities — available-for-sale	1,511	36	(25)	1,522
Debt securities — held-to-maturity:				
U.S. government and agency obligations	178	2	—	180
State and municipal obligations	19	—	—	19
Corporate obligations	298	—	—	298
Total debt securities — held-to-maturity	495	2	—	497
Total investments	$20,211	$425	$ (66)	$20,570
December 31, 2013				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,211	$ 5	$ (21)	$ 2,195
State and municipal obligations	6,902	147	(72)	6,977
Corporate obligations	7,265	130	(60)	7,335
U.S. agency mortgage-backed securities	2,256	23	(61)	2,218
Non-U.S. agency mortgage-backed securities	697	12	(7)	702
Total debt securities — available-for-sale	19,331	317	(221)	19,427
Equity securities — available-for-sale	1,576	9	(13)	1,572
Debt securities — held-to-maturity:				
U.S. government and agency obligations	181	1	—	182
State and municipal obligations	28	—	—	28
Corporate obligations	334	—	—	334
Total debt securities — held-to-maturity	543	1	—	544
Total investments	$21,450	$327	$(234)	$21,543

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination date as of December 31, 2014 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2014	$ 222	$ —	$ —	$ —	$ 222
2013	164	—	—	—	164
2012	81	—	—	—	81
2011	17	—	—	—	17
2010	23	—	—	—	23
2009	6	—	—	—	6
Pre - 2009	354	1	1	11	367
U.S. agency mortgage-backed securities	2,054	2	—	—	2,056
Total	$2,921	$ 3	$ 1	$ 11	$2,936

The Company includes any securities backed by Alt-A or subprime mortgages and any commercial mortgage loans in default in the non-investment grade column in the table above.

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,822	$ 1,826
Due after one year through five years	6,632	6,709
Due after five years through ten years	5,086	5,212
Due after ten years	1,771	1,868
U.S. agency mortgage-backed securities	2,022	2,056
Non-U.S. agency mortgage-backed securities	872	880
Total debt securities — available-for-sale	$18,205	$18,551

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 88	$ 88
Due after one year through five years	210	210
Due after five years through ten years	112	113
Due after ten years	85	86
Total debt securities — held-to-maturity	$495	$497

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2014						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 420	$ (1)	$ —	$ —	$ 420	$ (1)
State and municipal obligations	711	(4)	99	(1)	810	(5)
Corporate obligations	2,595	(17)	464	(9)	3,059	(26)
U.S. agency mortgage-backed securities	—	—	272	(5)	272	(5)
Non-U.S. agency mortgage-backed securities	254	(2)	114	(2)	368	(4)
Total debt securities — available-for-sale	$3,980	$ (24)	$949	$(17)	$4,929	$ (41)
Equity securities — available-for-sale	$ 107	$ (6)	$ 88	$(19)	$ 195	$ (25)
December 31, 2013						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$1,055	$ (19)	$ 17	$ (2)	$1,072	$ (21)
State and municipal obligations	2,491	(62)	128	(10)	2,619	(72)
Corporate obligations	2,573	(51)	103	(9)	2,676	(60)
U.S. agency mortgage-backed securities	1,393	(51)	105	(10)	1,498	(61)
Non-U.S. agency mortgage-backed securities	289	(6)	26	(1)	315	(7)
Total debt securities — available-for-sale	$7,801	$(189)	$379	$(32)	$8,180	$(221)
Equity securities — available-for-sale	$ 180	$ (13)	$ —	$ —	$ 180	$ (13)

The Company's unrealized losses from all securities as of December 31, 2014 were generated from approximately 6,000 positions out of a total of 22,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of December 31, 2014, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, venture capital funds, and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

(in millions)	For the Years Ended December 31, 2014	2013	2012
Total OTTI	$ (26)	$ (8)	$ (6)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(26)	(8)	(6)
Gross realized losses from sales	(47)	(9)	(13)
Gross realized gains from sales	284	198	175
Net realized gains (included in investment and other income on the Consolidated Statements of Operations)	211	181	156
Income tax effect (included in provision for income taxes on the Consolidated Statements of Operations)	(77)	(66)	(57)
Realized gains, net of taxes	$134	$115	$ 99

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2014 or 2013.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2014 or 2013.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based on recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Other Assets. The fair values of the Company's other assets are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-Related Investments. AARP Program-related investments consist of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Interest Rate Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-Related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2014				
Cash and cash equivalents	$ 7,472	$ 23	$ —	$ 7,495
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,427	193	—	1,620
State and municipal obligations	—	6,668	—	6,668
Corporate obligations	2	7,257	68	7,327
U.S. agency mortgage-backed securities	—	2,056	—	2,056
Non-U.S. agency mortgage-backed securities	—	874	6	880
Total debt securities — available-for-sale	1,429	17,048	74	18,551
Equity securities — available-for-sale	1,200	12	310	1,522
Interest rate swap assets	—	62	—	62
Total assets at fair value	$10,101	$17,145	$384	$27,630
Percentage of total assets at fair value	37%	62%	1%	100%
Interest rate swap liabilities	$ —	$ 55	$ —	$ 55
December 31, 2013				
Cash and cash equivalents	$ 7,005	$ 271	$ —	$ 7,276
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,750	445	—	2,195
State and municipal obligations	—	6,977	—	6,977
Corporate obligations	25	7,274	36	7,335
U.S. agency mortgage-backed securities	—	2,218	—	2,218
Non-U.S. agency mortgage-backed securities	—	696	6	702
Total debt securities — available-for-sale	1,775	17,610	42	19,427
Equity securities — available-for-sale	1,291	12	269	1,572
Total assets at fair value	$10,071	$17,893	$311	$28,275
Percentage of total assets at fair value	36%	63%	1%	100%
Interest rate swap liabilities	$ —	$ 163	$ —	$ 163

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2014					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$180	$ —	$ —	$ 180	$ 178
State and municipal obligations	—	—	19	19	19
Corporate obligations	46	10	242	298	298
Total debt securities — held-to-maturity	$226	$ 10	$261	$ 497	$ 495
Other assets	$ —	$ 478	$ —	$ 478	$ 484
Long-term debt and other financing obligations	$ —	$18,863	$ —	$18,863	$17,085
December 31, 2013					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$182	$ —	$ —	$ 182	$ 181
State and municipal obligations	—	—	28	28	28
Corporate obligations	47	9	278	334	334
Total debt securities — held-to-maturity	$229	$ 9	$306	$ 544	$ 543
Long-term debt and other financing obligations	$ —	$16,602	$ —	$16,602	$15,745

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2014			December 31, 2013			December 31, 2012		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$42	$ 269	$ 311	$ 17	$224	$241	$ 208	$209	$ 417
Purchases	32	105	137	38	71	109	11	71	82
Sales	(1)	(180)	(181)	(10)	(25)	(35)	—	(34)	(34)
Settlements	—	—	—	—	—	—	(1)	—	(1)
Net unrealized gains (losses) in other comprehensive income	1	6	7	(2)	(7)	(9)	—	(14)	(14)
Net realized gains (losses) in investment and other income	—	110	110	(1)	6	5	—	13	13
Transfer to held-to-maturity	—	—	—	—	—	—	(201)	(21)	(222)
Balance at end of period	$74	$ 310	$ 384	$ 42	$269	$311	$ 17	$224	$ 241

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
December 31, 2014					
Equity securities — available-for-sale					
Venture capital portfolios	$260	Market approach — comparable companies	Revenue multiple	1.0	6.0
			EBITDA multiple	8.0	10.0
	50	Market approach — recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$310				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $74 million of available-for-sale debt securities as of December 31, 2014, which were not significant.

The Company elected to measure the entirety of the AARP Program assets under management at fair value pursuant to the fair value option. See Note 2 for further detail on the AARP Program. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
December 31, 2014			
Cash and cash equivalents	$415	$ —	$ 415
Debt securities:			
U.S. government and agency obligations	409	245	654
State and municipal obligations	—	95	95
Corporate obligations	—	1,200	1,200
U.S. agency mortgage-backed securities	—	340	340
Non-U.S. agency mortgage-backed securities	—	177	177
Total debt securities	409	2,057	2,466
Other investments	—	81	81
Total assets at fair value	$824	$2,138	$2,962
Other liabilities	$ 5	$ 13	$ 18
December 31, 2013			
Cash and cash equivalents	$265	$ —	$ 265
Debt securities:			
U.S. government and agency obligations	426	301	727
State and municipal obligations	—	63	63
Corporate obligations	—	1,145	1,145
U.S. agency mortgage-backed securities	—	414	414
Non-U.S. agency mortgage-backed securities	—	139	139
Total debt securities	426	2,062	2,488
Equity securities — available-for-sale	—	4	4
Total assets at fair value	$691	$2,066	$2,757
Other liabilities	$ 3	$ 11	$ 14

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2014	December 31, 2013
Land and improvements	$ 310	$ 318
Buildings and improvements	2,295	2,051
Computer equipment	1,693	1,519
Furniture and fixtures	675	564
Less accumulated depreciation	(1,982)	(1,760)
Property and equipment, net	2,991	2,692
Capitalized software	2,399	2,233
Less accumulated amortization	(972)	(915)
Capitalized software, net	1,427	1,318
Total property, equipment and capitalized software, net	$ 4,418	$ 4,010

Depreciation expense for property and equipment for 2014, 2013 and 2012 was $532 million, $445 million and $449 million, respectively. Amortization expense for capitalized software for 2014, 2013 and 2012 was $422 million, $411 million and $412 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2013	$24,459	$2,818	$3,169	$840	$31,286
Acquisitions	408	48	483	—	939
Foreign currency effects and adjustments, net	(616)	(6)	1	—	(621)
Balance at December 31, 2013	24,251	2,860	3,653	840	31,604
Acquisitions	266	978	591	—	1,835
Foreign currency effects and adjustments, net	(487)	(4)	(8)	—	(499)
Balance at December 31, 2014	$24,030	$3,834	$4,236	$840	$32,940

In 2014, acquisitions were not material to the Company's Consolidated Financial Statements.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2014			December 31, 2013		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$5,021	$(2,399)	$2,622	$4,821	$(2,028)	$2,793
Trademarks and technology	527	(202)	325	433	(191)	242
Trademarks — indefinite-lived	539	—	539	589	—	589
Other	267	(84)	183	284	(64)	220
Total	$6,354	$(2,685)	$3,669	$6,127	$(2,283)	$3,844

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2014		2013	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$314	14 years	$55	12 years
Trademarks and technology	148	6 years	27	12 years
Other	2	14 years	—	
Total acquired finite-lived intangible assets	$464	11 years	$82	12 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2015	$518
2016	487
2017	442
2018	392
2019	288

Amortization expense relating to intangible assets for December 31, 2014, 2013 and 2012 was $524 million, $519 million and $448 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2014	2013	2012
Medical costs payable, beginning of period	$ 11,575	$ 11,004	$ 9,799
Acquisitions	—	—	1,029
Reported medical costs:			
Current year	93,677	89,970	81,086
Prior years	(420)	(680)	(860)
Total reported medical costs	93,257	89,290	80,226
Claim payments:			
Payments for current year	(82,374)	(78,989)	(71,832)
Payments for prior year	(10,418)	(9,730)	(8,218)
Total claim payments	(92,792)	(88,719)	(80,050)
Medical costs payable, end of period	$ 12,040	$ 11,575	$ 11,004

For the year ended December 31, 2014, the favorable medical cost reserve development was due to a number of individual factors that were not material. The net favorable development for the years ended December 31, 2013 and 2012 was primarily driven by lower than expected health system utilization levels. In 2012, reserves were also impacted by increased efficiency in claims processing and handling.

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2014			December 31, 2013		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 321	$ 321	$ 321	$ 1,115	$ 1,115	$ 1,115
4.750% notes due February 2014	—	—	—	172	173	173
5.000% notes due August 2014	—	—	—	389	397	400
Floating-rate notes due August 2014	—	—	—	250	250	250
4.875% notes due March 2015 (a)	416	419	419	416	431	436
0.850% notes due October 2015 (a)	625	625	627	625	624	628
5.375% notes due March 2016 (a)	601	623	634	601	641	657
1.875% notes due November 2016 (a)	400	397	406	400	398	408
5.360% notes due November 2016	95	95	103	95	95	107
6.000% notes due June 2017 (a)	441	466	489	441	479	506
1.400% notes due October 2017 (a)	625	616	624	625	613	617
6.000% notes due November 2017 (a)	156	164	175	156	168	178
1.400% notes due December 2017 (a)	750	745	749	—	—	—
6.000% notes due February 2018 (a)	1,100	1,106	1,238	1,100	1,116	1,271
1.625% notes due March 2019 (a)	500	496	493	500	489	481
2.300% notes due December 2019 (a)	500	496	502	—	—	—
3.875% notes due October 2020 (a)	450	450	477	450	435	474
4.700% notes due February 2021 (a)	400	413	450	400	416	436
3.375% notes due November 2021 (a)	500	496	519	500	472	494
2.875% notes due December 2021 (a)	750	748	759	—	—	—
2.875% notes due March 2022 (a)	1,100	1,042	1,104	1,100	981	1,046
0.000% notes due November 2022	15	10	11	15	9	10
2.750% notes due February 2023 (a)	625	604	613	625	563	572
2.875% notes due March 2023 (a)	750	777	745	750	729	698
5.800% notes due March 2036	850	845	1,052	850	845	935
6.500% notes due June 2037	500	495	670	500	495	593
6.625% notes due November 2037	650	646	888	650	645	786
6.875% notes due February 2038	1,100	1,085	1,544	1,100	1,084	1,370
5.700% notes due October 2040	300	298	378	300	298	329
5.950% notes due February 2041	350	348	455	350	348	397
4.625% notes due November 2041	600	593	646	600	593	567
4.375% notes due March 2042	502	486	536	502	486	459
3.950% notes due October 2042	625	611	621	625	611	530
4.250% notes due March 2043	750	740	786	750	740	673
Total commercial paper and long-term debt	$17,347	$17,256	$19,034	$16,952	$16,739	$17,596

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

The Company's long-term debt obligations also included $150 million and $121 million of other financing obligations, of which $34 million were current as of both December 31, 2014 and December 31, 2013.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2015	$ 1,396
2016	1,121
2017	1,980
2018	1,103
2019	1,027
Thereafter	10,870

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2014, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.4%.

The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2019 and November 2015, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2014. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of December 31, 2014, the annual interest rates on the bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Debt Covenants

The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio of not more than 50%. The Company was in compliance with its debt covenants as of December 31, 2014.

Interest Rate Swap Contracts

The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its variable rate financial assets. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are considered to be highly effective hedges and all changes in the fair values of the swaps are recorded as adjustments to the carrying value of the related debt with no net impact recorded on the Consolidated Statements of Operations.

The following table summarizes the location and fair value of the interest rate swap fair value hedges on the Company's Consolidated Balance Sheet:

Type of Fair Value Hedge	Notional Amount (in billions)	Fair Value (in millions)	Balance Sheet Location
December 31, 2014			
Interest rate swap contracts	$10.7	$ 62	Other assets
		55	Other liabilities
December 31, 2013			
Interest rate swap contracts	$ 6.2	$163	Other liabilities

The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Consolidated Statements of Operations:

	For the Years Ended December 31,		
(in millions)	**2014**	**2013**	**2012**
Hedge — interest rate swap gain (loss) recognized in interest expense	$ 170	$(166)	$ 3
Hedged item — long-term debt (loss) gain recognized in interest expense	(170)	166	(3)
Net impact on the Company's Consolidated Statements of Operations	$ —	$ —	$ —

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	**2014**	**2013**	**2012**
Current Provision:			
Federal	$3,883	$3,004	$2,638
State and local	271	237	150
Total current provision	4,154	3,241	2,788
Deferred provision	(117)	1	308
Total provision for income taxes	$4,037	$3,242	$3,096

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	**2014**		**2013**		**2012**	
Tax provision at the U.S. federal statutory rate	$3,380	35.0%	$3,120	35.0%	$3,018	35.0%
Industry tax	469	4.8	—	—	—	—
State income taxes, net of federal benefit	154	1.6	126	1.4	143	1.7
Tax-exempt investment income	(49)	(0.5)	(53)	(0.6)	(59)	(0.7)
Non-deductible compensation	96	1.0	39	0.5	22	0.2
Other, net	(13)	(0.1)	10	0.1	(28)	(0.3)
Provision for income taxes	$4,037	41.8%	$3,242	36.4%	$3,096	35.9%

The higher tax rate for 2014 is mostly due to the nondeductibility of the Industry Tax. The higher effective income tax rate for 2013 as compared to 2012 primarily resulted from the favorable resolution of various one-time tax matters in 2012.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2014	2013
Deferred income tax assets:		
Accrued expenses and allowances	$ 313	$ 284
U.S. federal and state net operating loss carryforwards	172	257
Share-based compensation	141	200
Long-term liabilities	222	170
Medical costs payable and other policy liabilities	120	155
Non-U.S. tax loss carryforwards	257	110
Unearned revenues	90	65
Unrecognized tax benefits	38	38
Other-domestic	36	57
Other-non-U.S.	141	89
Subtotal	1,530	1,425
Less: valuation allowances	(119)	(207)
Total deferred income tax assets	1,411	1,218
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(1,275)	(1,207)
Non-U.S. goodwill and intangible assets	(496)	(453)
Capitalized software	(506)	(481)
Net unrealized gains on investments	(129)	(31)
Depreciation and amortization	(272)	(268)
Prepaid expenses	(140)	(137)
Other-non-U.S.	(102)	(7)
Total deferred income tax liabilities	(2,920)	(2,584)
Net deferred income tax liabilities	$(1,509)	$(1,366)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $129 million expire beginning in 2021 through 2034; state net operating loss carryforwards expire beginning in 2015 through 2034. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2014, the Company had $391 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2014	2013	2012
Gross unrecognized tax benefits, beginning of period	$89	$81	$129
Gross increases:			
Current year tax positions	—	8	6
Prior year tax positions	4	5	18
Gross decreases:			
Prior year tax positions	—	—	(48)
Settlements	—	—	(10)
Statute of limitations lapses	(1)	(5)	(14)
Gross unrecognized tax benefits, end of period	$92	$89	$ 81

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During 2014 and 2013, the Company recognized $6 million and $4 million of interest expense, respectively. The Company recognized tax benefits from the net reduction of interest and penalties accrued of $20 million during the year ended December 31, 2012. The Company had $33 million and $27 million of accrued interest and penalties for uncertain tax positions as of December 31, 2014 and 2013, respectively. These amounts are not included in the reconciliation above. As of December 31, 2014, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $92 million.

The Company currently files income tax returns in the United States, various states and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2013 and prior. The Company's 2014 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2007 tax year. The Brazilian federal revenue service — Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed. Estimated taxes are paid monthly in Brazil with an annual return due on June 30 following the end of the taxable year.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $39 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2014, the Company's regulated subsidiaries paid their parent companies dividends of $4.6 billion, including $1.5 billion of extraordinary dividends. For the year ended December 31,

2013, the Company's regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $430 million of extraordinary dividends. As of December 31, 2014, $738 million of the Company's $7.5 billion of cash and cash equivalents was available for general corporate use.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $14.7 billion as of December 31, 2014. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $7.1 billion as of December 31, 2014.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2014, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2014, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock. During 2014, the Company repurchased 49 million shares at an average price of $82.57 per share and an aggregate cost of $4.0 billion.

Dividends

In June 2014, the Company's Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.50 per share, paid quarterly. Since June 2013, the Company had paid an annual cash dividend of $1.12 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2014 dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2014	$1.4050	$1,362
2013	1.0525	1,056
2012	0.8000	820

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted stock and restricted stock units (collectively, restricted shares). As of December 31, 2014, the Company had 25 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and awards for 11 million restricted shares. As of December 31, 2014, there were also 14 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2014 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	41	$48		
Granted	8	71		
Exercised	(15)	47		
Forfeited	(1)	62		
Outstanding at end of period	33	53	5.3	$1,569
Exercisable at end of period	19	45	3.1	1,085
Vested and expected to vest, end of period	32	53	5.3	1,544

Restricted Shares

Restricted share activity for the year ended December 31, 2014 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	11	$50
Granted	4	71
Vested	(6)	46
Nonvested at end of period	9	61

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2014	2013	2012
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 22	$ 19	$ 18
Total intrinsic value of stock options and SARs exercised	526	592	559
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	71	58	52
Total fair value of restricted shares vested	$437	$ 31	$716
Employee Stock Purchase Plan			
Number of shares purchased	2	3	3
Share-Based Compensation Items			
Share-based compensation expense, before tax	$364	$331	$421
Share-based compensation expense, net of tax effects	314	239	299
Income tax benefit realized from share-based award exercises	231	206	461

(in millions, except years)	December 31, 2014
Unrecognized compensation expense related to share awards	$373
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2014	2013	2012
Risk-free interest rate	1.7% - 1.8%	1.0% - 1.6%	0.7% - 0.9%
Expected volatility	24.1% - 39.6%	41.0% - 43.0%	43.2% - 44.0%
Expected dividend yield	1.6% - 1.9%	1.4% - 1.6%	1.2% - 1.7%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.4	5.3	5.3 - 5.6

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2014, 2013, and 2012.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $496 million and $441 million as of December 31, 2014 and 2013, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for 2014, 2013 and 2012 was $449 million, $438 million and $334 million, respectively.

As of December 31, 2014, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2015	$491
2016	386
2017	329
2018	293
2019	240
Thereafter	464

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of or for December 31, 2014, 2013, and 2012.

As of December 31, 2014, the Company had outstanding, undrawn letters of credit with financial institutions of $33 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI had never before issued a fine in excess of $8 million, CDI advocated a fine of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a nonbinding proposed decision recommending a fine of $11.5 million. The California Insurance Commissioner rejected the administrative law judge's recommendation and on June 9, 2014, issued his own decision imposing a fine of approximately $174 million. On July 10, 2014, the Company filed a lawsuit in California state court challenging the Commissioner's decision. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the wide range of possible outcomes, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting a regulatory fine in the event of a remand, and the various remedies and levels of judicial review that remain available to the Company.

Endoscopy Center of Southern Nevada Litigation. In April 2013, a Las Vegas jury awarded $24 million in compensatory damages and $500 million in punitive damages against a Company health plan and its parent corporation on the theory that they were negligent in their credentialing and monitoring of an in-network endoscopy center owned and operated by independent physicians who were subsequently linked by regulators to an outbreak of hepatitis C. The trial court reduced the overall award to $366 million. In 2014, the Company settled this and all other pending suits brought by individuals allegedly infected by hepatitis C for an amount that is not material to the Company's results of operations, financial position or cash flows. Although the Company remains party to two class actions brought on behalf of uninfected patients of the endoscopy center seeking the cost of medical monitoring, the Company does not believe these matters are material to its results of operations, financial position, or cash flows.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the Securities and Exchange Commission (SEC), the Internal Revenue Service, the SRF, the U.S. Department of Labor, the FDIC, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

Guaranty Fund Assessments

Under state guaranty fund laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies. In 2009, the Pennsylvania Insurance Commissioner placed long term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In 2012, the court denied the liquidation petition and ordered the Insurance Commissioner to submit a rehabilitation plan. The court recently set a hearing for July 2015 to consider the latest proposed rehabilitation plan.

If the current proposed rehabilitation plan, which contemplates the partial liquidation of Penn Treaty, is approved by the court, the Company's insurance entities and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through state guaranty association assessments in future periods. The Company intends to vigorously challenge the proposed rehabilitation plan. The Company is currently unable to estimate losses or ranges of losses because the Company cannot predict whether, when or to what extent Penn Treaty will ultimately be declared insolvent, the amount of the insolvency, if any, the amount and timing of any associated guaranty fund assessments or the availability and amount of any premium tax and other potential offsets.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global because they have similar economic characteristics, products and services, customers, distribution methods and operational processes and operate in a similar regulatory environment. The U.S. businesses also share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide and active and retired military and their families through the TRICARE program (West Region). UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program, and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.
- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling consumer health management and local care delivery through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, local care delivery services, consumer engagement and relationship management and sales distribution platform services and financial services.
- *OptumInsight* is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services, and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers pharmacy benefit management services and programs including retail pharmacy network management services, home delivery and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing, and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 29% for 2014, 2013 and 2012, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 95%, 95%, and 99% of consolidated total revenues for 2014, 2013 and 2012, respectively. Long-lived fixed assets located in the United States represented approximately 73% and 72% of the total long-lived fixed assets as of December 31, 2014 and 2013, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

2014 Business Realignment

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, are now included in OptumInsight's results of operations. The Company's historical segment results have been restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

Prior period reportable segment financial information has been recast to conform to the 2014 presentation. The following table presents the reportable segment financial information:

		Optum						
(in millions)	**UnitedHealthcare**	**OptumHealth**	**OptumInsight**	**OptumRx**	**Optum Eliminations**	**Optum**	**Corporate and Eliminations**	**Consolidated**
2014								
Revenues — external customers:								
Premiums	$112,645	$ 2,657	$ —	$ —	$ —	$ 2,657	$ —	$115,302
Services	6,516	1,300	2,224	111	—	3,635	—	10,151
Products	3	18	96	4,125	—	4,239	—	4,242
Total revenues — external customers	119,164	3,975	2,320	4,236	—	10,531	—	129,695
Total revenues — intersegment	—	6,913	2,906	27,740	(489)	37,070	(37,070)	—
Investment and other income	634	144	1	—	—	145	—	779
Total revenues	$119,798	$11,032	$5,227	$31,976	$(489)	$47,746	$(37,070)	$130,474
Earnings from operations	$ 6,992	$ 1,090	$1,002	$ 1,190	$ —	$ 3,282	$ —	$ 10,274
Interest expense	—	—	—	—	—	—	(618)	(618)
Earnings before income taxes	$ 6,992	$ 1,090	$1,002	$ 1,190	$ —	$ 3,282	$ (618)	$ 9,656
Total assets	$ 62,405	$11,148	$8,112	$ 5,474	$ —	$24,734	$ (757)	$ 86,382
Purchases of property, equipment and capitalized software	773	212	484	56	—	752	—	1,525
Depreciation and amortization	772	179	433	94	—	706	—	1,478
2013								
Revenues — external customers:								
Premiums	$107,024	$ 2,533	$ —	$ —	$ —	$ 2,533	$ —	$109,557
Services	6,076	819	2,006	96	—	2,921	—	8,997
Products	8	19	92	3,071	—	3,182	—	3,190
Total revenues — external customers	113,108	3,371	2,098	3,167	—	8,636	—	121,744
Total revenues — intersegment	—	6,357	2,615	20,839	(458)	29,353	(29,353)	—
Investment and other income	617	127	1	—	—	128	—	745
Total revenues	$113,725	$ 9,855	$4,714	$24,006	$(458)	$38,117	$(29,353)	$122,489
Earnings from operations	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ —	$ 9,623
Interest expense	—	—	—	—	—	—	(708)	(708)
Earnings before income taxes	$ 7,132	$ 949	$ 831	$ 711	$ —	$ 2,491	$ (708)	$ 8,915
Total assets	$ 61,942	$ 9,244	$6,880	$ 4,483	$ —	$20,607	$ (667)	$ 81,882
Purchases of property, equipment and capitalized software	670	185	363	89	—	637	—	1,307
Depreciation and amortization	766	158	359	92	—	609	—	1,375
2012								
Revenues — external customers:								
Premiums	$ 97,985	$ 1,743	$ —	$ —	$ —	$ 1,743	$ —	$ 99,728
Services	4,780	767	1,807	83	—	2,657	—	7,437
Products	1	21	87	2,664	—	2,772	—	2,773
Total revenues — external customers	102,766	2,531	1,894	2,747	—	7,172	—	109,938
Total revenues — intersegment	—	5,503	2,363	15,611	(364)	23,113	(23,113)	—
Investment and other income	566	113	—	1	—	114	—	680
Total revenues	$103,332	$ 8,147	$4,257	$18,359	$(364)	$30,399	$(23,113)	$110,618
Earnings from operations	$ 7,687	$ 538	$ 656	$ 373	$ —	$ 1,567	$ —	$ 9,254
Interest expense	—	—	—	—	—	—	(632)	(632)
Earnings before income taxes	$ 7,687	$ 538	$ 656	$ 373	$ —	$ 1,567	$ (632)	$ 8,622
Total assets	$ 62,971	$ 8,198	$6,367	$ 3,434	$ —	$17,999	$ (85)	$ 80,885
Purchases of property, equipment and capitalized software	382	163	409	116	—	688	—	1,070
Depreciation and amortization	635	164	411	99	—	674	—	1,309

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2014 and 2013 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2014				
Revenues	$31,708	$32,574	$32,759	$33,433
Operating costs	29,654	30,022	29,856	30,668
Earnings from operations	2,054	2,552	2,903	2,765
Net earnings	1,099	1,408	1,602	1,510
Net earnings attributable to UnitedHealth Group common shareholders	1,099	1,408	1,602	1,510
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.12	1.44	1.65	1.58
Diluted	1.10	1.42	1.63	1.55
2013				
Revenues	$30,340	$30,408	$30,624	$31,117
Operating costs	28,201	28,007	27,993	28,665
Earnings from operations	2,139	2,401	2,631	2,452
Net earnings	1,240	1,436	1,570	1,427
Net earnings attributable to UnitedHealth Group common shareholders	1,192	1,436	1,570	1,427
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.17	1.42	1.56	1.43
Diluted	1.16	1.40	1.53	1.41

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2014. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2014.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2014

UnitedHealth Group Incorporated and Subsidiaries' (the "Company") management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2014. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2014, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2014, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2014.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2014. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2014 of the Company and our report dated February 10, 2015 expressed an unqualified opinion on those consolidated financial statements.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 10, 2015, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP
(formerly Greenebaum Doll & McDonald PLLC)

Edson Bueno, M.D.
Founder and Chief Executive Officer
Amil

Richard T. Burke
Non-Executive Chairman
UnitedHealth Group

Robert J. Darretta
Retired Vice-Chairman and
Chief Financial Officer
Johnson & Johnson

Stephen J. Hemsley
Chief Executive Officer
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council, a company
focused on improving the governance
processes of corporate boards

Rodger A. Lawson
Chairman
E*TRADE Financial Corporation and
Retired President and Chief Executive Officer
Fidelity Investments — Financial Services

Douglas W. Leatherdale
Retired Chairman and Chief Executive Officer
The St. Paul Companies, Inc.
(currently known as Travelers Companies, Inc.)

Glenn M. Renwick
Chairman, President and Chief Executive Officer
The Progressive Corporation

Kenneth I. Shine, M.D.
Special Advisor to the Chancellor for Health Affairs
The University of Texas System

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE, an international health foundation

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller, and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance — Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The information required by Item 201(d) of Regulation S-K will be included under the heading "Securities Authorized for Issuance Under Equity Compensation Plans" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2015 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2014 and 2013.
- Consolidated Statement of Operations for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Comprehensive Income for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Changes in Shareholders' Equity for the years ended December 31, 2014, 2013, and 2012.
- Consolidated Statement of Cash Flows for the years ended December 31, 2014, 2013, and 2012.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

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

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.12	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)

*10.15	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.16	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.17	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.18	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.19	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.20	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.21	Summary of Non-Management Director Compensation, effective as of October 1, 2014 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.22	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.23	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.24	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)

*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.30	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.31	Amended and Restated Employment Agreement, dated as of August 8, 2011, between United HealthCare Services, Inc. and Gail K. Boudreaux (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)
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23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney

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32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2014 and 2013, and for each of the three years in the period ended December 31, 2014, and the Company's internal control over financial reporting as of December 31, 2014, and have issued our reports thereon dated February 10, 2015; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 10, 2015

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 559	$ 822
Short-term notes receivable from subsidiaries	27	11
Deferred income taxes and other current assets	271	214
Total current assets	857	1,047
Equity in net assets of subsidiaries	44,643	44,301
Long-term notes receivable from subsidiaries	4,635	4,215
Other assets	278	144
Total assets	$50,413	$49,707
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 332	$ 335
Note payable to subsidiary	215	215
Commercial paper and current maturities of long-term debt	1,365	1,935
Total current liabilities	1,912	2,485
Long-term debt, less current maturities	15,891	14,804
Deferred income taxes and other liabilities	156	269
Total liabilities	17,959	17,558
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 954 and 988 issued and outstanding	10	10
Retained earnings	33,836	33,047
Accumulated other comprehensive loss	(1,392)	(908)
Total UnitedHealth Group shareholders' equity	32,454	32,149
Total liabilities and shareholders' equity	$50,413	$49,707

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2014	2013	2012
Revenues:			
Investment and other income	$ 293	$ 252	$ 28
Total revenues	293	252	28
Operating costs:			
Operating costs	1	(9)	(2)
Interest expense	554	618	566
Total operating costs	555	609	564
Loss before income taxes	(262)	(357)	(536)
Benefit for income taxes	96	130	192
Loss of parent company	(166)	(227)	(344)
Equity in undistributed income of subsidiaries	5,785	5,852	5,870
Net earnings	5,619	5,625	5,526
Other comprehensive loss	(484)	(1,346)	(23)
Comprehensive income	$5,135	$ 4,279	$5,503

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2014	2013	2012
Operating activities			
Cash flows from operating activities	$ 7,445	$ 5,099	$ 6,116
Investing activities			
Issuance of notes to subsidiaries	(436)	(1,517)	(4,149)
Repayments of notes receivable from subsidiaries	—	275	—
Cash paid for acquisitions	(1,852)	(274)	(3,737)
Capital contributions to subsidiaries	(704)	(942)	(99)
Other, net	(9)	—	—
Cash flows used for investing activities	(3,001)	(2,458)	(7,985)
Financing activities			
Common stock repurchases	(4,008)	(3,170)	(3,084)
Proceeds from common stock issuances	462	598	1,078
Cash dividends paid	(1,362)	(1,056)	(820)
(Repayments of) proceeds from commercial paper, net	(794)	(474)	1,587
Proceeds from issuance of long-term debt	1,997	2,235	3,966
Repayments of long-term debt	(812)	(943)	(986)
Proceeds of note from subsidiary	—	40	30
Other	(190)	(74)	(383)
Cash flows (used for) from financing activities	(4,707)	(2,844)	1,388
Decrease in cash and cash equivalents	(263)	(203)	(481)
Cash and cash equivalents, beginning of period	822	1,025	1,506
Cash and cash equivalents, end of period	$ 559	$ 822	$ 1,025
Supplemental cash flow disclosures			
Cash paid for interest	$ 578	$ 618	$ 547
Cash paid for income taxes	4,028	2,765	2,666

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Transactions With Subsidiaries. During 2014 the parent company issued intercompany notes of $0.4 billion that were used for the subsidiaries' general corporate purposes. In 2013, the parent company issued intercompany notes of $1.5 billion that were used primarily to fund the purchase of Amil's remaining public shares. Additionally in 2013, the $2.6 billion term note issued in 2012 was reclassified to long-term. During 2012, the parent company completed a non-cash exchange of a $3.9 billion intercompany note to a subsidiary for a new term note of $2.6 billion and an equity interest of $1.3 billion.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.5 billion, $5.3 billion and $7.8 billion in 2014, 2013 and 2012, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include the other financing obligations at a subsidiary that totaled $150 million and $121 million at December 31, 2014 and 2013, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2015	$ 1,362
2016	1,096
2017	1,972
2018	1,100
2019	1,000
Thereafter	10,817

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 10, 2015

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director and Chief Executive Officer (principal executive officer)	February 10, 2015
/s/ DAVID S. WICHMANN **David S. Wichmann**	President and Chief Financial Officer (principal financial officer)	February 10, 2015
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 10, 2015
* **William C. Ballard, Jr.**	Director	February 10, 2015
* **Edson Bueno**	Director	February 10, 2015
* **Richard T. Burke**	Director	February 10, 2015
* **Robert J. Darretta**	Director	February 10, 2015
* **Michele J. Hooper**	Director	February 10, 2015
* **Rodger A. Lawson**	Director	February 10, 2015
 Douglas W. Leatherdale	Director	
* **Glenn M. Renwick**	Director	February 10, 2015
* **Kenneth I. Shine**	Director	February 10, 2015
* **Gail R. Wilensky**	Director	February 10, 2015

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.12	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.15	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.16	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.17	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.18	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.19	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.20	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.21	Summary of Non-Management Director Compensation, effective as of October 1, 2014 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.22	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)

*10.23	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.24	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 For the fiscal year ended December 31, 2013**

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®

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Minnesota	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(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)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2013 was $64,914,032,649 (based on the last reported sale price of $65.48 per share on June 30, 2013, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2014, there were 989,191,844 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2014 Annual Meeting of Stockholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to a full spectrum of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, as well as students and other individuals, and serves the nation's active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare International includes Amil, a health care company providing health and dental benefits and hospital and clinical services to individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, government, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance including optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: integrated care delivery, care management, consumer engagement, distribution services, health financial services, operational services and support, health care information technology and pharmacy services.

Through UnitedHealthcare and Optum, in 2013, we managed over $160 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

2014 Business Realignment

On January 1, 2014, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. Our Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, will be included in OptumInsight's results of operations. Our periodic filings with the Securities and Exchange Commission (SEC) beginning with our first quarter 2014 Form 10-Q will include historical segment results restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

UnitedHealthcare

UnitedHealthcare is advancing strategies to improve the way health care is delivered and financed, offering consumers a simpler, more affordable health care experience. Our market position is built on:

- a national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers.

UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx pharmacy benefit products and services, certain OptumHealth care management and integrated care delivery services and OptumInsight health information and technology solutions, consulting and other services.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include a total of over 820,000 physicians and other health care professionals and approximately 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive regulations. See further discussion of our regulatory environment below under "Government Regulation" and in Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, individuals, and the military, specifically TRICARE west region members. UnitedHealthcare Employer & Individual provides over 30 million Americans access to health care as of December 31, 2013. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups are more likely to purchase risk-based products because they are less willing or able to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate per individual served for a one-year period. When providing administrative and other management services

to customers that elect to self-fund the health care costs of their employees and employees' dependants, UnitedHealthcare Employer & Individual receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependants, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

UnitedHealthcare Employer & Individual also offers a variety of non-employer based insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families. As part of the new public health care exchange market that opened October 1, 2013, UnitedHealthcare Employer & Individual now offers health benefit plans through exchanges in 10 states and District of Columbia, including four individual exchanges and nine small group (SHOP) exchanges.

The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals.

UnitedHealthcare Employer & Individual typically distributes its products through consultant or direct sales in the larger employer and public sector segments. In the smaller group size segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and producers, including brokers and agents. UnitedHealthcare Employer & Individual also distributes products through general agents, each of which is a wholesale agent or agency that contracts with a carrier to distribute individual or group benefits, providing extensive services to customers. In recent years, UnitedHealthcare Employer & Individual has diversified its model more extensively, distributing through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs).

Direct-to-consumer sales will be supported by industry participation in multi-carrier health insurance marketplaces for individuals and small groups through state or federally led exchanges for coverage effective January 1, 2014. Additionally, UnitedHealthcare Employer & Individual has expanded distribution to include retail offerings responsive to the needs of individual consumers. Over the last few years, UnitedHealthcare Employer & Individual has opened several retail storefronts in various locations across the United States that provide solutions to consumers at all stages in life, from individual plans to employer coverage, as well as solutions for Medicare-Medicaid eligible (MME) individuals.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provide the flexibility to meet the needs of employers of all sizes as well as individuals shopping for health benefits coverage. UnitedHealthcare Employer & Individual emphasizes local markets and leverages its national scale to adapt products to meet specific local market needs. UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans such as Choice and Options PPO to more traditional indemnity offerings. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products and Tools. Consumer engagement products couple plan design with financial accounts to increase employee responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer activation services such as personalized behavioral incentive programs and consumer education information. For example, UnitedHealthcare Employer & Individual's Diabetes Health Plan

emphasizes health engagement for diabetics and prediabetics, with personalized health action plans, scorecards and benefits that are specifically designed to encourage consumers to participate actively in maintaining their health. During 2013, more than 45,000 employer-sponsored benefit plans, including nearly 270 employers in the large group self-funded market, purchased an HRA or HSA product. UnitedHealthcare Employer & Individual's consumer engagement tools provide members with online and/or mobile access to benefit, cost and quality information, such as myHealthcare Cost Estimator, Health4Me, and myClaims Manager with online bill payment.

Value-Based Products. UnitedHealthcare Employer & Individual's suite of consumer incentive products increases individual awareness for heightened consumer responsibility and behavior change. These products include: Small Business Wellness, which is a packaged wellness and incentives product offering gym reimbursement and encouraging completion of important wellness activities. For mid-sized clients, SimplyEngaged is a scalable activity-based reward program that ties incentives to completion of health improvement activities, while SimplyEngaged Plus provides richer incentives for achieving health outcome goals. For large, self-funded customers, the UnitedHealthcare Healthy Rewards program offers a flexible incentive design for employers to choose the right activities and biometric outcomes that best fit the needs of their population. Additionally, UnitedHealth Personal Rewards leverages a tailored approach to incentives by combining personalized scorecards with financial incentives for improving biometric scores, compliance with key health treatments and preventive care.

Essential Benefits Products. UnitedHealthcare Employer & Individual's portfolio of products drives value to consumers with lower costs, innovative designs and unique network programs that guide people to physicians recognized for providing high-quality, cost-efficient care to their patients. These approaches are designed to deliver sustainable health care costs for employers, enabling them to continue to offer their employees coverage at more affordable prices through benefit and local network access tradeoffs. UnitedHealthcare Employer & Individual's tiered benefit plans offer enhanced benefits in the form of greater coinsurance coverage and/or lower copays for using UnitedHealth Premium® designated care providers.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management programs, which complement our service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, improving health and decreasing medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured and self-funded), line of business (e.g. small business, key accounts, public sector and national accounts), and clinical need. UnitedHealthcare Employer & Individual's spectrum of clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to drive better unit costs, encouraging consumers to use drugs that offer better value and outcomes, and by supporting the appropriate use of drugs based on clinical evidence through physician and consumer programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, and disability product offerings through an integrated approach including a network of more than 58,000 vision professionals in private and retail settings, and more than 250,000 dental providers.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans is the provider of health care services for more than 2.9 million active duty and retired military service members and their families in 21 states (West Region) under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013 and includes a transition period and five one-year renewals at the government's option.

UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration, and customer services.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia, and most U.S. territories. It has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a spectrum of risk-based Medicare products which may be purchased by individuals or on a group basis, including Medicare Advantage plans, Medicare Prescription Drug Benefit (Medicare Part D) and Medicare Supplement/Medigap products that supplement traditional fee-for-service coverage. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 29% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2013, most of which were generated by UnitedHealthcare Medicare & Retirement under a number of contracts.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over; state and U.S. government agencies; and employer groups. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS and in some cases consumer premiums. Premium amounts vary based on the

geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement had approximately 3 million people enrolled in its Medicare Advantage products as of December 31, 2013.

Medicare Advantage plans are designed at the local level taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the long-term payment rate outlook for that geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly, see Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to outreach to members to create individualized care plans and to help members obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. UnitedHealthcare Medicare & Retirement offers two standalone Medicare Part D plans: the AARP Medicare Rx Preferred and the AARP Medicare Rx Saver plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans cover the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2013, UnitedHealthcare had enrolled approximately 8 million people in the Medicare Part D program, including approximately 5 million individuals in the stand-alone Medicare Part D plans and approximately 3 million in its Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers plans in all 50 states, the District of Columbia, and most U.S. territories. These products cover varying levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to providing diversified solutions to states' programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage in exchange for a fixed monthly premium per member from the applicable state. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), and other federal, state and community health care programs. As of December 31, 2013, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 4 million beneficiaries. The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) provides for optional Medicaid expansion effective January 1, 2014. Currently, more than half of our state customers have elected to expand Medicaid. For further discussion of the Medicaid expansion under Health Reform Legislation, see Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation including the state's commitment and consistency of support for

its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and our participation are:

- Temporary Assistance to Needy Families, primarily young women and children – 19 markets;
- CHIP – 19 markets;
- Dual SNP – 18 markets;
- Aged, Blind and Disabled (ABD) – 14 markets;
- Long-Term Care (LTC) – 10 markets;
- childless adults & programs for the uninsured – 7 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 5 markets; and
- administrative service offering – 1 market.

The health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group, delivering them at the local market level to support effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are eligible for care in nursing homes and assisted living. They often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also tend to face significant social and economic challenges. UnitedHealthcare Community & State recognizes that within these broad groups, there exist individuals whose collective physical, behavioral and social challenges are so significant that they drive an inordinate percentage of UnitedHealthcare Community & State's total medical costs. In UnitedHealthcare Community & State's insured Medicaid population, approximately 1% of its membership accounts for about 30% of total costs. Care providers sometimes refer to this group as super utilizers.

The LTC market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTC population is made up of nearly 4 million individuals who qualify for additional benefits under LTC programs and represent a subset of the more than 15 million ABD Americans. Currently, only one-quarter of the ABD population and less than 20% of the LTC eligible population are served by managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are nearly 10 million individuals eligible for both Medicare and Medicaid. This group has historically been referred to as dually eligible. MME beneficiaries typically have complex conditions with costs of care that are far higher than a typical Medicare or Medicaid beneficiary. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and optimize people's health status through close coordination of care.

Total annual expenditures for dually eligibles are estimated at more than $300 billion, or more than 10% of the total health care costs in the United States. As of December 31, 2013, UnitedHealthcare served more than 275,000 people in legacy dually eligible programs through Medicare Advantage and SNPs. In 2013, UnitedHealthcare Community & State implemented a managed fee-for-service demonstration model in the state of Washington. In 2014, UnitedHealthcare Community & State will help implement MME programs in the states of Ohio, Washington and Michigan. These programs are among the first in the country to leverage CMS' demonstrations to serve MMEs.

UnitedHealthcare International

UnitedHealthcare International participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare International's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals around the world. UnitedHealthcare International's goal is to create business solutions that are based on local infrastructure, culture and needs, and that blend local expertise with experiences from the U.S. health care industry. As of December 31, 2013, UnitedHealthcare International provided medical benefits to 4.8 million people, principally in Brazil, but also residing in more than 125 countries.

Amil. In 2012, UnitedHealthcare International acquired Amil, which provides health and dental benefits to nearly 7 million people and also operates 25 acute hospitals, as well as specialty clinics, primary care, and emergency services across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of 21,000 physicians and other health care professionals, 2,100 hospitals and 7,900 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare International also includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers and patients who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: physicians and other care providers, hospitals and clinical facilities seeking to modernize in ways that enable the best patient care and experience possible, delivered cost-effectively.
- Those who pay for care: insurers, employers and government agencies devoted to ensuring that those they sponsor receive high-quality care, administered and delivered efficiently.
- Those who innovate for care: life sciences and research focused organizations dedicated to developing more effective approaches, enabling technologies and medicines that improve the delivery and quality of care.

Using advanced data, analytics and technology, Optum helps improve overall health system performance by optimizing care quality, reducing costs and improving the consumer experience and care provider performance. Optum is organized in three reportable segments:

- OptumHealth focuses on care management, integrated care delivery, and consumer solutions, including financial services;
- OptumInsight delivers operational services and support and health information technology services; and
- OptumRx specializes in pharmacy services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and financial needs of more than 62 million unique individuals and enabling consumer health management through programs offered by employers, payers, government entities and, increasingly, directly through the care delivery system. OptumHealth's products and services can be deployed individually or integrated to provide more comprehensive solutions, addressing a broad base of needs within the health care system. These solutions are focused on improving quality and patient satisfaction and lowering costs by working to optimize the care delivery system through the creation of high-performing networks, centers of excellence across the care continuum, working directly with physicians to advance population health management and focusing on caring for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served, and on an administrative fee basis whereby it manages or administers delivery of the products or services in exchange for a fixed fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and integrated care delivery businesses.

OptumHealth is organized into two major operating groups: Physician Solutions and Consumer Solutions.

Physician Solutions. Physician Solutions includes the Specialty Networks and Integrated Care Delivery offerings.

- Specialty Networks. Within Specialty Networks, OptumHealth serves nearly 57 million people in two primary ways: 1) creating access to networks of provider specialists in the areas of behavioral health management (e.g., mental health, substance abuse), global well-being (e.g., international work/life solutions), chronic physical health management (e.g., chiropractic, physical therapy), and complex medical conditions (e.g., transplant, infertility); and 2) managing the care and health needs for consumers through a variety of programs utilizing predictive modeling, evidence-based clinical outcomes management and peer support. Specialty Networks address areas likely to have significant variation in clinical practice, where a disciplined, evidence-based approach can drive improved health outcomes and reduced costs. These range from more commonly accessed services (e.g., behavioral health and chiropractic) to less common procedures (e.g. transplant, infertility, bariatric surgery and kidney disease/end stage renal disease).
- Integrated Care Delivery. Integrated Care Delivery serves patients through a collaborative network aligned around total population health management and outcomes-based reimbursement. Within its local care delivery systems, OptumHealth works directly with medical groups and Independent Practice Associations to deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist

physicians in delivering high-quality care across the populations they serve. Integrated Care Delivery's complex population management services focus on improving care for patients with very challenging medical conditions by providing the optimal care in the most desirable setting. Integrated Care Delivery's LHI business designs and implements mobile care delivery solutions, providing occupational health, medical and dental readiness services, treatments and immunization programs for the U.S. military and U.S. Department of Health and Human Services (HHS), as well as for many commercial companies.

Consumer Solutions. Consumer Solutions includes health management solutions, distribution and financial services operations.

- Health Management Solutions: OptumHealth serves over 37 million people through population health management services including care management, complex conditions (e.g., cancer, neonatal and maternity) health and wellness, and advocacy decision support solutions. This set of services helps consumers navigate the health care system and make decisions about their care and treatment, resulting in better clinical outcomes and lower medical costs.
- Distribution: This business provides capabilities to help payers, aggregators and employers meet the needs of the consumers they serve. The consumer engagement and sales distribution platform is backed by a spectrum of health and wellness services. The consumer engagement platform is a technology-enabled engagement model that is helping health care companies, including health plans, grow and manage their consumer relationships. OptumHealth provides call center support, multi-modal communications software, data analysis and trained nurses that help clients acquire, retain and service large populations of health care consumers.
- Financial Services: This business is dedicated solely to providing financial solutions for the health care market, serving the needs of individuals, employers, health care professionals and payers. OptumHealth is a leading provider of consumer health care accounts including health savings, health reimbursement, health incentive, retiree reimbursement and flexible spending accounts, that help people plan and save for current and future health care expenses. Payers, health care professionals and employers rely upon OptumHealth's electronic payment solutions to manage compliance and improve the administrative efficiency of electronic claim payments. OptumHealth also offers health care related lending and credit to health care providers to support the modernization of their practices, and financial risk protection for third-party payers and self-funded employers. As of December 31, 2013, Financial Services and its wholly owned subsidiary, Optum Bank, had $2.3 billion in customer assets under management and during 2013 processed $78 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides technology, operational and consulting services to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.

Many of OptumInsight's software and information products, advisory consulting arrangements, and outsourcing contracts are performed over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. OptumInsight's aggregate backlog at December 31, 2013 was $5.5 billion, of which $2.7 billion is expected to be realized within the next 12 months. This includes $1.1 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2012 was $4.6 billion. The increase in 2013 backlog was attributable to the partnership with Dignity Health that established the Optum360 provider revenue management business. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services, the potential for cancellation, non-renewal, or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospitals), commercial payers, governments and life sciences.

Care Providers. Serving four out of five U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements, and deliver health intelligence. OptumInsight's offerings in clinical workflow, revenue management, health IT and analytics helps hospitals and physician practices improve patient outcomes, strengthen financial performance and meet quality measurement and compliance requirements, as well as transition to new collaborative and accountable care business models.

Commercial Payers. OptumInsight serves approximately 300 health plans with employer, individual, Medicare, and Medicaid membership. OptumInsight applies its solutions across the payer's operations, helping clients to improve operational and administrative efficiency, meet clinical performance and compliance goals, develop strong provider networks, manage risk and drive growth. OptumInsight is also helping payer clients adapt to new market models, including health insurance exchanges, consumer driven health care and engagement, pay-for-value contracting, and population health management.

Governments. OptumInsight provides services to state, federal and municipal agencies and departments, across 35 states and the District of Columbia. Services include financial management and program integrity services, policy and compliance consulting, data and analytics technology, systems integration and expertise to improve medical quality, access and costs.

Life Sciences. OptumInsight's Life Sciences business provides services to more than 400 global life sciences organizations. OptumInsight's services use real-world evidence to support market access and positioning of their products, to deliver strategic regulatory services, to provide insights into patient reported outcomes and to optimize and manage risk.

OptumRx

OptumRx provides a range of pharmacy benefit management (PBM) services to nearly 28 million people nationwide, managing approximately $33 billion in pharmaceutical spending annually and processing an annual run rate of more than one-half billion adjusted retail, mail and specialty drug prescriptions. OptumRx's PBM services include retail pharmacy network management services, mail order and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing, Medicare Part D services, and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services. OptumRx has a network of more than 67,000 retail pharmacies and two mail services facilities in California and Kansas.

The mail order and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component of its business, providing patients with convenient access to maintenance medications, offering a broad range of complex drug therapies and patient management services for individuals with chronic health conditions, and enabling OptumRx to manage its clients' drug costs through operating efficiencies and economies of scale.

OptumRx provides PBM services to UnitedHealthcare members enrolled in benefit plans that offer pharmacy benefits. Throughout the course of 2013, OptumRx transitioned 12 million new or migrating UnitedHealthcare commercial members. Additionally, OptumRx managed specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services including patient support and clinical programs that ensure quality and value for consumers. Specialty drug management is important in managing overall drug spend, as biologicals and other specialty medications are fast growing pharmacy expenditures. OptumRx also provides PBM services

to non-affiliated external clients, including public and private sector employer groups, insurance companies, Taft-Hartley Trust Funds, TPAs, managed care organizations (MCOs), Medicare-contracted plans, Medicaid plans and other sponsors of health benefit plans and individuals throughout the United States. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

In the event we fail to comply with, or we fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses, and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations including the submission of information relating to the health status of enrollees for purposes of determining the amount of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business will also be subject to audits related to risk adjustment and reinsurance data when the programs are implemented starting in 2014.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs has become and will continue to become increasingly complex as a result of Health Reform Legislation. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies that are held by our Optum businesses and UnitedHealthcare Military & Veterans business, such as our TRICARE West Region contract with the DoD.

Certain of our businesses, such as UnitedHealthcare's eyeglass manufacturing activities and Optum's high acuity clinical workflow software, hearing aid products and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration (FDA). Optum's clinical research activities are subject to laws and regulations outside of the United States that regulate clinical trials. Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Health Care Reform. Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system.

Among other requirements, Health Reform Legislation has expanded dependant coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain medical loss ratios (MLRs) are not met, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

Health Reform Legislation and the related federal and state regulations are affecting how we do business and could impact our results of operations, financial position and cash flows. The full impact of Health Reform Legislation remains difficult to predict and is not yet fully known. See also Item 1A, "Risk Factors" and Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" for a discussion of the risks related to Health Reform Legislation and related matters.

Privacy, Security, and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, will be replaced by ICD-10 code sets on October 1, 2014, and health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures for dates of services on or after such date.

The Health Information Technology for Economic and Clinical Health Act (HITECH) significantly expanded the privacy and security provisions of HIPAA. HITECH imposes additional requirements on uses and disclosures of health information; includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to HHS and the Federal Trade Commission and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the DOL as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate

those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where implemented by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures expanding the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. The NAIC also established the Risk Management and Own Risk and Solvency Assessment Model Act that by 2015 will require us to conduct additional group solvency assessments, maintain a risk management framework and file additional reports with state insurance regulators. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with Health Reform Legislation, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, MCO, utilization review (UR), or TPA-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker, and sales distributions laws and regulations. Our UnitedHealthcare Community & State and certain Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

***Guaranty Fund Assessments*.** Under state guaranty fund laws, certain insurance companies (and HMOs in some states) doing business in those states, including those issuing health, long-term care, life and accident insurance policies, can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Assessments generally are based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets.

Pharmacy Regulation. OptumRx's mail order pharmacies must be licensed as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In addition to the laws and regulations in the states where our mail order pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our mail order pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs.

Participation in these programs requires the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, "Risk Factors" for a discussion of the risks related to our PBM businesses.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct service providers to care delivery systems and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit certain entities from practicing medicine or employing physicians to practice medicine. Additionally, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be a matter of judicial or regulatory interpretation. These laws, regulations and interpretations have, in certain states, been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could be subjected to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses and operations are international in nature and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, tax, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary from jurisdiction to jurisdiction. We currently operate outside of the United States and may in the future acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and insurance industries

and regulation by Brazilian regulators including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar (ANS), whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Cigna Corporation, Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association, and, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength; and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2013, we employed approximately 156,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2014, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	61	President and Chief Executive Officer
David S. Wichmann	51	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations
Gail K. Boudreaux	53	Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare
Eric S. Rangen	57	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	60	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum
Marianne D. Short	62	Executive Vice President and Chief Legal Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000.

Mr. Wichmann is Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since January 2011. Mr. Wichmann has served as Executive Vice President and President of UnitedHealth Group Operations since April 2008.

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since January 2011. Ms. Boudreaux served as Executive Vice President of UnitedHealth Group and President of UnitedHealthcare from May 2008 to January 2011.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006.

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations (now UnitedHealthcare Medicare & Retirement).

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “plan,” “project,” “should” or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or 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. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this

regard, Health Reform Legislation established minimum MLRs for certain health plans and authorized HHS to maintain an annual price increase review process for commercial health plans, which could make it more difficult for us to price our products competitively. In addition, our OptumHealth Integrated Care Delivery business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to accurately predict, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies is typically at a fixed rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2013 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2013 would have been reduced by approximately $200 million, excluding any offsetting impact from premium rebates.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our results of operations, financial position and cash flows.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims, and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty fund laws, certain health, life and accident insurance companies and, in certain cases, HMOs can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business in these states, which would expose our business to the risk of insolvency of a competitor in these states.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit

companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, FDA regulations, state telemedicine regulations, debt collection laws, and state corporate practice of medicine doctrines and fee-splitting rules, some of which could impact our relationships with physicians, hospitals and customers. Additionally, we participate in the emerging private exchange markets and it is not yet known to what extent the states will issue new regulations that apply to private exchanges. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products, increase prices for certain regulated products, and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and/or managed care products are subject to regulatory review or approval in many states and by the federal government, and a number of states have enhanced (or are proposing to enhance) their rate review processes. Additionally, the final market reform rules released in February 2013 require that we submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. Moreover, geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Some of our businesses and operations are international in nature and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, capital (including minimum solvency margin and reserve requirements), management control, labor relations, fraud and corruption present compliance requirements and uncertainties for us that are different from those faced by U.S.-based businesses. We have acquired and may in the future acquire or commence additional businesses based outside of the United States. For example, our acquisition of Amil subjects us to Brazilian laws and regulations affecting the managed care and insurance industries, which vary from comparable U.S. laws and regulations, and to regulation by Brazilian regulators, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation, such as the implementation of Health Reform Legislation and associated exchanges. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

Health Reform Legislation could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity and ongoing implementation, Health Reform Legislation's impact remains difficult to predict, is not yet fully known and could adversely affect us. For example, if we do not maintain certain minimum MLRs, we are required to rebate ratable portions of our premiums to our customers annually. Beginning in 2014, commercial MLRs will need to factor in the effect of new premium stabilization provisions (risk adjustment, risk corridor and transitional reinsurance) for individual and small group markets. These factors, along with uncertainties in how MLR rules may be amended to address other changes required by Health Reform Legislation, decrease the predictability of medical loss rebates. Some state Medicaid programs are also imposing MLR requirements on Medicaid MCOs, which generally require such plans to rebate ratable portions of their premiums to their state customers if they cannot demonstrate they have met the minimum MLRs. Depending on our calculations of the MLR for each of our plans and the manner in which we adjust our business model in light of these requirements, there could be meaningful disruptions in our market share, results of operations, financial position and cash flows could be materially and adversely affected.

Several states have indicated they may not expand their Medicaid programs based on concerns over the costs of such programs when expanded federal funding is reduced starting in 2017. The extent to which states expand their Medicaid programs, or discontinue current expansion programs, could adversely impact our Medicaid enrollment levels, which could in turn materially and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation also includes a "maintenance of effort" (MOE) provision that requires states to maintain their eligibility rules for adults covered by Medicaid, until the Secretary of HHS determines that an insurance exchange is operational in a given state, and for children covered by Medicaid or CHIP, through the end of the 2019 federal fiscal year. States with, or projecting, a budget deficit may apply for an exception to the MOE provision. If states are successful in obtaining MOE waivers and allow certain Medicaid programs to expire, we could experience reduced Medicaid enrollment, which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, Health Reform Legislation requires the establishment of state based health insurance exchanges for individuals and small employers by 2014. The types of exchange participation requirements ultimately enacted by each state, the availability of federal subsidies for premiums and cost-sharing reductions within exchanges, the potential for differential imposition of state benefit mandates inside and outside the exchanges, the operation of reinsurance, risk corridors and risk adjustment mechanisms inside and outside the exchanges and the possibility that certain states may restrict the ability of health plans to continue to offer coverage to individuals and small employers outside of the exchanges could result in disruptions in local health care markets and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation also includes for 2014 specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. These changes may lead to significant disruptions in local health care markets, which could materially and adversely affect our results of operations, financial position and cash flows. Further, while risk adjustment will apply to most individual and small group plans in the commercial markets beginning in 2014, the availability of transitional relief makes the full extent of its impact difficult to predict and could further disrupt underlying exchange risk pools, impact pricing and market strategies, and result in adverse consequences to the marketplace. While we have made certain assumptions in our premium rate development relating to projected risk adjustment transfers, actual risk adjustment calculations and transfers could materially differ from our assumptions.

Premium increases or benefit reductions will be necessary to offset Health Reform Legislation's impact on our medical and operating costs. These premium increases are often subject to state regulatory approval, and the federal government is encouraging states to intensify their reviews of requests for rate increases by commercial health plans and providing funding to assist in those state-level reviews. If we are not able to secure approval for adequate premium increases to offset increases in our cost structure or if consumers forego coverage as a result of such premium increases, our margins, results of operations, financial position and cash flows could be materially and adversely affected. In addition, plans deemed to have a history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that become active under Health Reform Legislation in 2014.

Our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under Health Reform Legislation than we expect, if we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for Health Reform Legislation related products and capabilities offered by our Optum businesses is less than anticipated.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs, CHIP and our TRICARE West Region contract with the DoD, and receive substantial revenues from these programs. We also provide services to payers through our Optum businesses. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are expected in the next few years. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. For 2014, CMS has asked plans to submit additional information indicating whether or not medical conditions were diagnosed in a clinical setting. CMS has indicated that it will publish further guidance on the treatment of risk adjustment data in early 2015, including with respect to diagnoses made during "risk assessments," that may change the way in which Medicare Advantage payments are determined. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional

benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Medicare program or other programs on which we bid, or our competitors submit bids at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of Health Reform Legislation, CMS has a system that provides various quality bonus payments to plans that meet certain quality star ratings at the local plan level. In addition, under Health Reform Legislation, Congress authorized CMS and the states to implement MME managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MME demonstration programs for dually eligible beneficiaries, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the “error rate” identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service “error rate” adjuster that will be used in determining the payment adjustment. Depending on the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been and may in the future become involved in routine, regular, and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. While we have prepared for the transition to ICD-10 as a HIPAA-regulated entity, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2014, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and as a result, they collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business as a mail order pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and

regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; or other factors that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be materially and adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for services. Our results of operations and prospects are substantially dependent on our continued ability to contract for these services at competitive prices. Any failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, distract managements' attention and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of certain businesses, including OptumHealth Integrated Care Delivery and Amil, depend on maintaining satisfactory physician relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with primary care physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or to adequately price their contracts with these third party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

Because of the nature of our business, we are routinely subject to various litigation actions, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties and/or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

Because of the nature of our business, we are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort (including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we periodically acquire businesses or commence operations in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in select markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations, including our internal control environment, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we continue to expand our business outside the United States, acquired non-U.S. businesses, such as Amil, will present challenges that are different from those presented by acquisitions of domestic businesses, including

challenges in adapting to new markets, business, labor and cultural practices and regulatory environments that are different from those with which we are familiar in our U.S. operations. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated benefits or synergies from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation, and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through independent producers and consultants who assist in the sales and servicing of our business. We typically do not have long-term contracts with our producers and consultants, who generally do not provide services to us exclusively, but instead typically also market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be materially and adversely affected if we were unable to attract or retain independent producers and consultants or if we do not adequately provide support, training and education to them regarding our product portfolio, or if our sales strategy is not appropriately aligned across distribution channels.

Producer commissions will be under the same cost reduction pressures as other administrative costs. For example, such commissions are included as administrative expenses under MLR requirements of Health Reform Legislation and, therefore, are not included in the minimum MLR calculation. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment rates have caused and could continue to cause lower enrollment or lower rates of renewal in our employer group plans and our non-employer individual plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. All of these could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement

rates could be implemented retrospectively to apply to payments already negotiated and/or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2013. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal and/or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and shareholders' equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and credit ratings could be materially and adversely affected.

Goodwill and other intangible assets were $35.4 billion as of December 31, 2013, representing 43% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the manner in or the extent to which Health Reform Legislation is implemented may impact our ability to maintain the value of our goodwill and other intangible assets in our business. Similarly, the value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we periodically consolidate, integrate, upgrade and expand our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, and changing customer patterns. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install hardware and software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

We could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences if we sustain cyber-attacks or other privacy or data security incidents, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive personal information or proprietary or confidential information.

We routinely process, store and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We may be subject to breaches of the information technology systems we use for these purposes. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential customers. In addition, breaches of our security measures

and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flow could be materially and adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities outside the United States such as the ANS in Brazil. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position, and cash flow could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Litigation Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2014, there were 14,575 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE and cash dividends declared were as follows:

	High	Low	Cash Dividends Declared
2013			
First quarter	$58.26	$51.36	$0.2125
Second quarter	$66.19	$57.01	$0.2800
Third quarter	$75.88	$64.65	$0.2800
Fourth quarter	$75.54	$66.72	$0.2800
2012			
First quarter	$59.43	$49.82	$0.1625
Second quarter	$60.75	$53.78	$0.2125
Third quarter	$59.31	$50.32	$0.2125
Fourth quarter	$58.29	$51.09	$0.2125

DIVIDEND POLICY

In June 2013, our Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.12 per share, paid quarterly. Since June 2012, we had paid an annual cash dividend of $0.85 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2013

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
October 31, 2013	1	$68	1	94
November 30, 2013	—	—	—	94
December 31, 2013	11	71	11	83
Total	12	$71	12	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2013, the Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock in open market purchases or other types of transactions (including structured repurchase programs). There is no established expiration date for the program.

PERFORMANCE GRAPHS

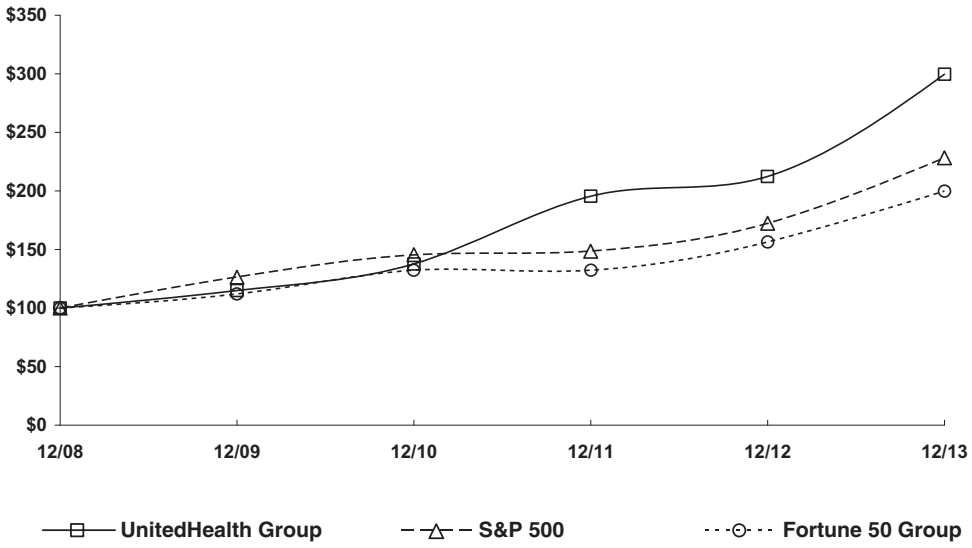
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group") for the five-year period ended December 31, 2013. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2013. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2008 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/08	12/09	12/10	12/11	12/12	12/13
UnitedHealth Group	**$100.00**	**$114.75**	**$137.58**	**$195.62**	**$212.42**	**$299.58**
S&P 500 Index	**100.00**	**126.46**	**145.51**	**148.59**	**172.37**	**228.19**
Fortune 50 Group	**100.00**	**111.82**	**132.11**	**132.08**	**156.49**	**200.00**

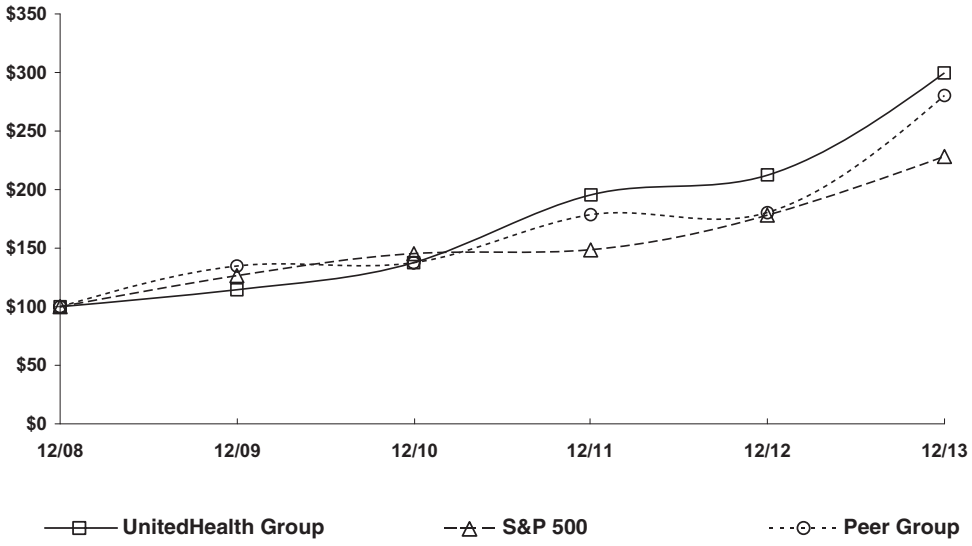
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Humana Inc. and WellPoint, Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and a Peer Group



	12/08	12/09	12/10	12/11	12/12	12/13
UnitedHealth Group	**$100.00**	**$114.75**	**$137.58**	**$195.62**	**$212.42**	**$299.58**
S&P 500 Index	**100.00**	**126.46**	**145.51**	**148.59**	**172.37**	**228.19**
Peer Group	**100.00**	**134.91**	**137.44**	**178.55**	**180.35**	**280.25**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(in millions, except percentages and per share data)	For the Year Ended December 31, 2013	2012 [a]	2011	2010	2009
Consolidated operating results					
Revenues	$122,489	$110,618	$101,862	$94,155	$87,138
Earnings from operations	9,623	9,254	8,464	7,864	6,359
Net earnings attributable to UnitedHealth Group common shareholders	5,625	5,526	5,142	4,634	3,822
Return on equity (b)	17.7%	18.7%	18.9%	18.7%	17.3%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 5.59	$ 5.38	$ 4.81	$ 4.14	$ 3.27
Diluted earnings per share attributable to UnitedHealth Group common shareholders	5.50	5.28	4.73	4.10	3.24
Cash dividends declared per common share	1.0525	0.8000	0.6125	0.4050	0.0300
Consolidated cash flows from (used for)					
Operating activities	$ 6,991	$ 7,155	$ 6,968	$ 6,273	$ 5,625
Investing activities	(3,089)	(8,649)	(4,172)	(5,339)	(976)
Financing activities	(4,946)	471	(2,490)	(1,611)	(2,275)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 28,818	$ 29,148	$ 28,172	$25,902	$24,350
Total assets	81,882	80,885	67,889	63,063	59,045
Total commercial paper and long-term debt	16,860	16,754	11,638	11,142	11,173
Redeemable noncontrolling interests	1,175	2,121	—	—	—
Shareholders' equity	32,149	31,178	28,292	25,825	23,606
Debt to debt-plus-equity ratio	34.4%	35.0%	29.1%	30.1%	32.1%

(a) Includes the effects of the October 2012 Amil acquisition and related debt and equity issuances.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Item 1, "Business" and in Note 13 to the Consolidated Financial Statements in Item 8, "Financial Statements."

2014 Business Realignment. On January 1, 2014, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. Our Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, will be included in OptumInsight's results of operations. Our periodic filings with the SEC beginning with our first quarter 2014 Form 10-Q will include historical segment results restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

Business Trends

Our businesses participate in the U.S., Brazilian and certain other international health economies. In the United States, health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, including enacted health care reforms in the United States, which could also impact our results of operations.

Pricing Trends. We seek to price our health care benefit products consistent with anticipated underlying medical trends, while balancing growth, margins, and competitive dynamics (such as product positioning and price competitiveness) and legislative and regulatory changes such as cost increases for the industry fees and tax provisions of Health Reform Legislation. We continue to expect premium rates to be under pressure from ongoing market competition in commercial products and from government payment rates. Aggregating UnitedHealthcare's businesses, and before giving effect to Health Reform Legislation taxes, we believe the medical care ratio will rise over time as we continue to grow in the senior and public markets and participate in the emerging public health benefit exchange market.

In response to Health Reform Legislation, HHS established a review threshold of annual commercial premium rate increases generally at or above 10% and enacted a new rule requiring the production of information for any proposed rate increase. HHS review does not supersede existing state review and approval procedures. We have experienced regulatory challenges to appropriate premium rate increases in several states, including California and New York. The competitive forces common in our markets do not support unjustifiable rate increases. Further, our rates and rate filings are developed using methods consistent with the standards of actuarial practices and we endeavor to sustain a commercial medical care ratio in a stable range for an equivalent mix of business. We have requested and received rate increases above 10% in a number of markets due to the combination of medical cost trends and the incremental costs of health care reform. We expect commercial pricing to continue to be highly competitive. The intensity of pricing competition depends on local market conditions and competitive dynamics. Overall, the industry has experienced lower medical costs trends due to moderated utilization, which has impacted pricing trends. Conversely, carriers are generally reflecting the 2014 Health Reform Legislation industry fees in their pricing. In some markets, competitors have adjusted their pricing to reflect recent medical cost trend experience as well as the implication of rate review rules and new benefit changes from Health Reform Legislation. In other areas we are seeing greater price competition due to pricing adjustments and other varied approaches used by competitors.

The Medicare Advantage rate structure is changing and funding has been cut in recent years, with additional reductions to take effect in 2014 and 2015, as discussed below in "Regulatory Trends and Uncertainties." We expect these factors to result in year-over-year pressure on gross margin percentages for our Medicare business during 2014.

States are struggling to balance budget pressures with increases in their Medicaid expenditures. During 2013, rate changes for some Medicaid programs were slightly negative year-over-year. In general, we expect continued pressure on net margin percentages due to the Medicaid reimbursement rate environment, which we expect will remain tight due to the potential non-collectability of the insurer fee primarily related to Medicare Dual SNP programs and Medicaid. We continue to work with our state customers to advocate for actuarially sound rates that are commensurate with our medical cost trends, including fees and related taxes, and to take a prudent, market-sustainable posture for both new bids and maintenance of existing Medicaid contracts.

Medical Cost Trends. We expect our 2014 commercial medical cost trend to be in the range of 6.0% plus or minus 50 basis points, compared to approximately 5% in 2013. In 2014, we expect relatively consistent unit cost and utilization trends compared to 2013, before taking into account reform impacts. The impact of Health Reform Legislation and mandates is expected to pressure 2014 medical cost trends. Driving the increases are mandated essential health benefits and limits on out-of-pocket maximums. Consistent with recent years, our 2014 trend is expected to be driven primarily by continued unit cost pressure from health care providers. We expect 2014 pharmacy trends to be consistent with 2013. The primary drivers of prescription drug trends continue to be unit cost pressure on brand name drugs and a shift towards expensive new specialty drugs. In recent years, the recent weak economic environment combined with our medical cost management strategies has had a favorable impact on utilization trends. We believe the expected stability in the utilization trends in 2014 is influenced by our medical management strategies, our continued focus on value-based contracting arrangements and greater consumer engagement.

Delivery System and Payment Modernization. The health care market is changing based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care for people, improve the health of populations and reduce costs. The focus on delivery system modernization and payment reform is critical and the alignment of incentives between key constituents remains an important theme.

Through expansion of our existing programs and the creation of new programs, we are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2013, more than 2 million people we serve were directly aligned through the most progressive of these arrangements, including full risk, shared risk and bundled episode of care payment approaches.

This trend is also creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investment in new clinical and administrative information and management systems, providing growth opportunities for our Optum business platform.

Government Reliance on Private Sector. The government, as a benefit sponsor, has been increasingly relying on private sector programs. We expect this trend to continue as we believe the private sector provides a more flexible, better managed, higher quality health care experience than do traditional passive indemnity programs typically used in governmental benefit programs.

Many states are expanding their interest in managed care with particular emphasis on consumers who have complex and expensive health care needs. Medicaid managed care is increasingly viewed as an effective method to improve quality and manage costs. For example, there are nearly 10 million dually eligible beneficiaries who typically have complex conditions, with costs of care that are far higher than those of a typical Medicare or Medicaid beneficiary. Similarly, a small but complex group of nearly 4 million individuals who qualify for additional benefits under LTC programs represent only 6% of the total Medicaid population yet account for more than 30% of total Medicaid expenditures. The long-term care market represents a portion of the more than 15 million ABD Americans. While these individuals' health needs are more complex and more costly, they have primarily been historically served in unmanaged environments. These markets provide UnitedHealthcare and Optum with an opportunity to work with governments to improve the health status of these populations through coordination of care. As of December 31, 2013, UnitedHealthcare served more than 275,000 people in legacy dually eligible programs through Medicare Advantage and SNPs. In the first half of 2014, UnitedHealthcare Community & State will help implement Integrated MME program awards in three states.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of Health Reform Legislation and other regulatory items; for additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Item 1, "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage payment benchmarks have been cut over the last several years, including 2013, with additional funding reductions to be phased-in through 2017. Additionally, Congress passed the Budget Control Act of 2011, which as amended by the American Taxpayer Relief Act of 2012, triggered automatic across-the-board budget cuts (known as sequestration), including a 2% reduction in Medicare Advantage and Medicare Part D payments beginning April 1, 2013. The CMS final notice of 2014 Medicare Advantage benchmark rates and payment policies includes significant reductions to 2014 Medicare Advantage payments, including the benchmark reductions described previously. These reductions and Health Reform Legislation insurance industry tax described below result in revenue reductions and incremental assessments totaling more than 4% in 2014, against a typical industry forward medical cost trend outlook of 3%. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. Compared to 2013, and prior to any efforts to mitigate these funding reductions,

we estimate that the net impact on our 2014 consolidated after-tax earnings will be approximately $0.9 billion. These factors affected our plan benefit designs, market participation, growth prospects and earnings potential for our Medicare Advantage plans in 2014. Further, beginning in 2014, Medicare Advantage and Medicare Part D plans will be required to have minimum MLRs of 85%. We do not believe the minimum MLR standard will have a material impact on our earnings. CMS is expected to release the proposed 2015 Medicare Advantage Rates on February 21, 2014. We expect sustained Medicare Advantage rate pressures in 2015 due to the continuing effect of the factors described above.

Health Reform Legislation directed HHS to establish a program to reward high-quality Medicare Advantage plans beginning in 2012. Accordingly, our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on a plan's star rating. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan's revenue. The current expanded stars bonus program that pays bonuses to qualifying plans rated 3 stars or higher is set to expire after 2014. In 2015, quality bonus payments will only be paid to 4 and 5 star plans. For the 2014 payment year, approximately 57% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and approximately 9% are enrolled in plans that will be rated 4 stars or higher. For the 2015 payment year, based on scoring released by CMS in October 2013, approximately 70% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and approximately 24% are enrolled in plans that will be rated 4 stars or higher.

The ongoing reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we can make and are making to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase member premiums over and above the monthly payments we receive from the government, and decide on a county-by-county basis where we will offer Medicare Advantage plans. The depth of the underfunding of these benefits has caused us to exit certain plans and market areas for 2014 in which we served approximately 150,000 Medicare Advantage beneficiaries in 2013. In other markets, we may experience some reduction in membership in the plans with the greatest benefit cuts, but expect stable or growing membership in our strongest markets. We are dedicating substantial resources to improving our quality scores and star ratings to improve the performance and sustainability of our local market programs for 2016 and beyond.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries increasing the demand for other senior health benefits products such as our Medicare Supplement and Medicare Part D insurance offerings.

Industry Fees and Taxes. Health Reform Legislation includes an annual, non-deductible insurance industry tax to be levied proportionally across the insurance industry for risk-based products, beginning January 1, 2014. The industry-wide amount of the annual tax is $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will equal the annual tax for the preceding year increased by the rate of premium growth for the preceding year. The annual tax will be allocated to each market participant based on the ratio of the entity's net premiums written during the preceding calendar year to the total health insurance industry's net premiums written for any U.S. health risk-based products during the preceding calendar year, subject to certain exceptions. This tax will first be expensed ratably throughout 2014 and our first payment will be made in September 2014.

With the introduction of state health insurance exchanges and other significant market reforms in the individual and small group markets in 2014, Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs encompass: a transitional reinsurance program; a temporary risk

corridors program; and a permanent risk adjustment program. The transitional reinsurance program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements, $25 billion over a three-year period beginning in 2014 of which $20 billion, subject to increases based on state decisions, will fund the reinsurance pool and $5 billion will fund the U.S. Treasury (Reinsurance Program). While funding for the Reinsurance Program will come from all commercial lines of business, only non-grandfathered, market reform compliant individual business will be eligible for reinsurance recoveries.

We expect our share of the industry fee to be approximately $1.3 billion to $1.4 billion in 2014. We estimate a significant increase of approximately 500 basis points in our 2014 effective income tax rate because this fee is not deductible. We estimate that the 2014 effect on earnings from operations due to our tax deductible contributions to the Reinsurance Program will be approximately $0.5 billion in 2014, payable in 2015. We do not expect material payments or receipts related to the temporary risk corridors program, permanent risk adjustment program or reinsurance recoveries in 2014. Our 2014 results of operations will include estimates related to these fees and programs. To the extent possible, we include the reform fees and related tax impacts in our pricing, which is expected to result in $1.4 billion to $1.6 billion of additional premium in 2014. Since the industry fee will be included in operating costs, we expect our medical care ratio to decrease in 2014 compared to historical results; the industry fee cost will be factored in, however, when calculating minimum MLR rebates.

Exchanges and Coverage Expansion. Across markets, we and our competitors are adapting product, network and marketing strategies to anticipate new distribution or expanding distribution channels including public exchanges, private exchanges and off exchange purchasing. Effective in 2014, states may create their own public exchange, enter a partnership exchange or rely on the federally facilitated exchange for individuals and small employers, with enrollment processes that commenced in October 2013. Exchanges create new market dynamics that could impact our existing businesses, depending on the ultimate member migration patterns for each market, the pace of migration in the market and the impact of the migration on our established membership. For example, over time certain employers may no longer offer health benefits to their employees and some employers purchasing full risk products could convert to self-funded programs. Our level of participation in public exchanges has been and will continue to be determined on a state-by-state basis. Each state is evaluated based on factors such as growth opportunities, our current local presence, our competitive positioning, our ability to honor our commitments to our local customers and members and the regulatory environment. In 2014, we are participating in 13 exchanges in 10 states and the District of Columbia, including four individual and nine SHOP exchanges.

Health Reform Legislation and related U.S. Supreme Court ruling also provide for optional expanded Medicaid coverage effective in January 2014. These measures remain subject to implementation at the state level, with varying levels of state adoption planned for January 1, 2014. We participate in programs in 24 states and the District of Columbia, and of these, more than half have opted to expand Medicaid.

Individual & Small Group Market Reforms. Health Reform Legislation includes several provisions, for most individual and small group plans with plan years beginning on January 1, 2014, that are expected to alter the individual and small group marketplace, including, among other matters: (1) adjusted community rating requirements, which will change how individual and small group plans are priced in many states; (2) essential health benefit requirements, which will result in benefit changes for many individual and small group policyholders; (3) actuarial value requirements, which will significantly impact benefit designs in the individual market, such as member cost sharing requirements; and (4) guaranteed issue requirements, which will require carriers to provide coverage to any qualified group or individual. These changes have resulted in significant benefit design and pricing changes for a substantial portion of the fully insured individual and small group markets. In 2014, we expect a decrease in individual membership due to a reduction in the number of states in which we will offer policies to new customers.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2013	2012	2011	Increase/ (Decrease) 2013 vs. 2012		Increase/ (Decrease) 2012 vs. 2011	
Revenues:							
Premiums	$109,557	$ 99,728	$ 91,983	$ 9,829	10%	$7,745	8%
Services	8,997	7,437	6,613	1,560	21	824	12
Products	3,190	2,773	2,612	417	15	161	6
Investment and other income	745	680	654	65	10	26	4
Total revenues	122,489	110,618	101,862	11,871	11	8,756	9
Operating costs:							
Medical costs	89,290	80,226	74,332	9,064	11	5,894	8
Operating costs	19,362	17,306	15,557	2,056	12	1,749	11
Cost of products sold	2,839	2,523	2,385	316	13	138	6
Depreciation and amortization	1,375	1,309	1,124	66	5	185	16
Total operating costs	112,866	101,364	93,398	11,502	11	7,966	9
Earnings from operations	9,623	9,254	8,464	369	4	790	9
Interest expense	(708)	(632)	(505)	76	12	127	25
Earnings before income taxes	8,915	8,622	7,959	293	3	663	8
Provision for income taxes	(3,242)	(3,096)	(2,817)	146	5	279	10
Net earnings	5,673	5,526	5,142	147	3	384	7
Earnings attributable to noncontrolling interests	(48)	—	—	48	—	—	nm
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,625	$ 5,526	$ 5,142	$ 99	2%	$ 384	7%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 5.50	$ 5.28	$ 4.73	$ 0.22	4%	$ 0.55	12%
Medical care ratio (a)	81.5%	80.4%	80.8%	1.1%		(0.4)%	
Operating cost ratio	15.8	15.6	15.3	0.2		0.3	
Operating margin	7.9	8.4	8.3	(0.5)		0.1	
Tax rate	36.4	35.9	35.4	0.5		0.5	
Net margin	4.6	5.0	5.0	(0.4)		—	
Return on equity (b)	17.7%	18.7%	18.9%	(1.0)%		(0.2)%	

nm = not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2013 year-over-year operating comparisons to 2012 and other 2013 significant items.

- Consolidated revenues increased by 11%, UnitedHealthcare revenues increased by 10% and Optum revenues grew by 26%.
- Earnings from operations increased by 4%, including a decrease of 6% at UnitedHealthcare and an increase of 61% at Optum.
- UnitedHealthcare medical enrollment grew organically by 4.5 million people, including 2.9 million military beneficiaries through the TRICARE contract. Medicare Part D stand-alone membership grew by 725,000 people.
- OptumRx completed the insourcing of pharmacy services for 12 million new and migrating customers served by UnitedHealthcare.
- The consolidated medical care ratio of 81.5% increased 110 basis points.
- As of December 31, 2013, there was $1.0 billion of cash available for general corporate use and 2013 cash flows from operations were $7.0 billion.

2013 RESULTS OF OPERATIONS COMPARED TO 2012 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during 2013 were primarily driven by the full year effect of 2012 acquisitions, including Amil, growth in the number of individuals served through benefit products and overall organic growth in each of Optum's major businesses. The revenue impact of these factors was partially offset by the reduction in Medicare Advantage rates. Also offsetting the revenue increase was the first quarter conversion of a large fully-insured commercial customer from a risk-based to a fee-based arrangement affecting 1.1 million members. While this conversion reduced our full-year 2013 consolidated revenues by $2.3 billion, the impact to earnings from operations and cash flows was negligible.

Medical Costs and Medical Care Ratio

Medical costs during 2013 increased due to risk-based membership growth in our international and public and senior markets businesses, partially offset by the funding conversion of the large client discussed above. The year-over-year medical care ratio increased primarily due to funding reductions for Medicare Advantage products, changes in business mix favoring governmental benefit programs, and reduced levels of favorable medical cost reserve development for the year ended December 31, 2013 of $680 million, compared to $860 million for the year ended December 31, 2012.

Operating Costs

The increase in our operating costs during 2013 was due to business growth, including an increase in fee-based benefits and fee-based service revenues and a greater mix of international business, which carry comparatively higher operating costs, partially offset by our ongoing cost containment efforts.

The following table presents reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2013	2012	2011	Increase/ (Decrease) 2013 vs. 2012		Increase/ (Decrease) 2012 vs. 2011	
Revenues							
UnitedHealthcare	$113,829	$103,419	$ 95,336	$10,410	10%	$8,083	8%
OptumHealth	9,855	8,147	6,704	1,708	21	1,443	22
OptumInsight	3,174	2,882	2,671	292	10	211	8
OptumRx	24,006	18,359	19,278	5,647	31	(919)	(5)
Total Optum	37,035	29,388	28,653	7,647	26	735	3
Eliminations	(28,375)	(22,189)	(22,127)	6,186	28	62	—
Consolidated revenues	$122,489	$110,618	$101,862	$11,871	11%	$8,756	9%
Earnings from operations							
UnitedHealthcare	$ 7,309	$ 7,815	$ 7,203	$ (506)	(6)%	$ 612	8%
OptumHealth	976	561	423	415	74	138	33
OptumInsight	603	485	381	118	24	104	27
OptumRx	735	393	457	342	87	(64)	(14)
Total Optum	2,314	1,439	1,261	875	61	178	14
Consolidated earnings from operations	$ 9,623	$ 9,254	$ 8,464	$ 369	4%	$ 790	9%
Operating margin							
UnitedHealthcare	6.4%	7.6%	7.6%	(1.2)%		—%	
OptumHealth	9.9	6.9	6.3	3.0		0.6	
OptumInsight	19.0	16.8	14.3	2.2		2.5	
OptumRx	3.1	2.1	2.4	1.0		(0.3)	
Total Optum	6.2	4.9	4.4	1.3		0.5	
Consolidated operating margin	7.9%	8.4%	8.3%	(0.5)%		0.1%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenue by business:

(in millions, except percentages)	For the Years Ended December 31, 2013	2012	2011	Increase/ (Decrease) 2013 vs. 2012		Increase/ (Decrease) 2012 vs. 2011	
UnitedHealthcare Employer & Individual	$ 44,951	$ 46,596	$45,404	$ (1,645)	(4)%	$1,192	3%
UnitedHealthcare Medicare & Retirement	44,225	39,257	34,933	4,968	13	4,324	12
UnitedHealthcare Community & State	18,268	16,422	14,954	1,846	11	1,468	10
UnitedHealthcare International	6,385	1,144	45	5,241	nm	1,099	nm
Total UnitedHealthcare revenue	$113,829	$103,419	$95,336	$10,410	10%	$8,083	8%

nm= not meaningful

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2013	2012	2011	Increase/ (Decrease) 2013 vs. 2012		Increase/ (Decrease) 2012 vs. 2011	
Commercial risk-based	8,185	9,340	9,550	(1,155)	(12)%	(210)	(2)%
Commercial fee-based	19,055	17,585	16,320	1,470	8	1,265	8
Commercial fee-based TRICARE	2,920	—	—	2,920	nm	—	nm
Total commercial	30,160	26,925	25,870	3,235	12	1,055	4
Medicare Advantage	2,990	2,565	2,165	425	17	400	18
Medicaid	4,035	3,830	3,600	205	5	230	6
Medicare Supplement (Standardized)	3,455	3,180	2,935	275	9	245	8
Total public and senior	10,480	9,575	8,700	905	9	875	10
International	4,805	4,425	—	380	9	4,425	nm
Total UnitedHealthcare — medical	45,445	40,925	34,570	4,520	11%	6,355	18%
Supplemental Data:							
Medicare Part D stand-alone	4,950	4,225	4,855	725	17%	(630)	(13)%

nm = not meaningful

The number of people served under commercial risk-based arrangements decreased in 2013 primarily due to the conversion of 1.1 million risk-based consumers of a large public sector client to a fee-based arrangement. The number of individuals in commercial fee-based arrangements increased due to this conversion as well as new business awards and strong customer retention. On April 1, 2013, UnitedHealthcare Military & Veterans began service under the TRICARE West Region Managed Care Support Contract. This administrative services contract for health care operations added 2.9 million people and includes a transition period and five one-year renewals at the government's option. Medicare Advantage participation increased due to solid execution in product design, marketing and local engagement, which drove sales growth. Medicaid growth was due to a combination of winning new state accounts and growth within existing state customers, partially offset by the first quarter 2013 divestiture of our Medicaid business in South Carolina and a fourth quarter 2012 market withdrawal from one product in Wisconsin, which combined affected 235,000 Medicaid beneficiaries. Medicare Supplement growth reflected strong customer retention and new sales. In our Medicare Part D stand-alone business, the number of people served increased primarily as a result of new product introductions and strong customer retention in the market. International represents commercial customers in Brazil added in the fourth quarter of 2012 as a result of the Amil acquisition, and subsequent organic growth.

UnitedHealthcare's revenue growth in 2013 was primarily attributable to the impact of 2012 acquisitions and the growth in the number of individuals served. The effect of these factors was partially offset by the government funding reductions described previously and the customer funding conversion discussed above.

UnitedHealthcare's earnings from operations and operating margins in 2013 decreased compared to the prior year as operating margins were pressured by the funding reductions that decreased revenues and by decreased levels of favorable reserve development.

Optum

Total revenues increased in 2013 primarily due to broad-based growth across Optum's services portfolio with growth in each of Optum's major businesses led by pharmacy growth from the insourcing of UnitedHealthcare commercial customers and external clients.

Optum's earnings from operations and operating margin in 2013 increased significantly compared to 2012, reflecting progress on Optum's plan to accelerate growth and improve productivity by strengthening integration and business alignment.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth in 2013 were primarily due to market expansion, including growth related to 2012 acquisitions in local care delivery, and organic growth.

Earnings from operations and operating margins in 2013 increased primarily due to revenue growth and an improved cost structure across the business, including local care delivery, population health and wellness solutions, and health-related financial services offerings.

OptumInsight

Revenues at OptumInsight in 2013 increased primarily due to the impact of a 2012 acquisition and growth in services to commercial payers.

The increases in earnings from operations and operating margins in 2013 reflected increased revenues, changes in product mix and continuing improvements in business alignment and efficiency.

OptumRx

The increase in OptumRx revenues in 2013 were due to the insourcing of UnitedHealthcare's commercial pharmacy benefit programs and growth in both UnitedHealthcare's Medicare Part D members and external clients. Over the course of 2013, we completed our transition of 12 million migrating and new members to the OptumRx platform from a third party.

Earnings from operations and operating margins in 2013 increased primarily due to strong revenue growth, pricing disciplines, and greater use of generic medications.

2012 RESULTS OF OPERATIONS COMPARED TO 2011 RESULTS

Consolidated Financial Results

Revenues

Revenue increases in 2012 were driven by growth in the number of individuals served and premium rate increases related to underlying medical cost trends in our UnitedHealthcare businesses and growth in our Optum health service and technology offerings.

Medical Costs

Medical costs increased in 2012 due to risk-based membership growth in our public and senior markets businesses, unit cost inflation across all businesses and continued moderate increases in health system use, partially offset by an increase in favorable medical reserve development. Unit cost increases represented the primary driver of our medical cost trend, with the largest contributor being price increases to hospitals.

Operating Costs

The increases in operating costs for 2012 were due to business growth, including increases in revenues from UnitedHealthcare fee-based benefits and Optum services, which carry comparatively higher operating costs, as well as investments in the OptumRx pharmacy management services and UnitedHealthcare Military & Veterans businesses.

Income Tax Rate

The increase in our effective income tax rate for 2012 was due to the favorable resolution of various tax matters in 2011, which lowered the 2011 effective income tax rate.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth in 2012 was primarily due to growth in the number of individuals served, commercial premium rate increases related to expected increases in underlying medical cost trends and the impact of lower premium rebates.

UnitedHealthcare's earnings from operations for 2012 increased compared to the prior year primarily due to the factors that increased revenues combined with an improvement in the medical care ratio that was driven by effective management of medical costs and increased favorable medical reserve development. The favorable development for 2012 was driven by lower than expected health system utilization levels and increased efficiency in claims handling and processing.

Optum. Total revenues increased in 2012 due to business growth and 2011 acquisitions at OptumHealth, partially offset by a reduction in pharmacy service revenues related to reduced levels of UnitedHealthcare Medicare Part D prescription drug membership and related prescription volumes.

Optum's earnings from operations and operating margin for 2012 increased compared to 2011 due to improvements in operating cost structure stemming from advances in business simplification, integration and overall efficiency and revenue growth in higher margin products.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth for 2012 were primarily due to market expansion, including growth related to 2011 acquisitions in integrated care delivery, and strong overall business growth.

Earnings from operations for 2012 and operating margins increased compared to 2011 primarily due to gains in operating efficiency and cost management as well as increases in earnings from integrated care operations.

OptumInsight

Revenues at OptumInsight for 2012 increased primarily due to the impact of growth in compliance services for care providers and payment integrity offerings for commercial payers, which was partially offset by the June 2011 divestiture of the clinical trials services business.

The increases in earnings from operations and operating margins for 2012 reflect an improved mix of services and advances in operating efficiency and cost management.

OptumRx

The decreases in OptumRx revenues in 2012 were due to the reduction in UnitedHealthcare Medicare Part D plan participants.

OptumRx earnings from operations and operating margins for 2012 decreased primarily due to decreased prescription volume in the Medicare Part D business and investments to support growth initiatives, which were partially offset by earnings contributions from specialty pharmacy growth and greater use of generic medications.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before non-cash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the NAIC. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2013, based on the 2012 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could be paid by our U.S. regulated subsidiaries to their parent companies was $4.3 billion. In 2013, our regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $430 million of extraordinary dividends. This level of dividends maintained our target consolidated risk-based capital level. In 2012, our regulated subsidiaries paid their parent companies dividends of $4.9 billion, including $1.2 billion of extraordinary dividends.

Our non-regulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash

(in millions)	For the Years Ended December 31, 2013	2012	2011	Increase/(Decrease) 2013 vs. 2012	2012 vs. 2011
Sources of cash:					
Cash provided by operating activities	$ 6,991	$ 7,155	$ 6,968	$ (164)	$ 187
Proceeds from common stock issuances	598	1,078	381	(480)	697
Proceeds from issuances of long-term debt and commercial paper, net of repayments	152	4,567	346	(4,415)	4,221
Other	31	—	428	31	(428)
Total sources of cash	7,772	12,800	8,123		
Uses of cash:					
Common stock repurchases	(3,170)	(3,084)	(2,994)	(86)	(90)
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed and dispositions	(1,791)	(6,599)	(1,459)	4,808	(5,140)
Purchases of investments, net of sales and maturities	(1,611)	(1,299)	(1,695)	(312)	396
Purchases of property, equipment and capitalized software, net	(1,161)	(1,070)	(1,018)	(91)	(52)
Cash dividends paid	(1,056)	(820)	(651)	(236)	(169)
Customer funds administered	—	(324)	—	324	(324)
Other	(27)	(627)	—	600	(627)
Total uses of cash	(8,816)	(13,823)	(7,817)		
Effect of exchange rate changes on cash and cash equivalents	(86)	—	—	nm	nm
Net (decrease) increase in cash	$(1,130)	$ (1,023)	$ 306	$ (107)	$(1,329)

nm = not meaningful

2013 Cash Flows Compared to 2012 Cash Flows

Cash flows provided by operating activities in 2013 decreased due to the net effects of changes in operating assets and liabilities, including: (a) an increase in pharmacy rebates receivables stemming from the increased membership at OptumRx, the effects of which were partially offset by (b) increases in medical costs payable due to the growth in the number of individuals served in our public and senior markets and international businesses.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) decreased investments in acquisitions and noncontrolling interest shares (the activity in 2013 primarily related to the acquisition of the remaining publicly traded shares of Amil during the second quarter of 2013 for $1.5 billion); (b) a decrease in net proceeds from commercial paper and long-term debt, as proceeds from 2013 debt issuances were fully offset by scheduled maturities and the redemption of all of our outstanding subsidiary debt (in 2012, the increased cash flows from common stock issuances and proceeds from issuances of commercial paper and long-term debt primarily related to the Amil acquisition); and (c) increased net purchases of investments.

2012 Cash Flows Compared to 2011 Cash Flows

Cash flows from operating activities for 2012 increased due to increased net income and related tax accruals, which were partially offset by the payment in 2012 of 2011 premium rebate obligations as 2012 was the first year in which rebate payments were made under Health Reform Legislation.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) increased investments in acquisitions in 2012; (b) increases in long-term debt, commercial paper and common stock issuances, primarily related to the Amil acquisition; (c) increases in cash paid for customer funds related to Medicare Part D and increased shareholder dividend payments.

Financial Condition

As of December 31, 2013, our cash, cash equivalent and available-for-sale investment balances of $28.3 billion included $7.3 billion of cash and cash equivalents (of which $1.0 billion was available for general corporate use), $19.4 billion of debt securities and $1.6 billion of investments in equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. The use of different market assumptions or valuation methodologies, especially those used in valuing our $311 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our cash, cash equivalent and available-for-sale debt portfolio had a weighted-average duration of 2.5 years. Our available-for-sale debt portfolio had a weighted-average duration of 3.6 years and a weighted-average credit rating of “AA” as of December 31, 2013. Included in the debt securities balance was $1.4 billion of state and municipal obligations that are guaranteed by a number of third parties. Due to the high underlying credit ratings of the issuers, the weighted-average credit rating of these securities with and without the guarantee was “AA” as of December 31, 2013. We do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a $4.0 billion commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers. The commercial paper program is supported by the bank credit facilities described below. As of December 31, 2013, we had $1.1 billion of commercial paper outstanding at a weighted-average annual interest rate of 0.2%.

Bank Credit Facilities**.** We have $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2018 and November 2014, respectively. These facilities provide liquidity support for our commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2013. The interest rates on borrowings are variable depending on term and are calculated based on the LIBOR plus a credit spread based on our senior unsecured credit ratings. As of December 31, 2013, the annual interest rates on both bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Our bank credit facilities contain various covenants, including covenants requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, which reasonably approximates the actual covenant ratio, was 34.4% as of December 31, 2013. We were in compliance with our debt covenants as of December 31, 2013.

Long-term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

In February 2013, we issued $2.25 billion in senior unsecured notes, which included: $250 million of floating-rate notes due August 2014, $500 million of 1.625% fixed-rate notes due March 2019, $750 million of 2.875% fixed-rate notes due March 2023 and $750 million of 4.250% fixed-rate notes due March 2043.

In March and April of 2013, we redeemed all of our outstanding subsidiary variable rate debt for $619 million.

Credit Ratings. Our credit ratings at December 31, 2013 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A	Positive	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Share Repurchase Program. Under our Board of Directors' authorization, we maintain a share repurchase program. The objectives of the share repurchase program are to optimize our capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including structured share repurchase programs), subject to certain Board restrictions. In June 2013, our Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock. As of December 31, 2013, we had Board authorization to purchase up to an additional 83 million shares of our common stock.

Dividends. In June 2013, our Board of Directors increased our cash dividend to shareholders to an annual dividend rate of $1.12 per share, paid quarterly. Since June 2012, we had paid an annual cash dividend of $0.85 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Amil Tender Offer. We acquired all of Amil's remaining public shares for $1.5 billion in the second quarter of 2013, bringing our ownership in Amil to 90%.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2013, under our various contractual obligations and commitments:

(in millions)	2014	2015 to 2016	2017 to 2018	Thereafter	Total
Debt (a)	$2,644	$3,450	$3,411	$18,147	$27,652
Operating leases	487	800	572	544	2,403
Purchase obligations (b)	250	174	14	—	438
Future policy benefits (c)	136	258	267	1,940	2,601
Unrecognized tax benefits (d)	—	—	—	78	78
Other liabilities recorded on the Consolidated Balance Sheet (e)	186	43	—	1,482	1,711
Other obligations (f)	94	113	49	12	268
Redeemable noncontrolling interests (g)	54	158	963	—	1,175
Total contractual obligations	$3,851	$4,996	$5,276	$22,203	$36,326

(a) Includes interest coupon payments and maturities at par or put values. For variable rate debt, the rates in effect at December 31, 2013 were used to calculate the interest coupon payments. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2013.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, they have been classified as due "Thereafter."

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."

(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

(g) Includes commitments for redeemable shares of our subsidiaries, primarily the shares owned by Amil's remaining non-public shareholders.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications, and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2013, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

We have determined that there have been no recently issued, but not yet adopted, accounting standards that will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

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 processing backlogs, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the 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. As of December 31, 2013, our days outstanding in medical payables was 47 days, calculated as total medical payables divided by total medical costs times 365 days.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates and include the changes in estimates in medical costs in the period in which the change is identified. Therefore, 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). Medical costs in 2013, 2012, and 2011 included favorable medical cost development related to prior years of $680 million, $860 million and $720 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion factors. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2013:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 291
(0.50)	194
(0.25)	97
0.25	(96)
0.50	(192)
0.75	(287)

Medical cost PMPM trend factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design, and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates including: our ability and practices to manage medical costs, changes in level and mix of services utilized, mix of benefits offered including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2013:

Medical Costs PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 573
2	382
1	191
(1)	(191)
(2)	(382)
(3)	(573)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2013, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2013; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2013 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2013 net earnings would have increased or decreased by $65 million.

Revenues

We derive a substantial portion of our revenues 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.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for additional information regarding these audits. Additionally, beginning in 2014, Medicare Advantage and Medicare Part D plans will be subject to a minimum MLR threshold of 85%. We will include in our estimates of premiums to be recognized the expected premium minimum MLR rebates, if any.

U.S. commercial health plans with MLRs on fully insured products, as calculated under the definitions in Health Reform Legislation, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals) are required to rebate ratable portions of their premiums to their customers annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because we are able to reasonably estimate the ultimate premiums of these contracts. Each period, we estimate premium rebates based on the expected financial performance of the applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Impairment tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the "Medical Cost Trend" section of Executive Overview-Business Trends above and the discussion in the "Medical Costs Payable" critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, "Business—Government Regulation." For additional discussions regarding how the enactment or implementation of health care reforms and other factors could affect our business and the related long-term forecasts, see Item 1A, "Risk Factors" in Part I and "Regulatory Trends and Uncertainties" above.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2014. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible assets. Our recorded separately-identifiable intangible assets were acquired in business combinations and represent future expected benefits but they lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). These intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis. Both finite-lived and indefinite-lived intangible assets are evaluated for impairment between annual periods if an event occurs or circumstances change that may indicate impairment. Our most significant intangible assets are customer-related intangibles, which represent 73% of our total intangible asset balance of $3.8 billion as of December 31, 2013.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and

earnings growth, retention rates, perpetuity growth rates and discount rates. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset (or asset group) using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that an impairment exists, the amount by which the carrying value exceeds its estimated fair value would be recorded as an impairment.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we assess qualitative factors to determine whether the existence of events and circumstances indicates that it is more-likely-than-not that the indefinite-lived intangible asset's carrying value exceeds its fair value. If, after assessing the totality of events and circumstances, we conclude that it is not more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value, no impairment exists and no further testing is performed. If we conclude otherwise, we would perform a quantitative analysis by comparing its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not materially impaired in 2013.

Investments

As of December 31, 2013, we had investments with a carrying value of $21.5 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from net earnings and report net unrealized gains or losses, net of income tax effects, as other comprehensive income and 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, 2013, our available-for-sale investments had gross unrealized gains of $326 million and gross unrealized losses of $234 million.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell the security before recovery of the entire amortized cost basis or maturity of the security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, and recognized in net earnings, and all other causes, and recognized in other comprehensive income.

For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in net earnings.

The most significant judgments and estimates related to investments are related to determination of their fair values and the other-than-temporary impairment assessment.

Fair values. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses of the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- prices received from the pricing service to prices reported by a secondary pricing service, our custodian, our investment consultant and/or third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-than-temporary impairment assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. We do not expect that trend to change in the near term. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

The unrealized losses of $234 million and $9 million at December 31, 2013 and 2012, respectively, were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments during the years ended December 31, 2013, 2012 and 2011 were $8 million, $6 million and $12 million, respectively. Our available-for-sale debt portfolio had a weighted-average credit rating of “AA” as of December 31, 2013. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A “Quantitative and Qualitative Disclosures About Market Risk” a 1% increase in market interest rates would have the effect of decreasing the fair value of our investment portfolio by $756 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements.

Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes. We have established a valuation allowance against certain deferred tax assets for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized.

An uncertain tax position is recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax positions due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2013 earnings before income taxes would have caused the provision for income taxes and net earnings to change by $89 million.

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 where appropriate. Our estimates are developed in consultation with legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of costs resulting from legal and regulatory matters are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, in many cases, we are unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Similarly, the assessment of the likelihood of assertion of unasserted claims involves significant judgment.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures in each reporting period. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for a discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2013, we had an aggregate $1.8 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and record the reinsurance receivable only to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as "A+." As of December 31, 2013, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and (c) changes in equity prices that impact the value of our equity investments.

As of December 31, 2013, we had $8.7 billion of cash, cash equivalents and investments on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also, $9.6 billion of our commercial paper, debt and deposit liabilities as of December 31, 2013 were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2013, $18.5 billion of our investments were fixed-rate debt securities and $10.2 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or periodically through the use of interest rate swap contracts.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% or 2% as of December 31, 2013 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2013			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2%	$175	$189	$(1,474)	$(1,786)
1	87	95	(756)	(974)
(1)	(52)	(17)	704	1,167
(2)	nm	nm	1,224	2,505

	December 31, 2012			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2%	$189	$134	$(1,303)	$(2,200)
1	94	67	(656)	(1,194)
(1)	(18)	(14)	518	1,366
(2)	nm	nm	686	2,747

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2013 and 2012, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2013 and 2012, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign currency financial statements into U.S. dollars are included in shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2013, a hypothetical 10% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $490 million. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies.

As of December 31, 2013, we had $1.6 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds, employee savings plan related investments, private equity funds, and dividend paying stocks. Valuations in non-US dollar funds are subject to foreign exchange rates. Valuations in private equity are subject to conditions affecting health care and technology stocks, and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive income, changes in shareholders' equity and cash flows for each of the three years in the period ended December 31, 2013. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control-Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 12, 2014, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2014

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	$ 7,276	$ 8,406
Short-term investments	1,937	3,031
Accounts receivable, net of allowances of $196 and $189	3,052	2,709
Other current receivables, net of allowances of $169 and $206	3,998	2,889
Assets under management	2,757	2,773
Deferred income taxes	430	463
Prepaid expenses and other current assets	930	781
Total current assets	20,380	21,052
Long-term investments	19,605	17,711
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,675 and $2,564	4,010	3,939
Goodwill	31,604	31,286
Other intangible assets, net of accumulated amortization of $2,283 and $1,824	3,844	4,682
Other assets	2,439	2,215
Total assets	$81,882	$80,885
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$11,575	$11,004
Accounts payable and accrued liabilities	7,458	6,984
Other policy liabilities	5,279	4,910
Commercial paper and current maturities of long-term debt	1,969	2,713
Unearned revenues	1,600	1,505
Total current liabilities	27,881	27,116
Long-term debt, less current maturities	14,891	14,041
Future policy benefits	2,465	2,444
Deferred income taxes	1,796	2,450
Other liabilities	1,525	1,535
Total liabilities	48,558	47,586
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,175	2,121
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 988 and 1,019 issued and outstanding	10	10
Additional paid-in capital	—	66
Retained earnings	33,047	30,664
Accumulated other comprehensive (loss) income	(908)	438
Total shareholders' equity	32,149	31,178
Total liabilities and shareholders' equity	$81,882	$80,885

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2013	2012	2011
Revenues:			
Premiums	$109,557	$ 99,728	$ 91,983
Services	8,997	7,437	6,613
Products	3,190	2,773	2,612
Investment and other income	745	680	654
Total revenues	122,489	110,618	101,862
Operating costs:			
Medical costs	89,290	80,226	74,332
Operating costs	19,362	17,306	15,557
Cost of products sold	2,839	2,523	2,385
Depreciation and amortization	1,375	1,309	1,124
Total operating costs	112,866	101,364	93,398
Earnings from operations	9,623	9,254	8,464
Interest expense	(708)	(632)	(505)
Earnings before income taxes	8,915	8,622	7,959
Provision for income taxes	(3,242)	(3,096)	(2,817)
Net earnings	5,673	5,526	5,142
Earnings attributable to noncontrolling interests	(48)	—	—
Net earnings attributable to UnitedHealth Group common shareholders	$ 5,625	$ 5,526	$ 5,142
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 5.59	$ 5.38	$ 4.81
Diluted	$ 5.50	$ 5.28	$ 4.73
Basic weighted-average number of common shares outstanding	1,006	1,027	1,070
Dilutive effect of common share equivalents	17	19	17
Diluted weighted-average number of common shares outstanding	1,023	1,046	1,087
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	17	47
Cash dividends declared per common share	$ 1.0525	$ 0.8000	$ 0.6125

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2013	2012	2011
Net earnings	$ 5,673	$5,526	$5,142
Other comprehensive (loss) income:			
Gross unrealized holding (losses) gains on investment securities during the period	(543)	217	422
Income tax effect	196	(78)	(154)
Total unrealized (losses) gains, net of tax	(347)	139	268
Gross reclassification adjustment for net realized gains included in net earnings	(181)	(156)	(113)
Income tax effect	66	57	41
Total reclassification adjustment, net of tax	(115)	(99)	(72)
Total foreign currency translation (losses) gains	(884)	(63)	13
Other comprehensive (loss) income	(1,346)	(23)	209
Comprehensive income	4,327	5,503	5,351
Comprehensive income attributable to noncontrolling interests	(48)	—	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$ 4,279	$5,503	$5,351

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Total Shareholders' Equity
Balance at January 1, 2011	1,086	$11	$ —	$25,562	$ 280	$ (28)	$25,825
Net earnings				5,142			5,142
Other comprehensive income					196	13	209
Issuances of common shares, and related tax effects	18	—	308				308
Share-based compensation, and related tax benefits			453				453
Common share repurchases	(65)	(1)	(761)	(2,232)			(2,994)
Cash dividends paid on common shares				(651)			(651)
Balance at December 31, 2011	1,039	10	—	27,821	476	(15)	28,292
Net earnings				5,526			5,526
Other comprehensive income (loss)					40	(63)	(23)
Issuances of common shares, and related tax effects	37	—	704				704
Share-based compensation, and related tax benefits			594				594
Common share repurchases	(57)	—	(1,221)	(1,863)			(3,084)
Acquisitions of noncontrolling interests			(11)				(11)
Cash dividends paid on common shares				(820)			(820)
Balance at December 31, 2012	1,019	10	66	30,664	516	(78)	31,178
Net earnings attributable to UnitedHealth Group common shareholders				5,625			5,625
Other comprehensive loss					(462)	(884)	(1,346)
Issuances of common shares, and related tax effects	17	—	431				431
Share-based compensation, and related tax benefits			406				406
Common share repurchases	(48)	—	(984)	(2,186)			(3,170)
Acquisitions of noncontrolling interests, and related tax effects			81				81
Cash dividends paid on common shares				(1,056)			(1,056)
Balance at December 31, 2013	988	$10	$ —	$33,047	$ 54	$(962)	$32,149

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2013	2012	2011
Operating activities			
Net earnings	$ 5,673	$ 5,526	$ 5,142
Non-cash items:			
Depreciation and amortization	1,375	1,309	1,124
Deferred income taxes	1	308	59
Share-based compensation	331	421	401
Other, net	(83)	(231)	(67)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(317)	(130)	(267)
Other assets	(838)	(295)	(121)
Medical costs payable	509	101	377
Accounts payable and other liabilities	459	199	146
Other policy liabilities	(221)	(81)	482
Unearned revenues	102	28	(308)
Cash flows from operating activities	6,991	7,155	6,968
Investing activities			
Purchases of investments	(12,176)	(9,903)	(9,895)
Sales of investments	5,706	3,794	3,949
Maturities of investments	4,859	4,810	4,251
Cash paid for acquisitions, net of cash assumed	(362)	(6,280)	(1,844)
Cash received from dispositions	45	—	385
Purchases of property, equipment and capitalized software	(1,307)	(1,070)	(1,067)
Proceeds from disposal of property and equipment	146	—	49
Cash flows used for investing activities	(3,089)	(8,649)	(4,172)
Financing activities			
Acquisition of noncontrolling interest shares	(1,474)	(319)	—
Common stock repurchases	(3,170)	(3,084)	(2,994)
Proceeds from issuance of long-term debt	2,235	3,966	2,234
Repayments of long-term debt	(1,609)	(986)	(955)
(Repayments of) proceeds from commercial paper, net	(474)	1,587	(933)
Cash dividends paid	(1,056)	(820)	(651)
Customer funds administered	31	(324)	37
Proceeds from common stock issuances	598	1,078	381
Interest rate swap termination	—	—	132
Other, net	(27)	(627)	259
Cash flows (used for) from financing activities	(4,946)	471	(2,490)
Effect of exchange rate changes on cash and cash equivalents	(86)	—	—
(Decrease) increase in cash and cash equivalents	(1,130)	(1,023)	306
Cash and cash equivalents, beginning of period	8,406	9,429	9,123
Cash and cash equivalents, end of period	$ 7,276	$ 8,406	$ 9,429
Supplemental cash flow disclosures			
Cash paid for interest	$ 724	$ 600	$ 472
Cash paid for income taxes	2,785	2,666	2,739

See Notes to the Consolidated Financial Statements

UnitedHealth Group

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone.

Through the Company's diversified family of businesses, it leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs payable, revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of certain investments, and estimates and judgments related to income taxes and contingent liabilities. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from its customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, and beginning in 2014, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the Centers for Medicare and Medicaid Services' (CMS) risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect,

capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans is subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependants. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependants, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

For the Company's OptumRx pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies or mail services, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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 processing backlogs, care provider contract rate changes, medical care utilization and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Medical costs also include the direct cost of patient care rendered through OptumHealth.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

The Company had checks outstanding of $1.3 billion as of both December 31, 2013 and 2012, which were classified as Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets and the change in this balance has been reflected within other financing activities in the Consolidated Statements of Cash Flows. The outstanding checks are primarily related to zero balance accounts; the Company does not net checks outstanding with deposits in other accounts.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of shareholders' equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends to either sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in Investment and Other Income. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.
- For equity securities, the Company recognizes impairments in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the impairment in Investment and Other Income.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program), and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2020 for the AARP Program and give the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings until December 31, 2020, subject to certain limited exclusions.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the RSF and were $101 million, $109 million and $99 million in the years ended December 31, 2013, 2012 and 2011, respectively.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of whom provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of Product Revenue. The Company generally receives rebates from two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivable" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.

- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to Premium Revenues in the Consolidated Statements of Operations and Other Policy Liabilities or Other Current Receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Health Reform Legislation mandated a consumer discount on brand name prescription drugs for Medicare Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Accordingly, amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as Premium Revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in Unearned Revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in Medical Costs and Operating Costs, respectively, in the Consolidated Statements of Operations.

The final 2013 risk-share amount is expected to be settled during the second half of 2014, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2013			December 31, 2012		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$881	$425	$ —	$461	$314	$ —
Other policy liabilities	—	152	214	—	319	438

As of January 1, 2014, certain changes were made to the Medicare Part D individual coverage levels by CMS, including:

- The initial coverage limit decreased to $2,850 from $2,970 in 2013.
- The catastrophic coverage begins at $6,455 as compared to $6,734 in 2013.
- The annual out-of-pocket maximum decreased to $4,550 from $4,750 in 2013.
- The discount on prescription drugs within the coverage gap of 52.5% is consistent with 2013 for brand name drugs and increased to 28% from 21% in 2013 for generic drugs.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. First, the Company estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

As of December 31, 2013, no reporting unit had a fair value less than its carrying value and the Company concluded that there was no need for any impairment of goodwill.

Intangible assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There were no material impairments of intangible assets during the year ended December 31, 2013.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program (described below), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit

accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Underwriting gains or losses related to the AARP Program are directly 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. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF; losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. Changes in the RSF are reported in Medical Costs in the Consolidated Statement of Operations. As of December 31, 2013 and 2012, the balance in the RSF was $1.3 billion.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2013, the Company had an aggregate $1.8 billion reinsurance receivable, of which $136 million was recorded in Other Current Receivables and $1.7 billion was recorded in Other Assets in the Consolidated Balance Sheets. As of December 31, 2012, the Company had an aggregate $1.9 billion reinsurance receivable, of which $135 million was recorded in Other Current Receivables and $1.8 billion was recorded in Other Assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. As of December 31, 2013, the reinsurer was rated by A.M. Best as "A+."

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Noncontrolling Interests

Noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The redeemable noncontrolling interests are primarily related to non-public shareholders of Amil. During 2013, the Company increased its ownership of Amil to 90%. For the year ended December 31, 2013, redeemable noncontrolling interests were reduced by $946 million primarily due to the acquisition of all of Amil's remaining public shares for $1.4 billion, with an additional $57 million recorded as a reduction to Additional Paid in Capital, partially offset by 2013 acquisitions that included redeemable noncontrolling interests of $471 million. At Amil's acquisition date in 2012, the Company purchased approximately 60% of the outstanding shares of Amil for $3.2 billion, and recorded a noncontrolling interest of $2.2 billion. Subsequently in 2012, the Company purchased an additional 5% of the outstanding shares of Amil for $319 million.

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on

a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably; primarily over three to four years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP) eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in Operating Costs in the Company's Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP, (collectively, common stock equivalents) using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise, any unrecognized compensation cost and any related excess tax benefit. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Standards

In February 2013, the Financial Accounting Standards Board (FASB) issued Accounting Standards Updated (ASU) No. 2013-02, "Comprehensive Income (Topic 220): Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income" (ASU 2013-02). ASU 2013-02 requires companies to report the effect of significant reclassifications out of accumulated other comprehensive income, by component, either on the face of the financial statements or in the notes to the financial statements and is intended to help entities improve the transparency of changes in other comprehensive income. ASU 2013-02 does not amend any existing requirements for reporting net income or other comprehensive income in the financial statements. ASU 2013-02 became effective for the Company's fiscal year 2013 and the new disclosures have been included with the Company's investment disclosures in Note 3.

ASU No. 2011-06, "Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers a consensus of the FASB Emerging Issues Task Force" (ASU 2011-06) addresses the recognition and classification of an entity's share of the annual health insurance industry assessment (the industry fee) mandated by Health Reform Legislation. The industry fee is levied on health insurers for each calendar year beginning on or after January 1, 2014 and is not deductible for income tax purposes. The amount of the industry fee for each health insurer is based on a ratio of the insurer's net health insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total net premiums. In accordance with the amendments in ASU 2011-06 on January 1, 2014, the liability for the industry fee payable in 2014 will be estimated and recorded in full within the Company's 2014 financial statements, with a corresponding deferred cost that will be amortized to expense using a straight-line method of allocation over the calendar year that it is payable.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2013				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,211	$ 5	$ (21)	$ 2,195
State and municipal obligations	6,902	147	(72)	6,977
Corporate obligations	7,265	130	(60)	7,335
U.S. agency mortgage-backed securities	2,256	23	(61)	2,218
Non-U.S. agency mortgage-backed securities	697	12	(7)	702
Total debt securities — available-for-sale	19,331	317	(221)	19,427
Equity securities — available-for-sale	1,576	9	(13)	1,572
Debt securities — held-to-maturity:				
U.S. government and agency obligations	181	1	—	182
State and municipal obligations	28	—	—	28
Corporate obligations	334	—	—	334
Total debt securities — held-to-maturity	543	1	—	544
Total investments	$21,450	$327	$(234)	$21,543
December 31, 2012				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,501	$ 38	$ (1)	$ 2,538
State and municipal obligations	6,282	388	(3)	6,667
Corporate obligations	6,930	283	(4)	7,209
U.S. agency mortgage-backed securities	2,168	70	—	2,238
Non-U.S. agency mortgage-backed securities	538	36	—	574
Total debt securities — available-for-sale	18,419	815	(8)	19,226
Equity securities — available-for-sale	668	10	(1)	677
Debt securities — held-to-maturity:				
U.S. government and agency obligations	168	6	—	174
State and municipal obligations	30	—	—	30
Corporate obligations	641	2	—	643
Total debt securities — held-to-maturity	839	8	—	847
Total investments	$19,926	$833	$ (9)	$20,750

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination date as of December 31, 2013 were as follows:

(in millions)	AAA	AA	Non-Investment Grade	Total Fair Value
2013	$ 130	$ —	$ —	$ 130
2012	106	—	—	106
2011	20	—	—	20
2010	26	—	—	26
2009	2	—	—	2
2007	63	—	2	65
Pre-2007	340	3	10	353
U.S. agency mortgage-backed securities	2,218	—	—	2,218
Total	$2,905	$ 3	$ 12	$2,920

The Company includes any securities backed by Alt-A or sub-prime mortgages and any commercial mortgage loans in default in the non-investment grade column in the table above.

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2013, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 2,042	$ 2,054
Due after one year through five years	7,121	7,235
Due after five years through ten years	5,164	5,182
Due after ten years	2,051	2,036
U.S. agency mortgage-backed securities	2,256	2,218
Non-U.S. agency mortgage-backed securities	697	702
Total debt securities — available-for-sale	$19,331	$19,427

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2013, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 78	$ 78
Due after one year through five years	231	230
Due after five years through ten years	154	156
Due after ten years	80	80
Total debt securities — held-to-maturity	$543	$544

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2013						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$1,055	$ (19)	$ 17	$ (2)	$1,072	$ (21)
State and municipal obligations	2,491	(62)	128	(10)	2,619	(72)
Corporate obligations	2,573	(51)	103	(9)	2,676	(60)
U.S. agency mortgage-backed securities	1,393	(51)	105	(10)	1,498	(61)
Non-U.S. agency mortgage-backed securities	289	(6)	26	(1)	315	(7)
Total debt securities — available-for-sale	$7,801	$(189)	$ 379	$ (32)	$8,180	$(221)
Equity securities — available-for-sale	$ 180	$ (13)	$ —	$ —	$ 180	$ (13)
December 31, 2012						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 183	$ (1)	$ —	$ —	$ 183	$ (1)
State and municipal obligations	362	(3)	—	—	362	(3)
Corporate obligations	695	(4)	—	—	695	(4)
Total debt securities — available-for-sale	$1,240	$ (8)	$ —	$ —	$1,240	$ (8)
Equity securities — available-for-sale	$ 13	$ (1)	$ —	$ —	$ 13	$ (1)

The unrealized losses from all securities as of December 31, 2013 were generated from approximately 6,400 positions out of a total of 19,700 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). Therefore, the Company believes these losses to be temporary. As of December 31, 2013, the Company did not have the intent to sell any of the securities in an unrealized loss position.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, private equity funds, and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

(in millions)	For the Years Ended December 31, 2013	2012	2011
Total OTTI	$ (8)	$ (6)	$ (12)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(8)	(6)	(12)
Gross realized losses from sales	(9)	(13)	(11)
Gross realized gains from sales	198	175	136
Net realized gains (included in Investment and Other Income on the Consolidated Statements of Operations)	181	156	113
Income tax effect (included in Provision for Income Taxes on the Consolidated Statements of Operations)	(66)	(57)	(41)
Realized gains, net of taxes	$115	$ 99	$ 72

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2013 or 2012.

Non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2013, 2012, or 2011.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; and similar preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based off of recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

AARP Program-related Investments. AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's debt and equity securities.

Interest Rate and Currency Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-term Debt. The fair value of the Company's long-term debt is estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2013				
Cash and cash equivalents	$ 7,005	$ 271	$ —	$ 7,276
Debt securities—available-for-sale:				
U.S. government and agency obligations	1,750	445	—	2,195
State and municipal obligations	—	6,977	—	6,977
Corporate obligations	25	7,274	36	7,335
U.S. agency mortgage-backed securities	—	2,218	—	2,218
Non-U.S. agency mortgage-backed securities	—	696	6	702
Total debt securities—available-for-sale	1,775	17,610	42	19,427
Equity securities—available-for-sale	1,291	12	269	1,572
Total assets at fair value	$10,071	$17,893	$311	$28,275
Percentage of total assets at fair value	36%	63%	1%	100%
Interest rate swap liabilities	$ —	$ 163	$ —	$ 163
December 31, 2012				
Cash and cash equivalents	$ 7,615	$ 791	$ —	$ 8,406
Debt securities—available-for-sale:				
U.S. government and agency obligations	1,752	786	—	2,538
State and municipal obligations	—	6,667	—	6,667
Corporate obligations	13	7,185	11	7,209
U.S. agency mortgage-backed securities	—	2,238	—	2,238
Non-U.S. agency mortgage-backed securities	—	568	6	574
Total debt securities—available-for-sale	1,765	17,444	17	19,226
Equity securities—available-for-sale	450	3	224	677
Interest rate swap assets	—	14	—	14
Total assets at fair value	$ 9,830	$18,252	$241	$28,323
Percentage of total assets at fair value	35%	64%	1%	100%
Interest rate and currency swap liabilities	$ —	$ 14	$ —	$ 14

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2013					
Debt securities—held-to-maturity:					
U.S. government and agency obligations	$182	$ —	$ —	$ 182	$ 181
State and municipal obligations	—	—	28	28	28
Corporate obligations	47	9	278	334	334
Total debt securities—held-to-maturity	$229	$ 9	$306	$ 544	$ 543
Long-term debt and other financing obligations	$ —	$16,602	$ —	$16,602	$15,745
December 31, 2012					
Debt securities—held-to-maturity:					
U.S. government and agency obligations	$174	$ —	$ —	$ 174	$ 168
State and municipal obligations	—	1	29	30	30
Corporate obligations	10	346	287	643	641
Total debt securities—held-to-maturity	$184	$ 347	$316	$ 847	$ 839
Long-term debt	$ —	$17,034	$ —	$17,034	$15,167

The carrying amounts reported in the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2013			December 31, 2012			December 31, 2011		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 17	$224	$241	$ 208	$209	$ 417	$141	$208	$349
Purchases	38	71	109	11	71	82	92	35	127
Sales	(10)	(25)	(35)	—	(34)	(34)	—	(17)	(17)
Settlements	—	—	—	(1)	—	(1)	(25)	(7)	(32)
Net unrealized losses in accumulated other comprehensive income	(2)	(7)	(9)	—	(14)	(14)	—	(4)	(4)
Net realized (losses) gains in investment and other income	(1)	6	5	—	13	13	—	(6)	(6)
Transfers to held-to-maturity	—	—	—	(201)	(21)	(222)	—	—	—
Balance at end of period	$ 42	$269	$311	$ 17	$224	$ 241	$208	$209	$417

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
December 31, 2013					
Equity securities-available-for-sale					
Venture capital portfolios	$233	Market approach - comparable companies	Revenue multiple	1.0	6.0
			EBITDA multiple	8.0	9.0
	36	Market approach - recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$269				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $42 million of available-for-sale debt securities at December 31, 2013, which were not significant.

The Company elected to measure the entirety of the AARP Assets Under Management at fair value pursuant to the fair value option. See Note 2 for further information on the AARP Program. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
December 31, 2013			
Cash and cash equivalents	$265	$ —	$ 265
Debt securities:			
U.S. government and agency obligations	426	301	727
State and municipal obligations	—	63	63
Corporate obligations	—	1,145	1,145
U.S. agency mortgage-backed securities	—	414	414
Non-U.S. agency mortgage-backed securities	—	139	139
Total debt securities	426	2,062	2,488
Equity securities-available-for-sale	—	4	4
Total assets at fair value	$691	$2,066	$2,757
Other liabilities	$ 3	$ 11	$ 14
December 31, 2012			
Cash and cash equivalents	$230	$ —	$ 230
Debt securities:			
U.S. government and agency obligations	545	244	789
State and municipal obligations	—	51	51
Corporate obligations	—	1,118	1,118
U.S. agency mortgage-backed securities	—	427	427
Non-U.S. agency mortgage-backed securities	—	155	155
Total debt securities	545	1,995	2,540
Equity securities-available-for-sale	—	3	3
Total assets at fair value	$775	$1,998	$2,773
Other liabilities	$ 23	$ 58	$ 81

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2013	December 31, 2012
Land and improvements	$ 318	$ 358
Buildings and improvements	2,051	1,910
Computer equipment	1,519	1,447
Furniture and fixtures	564	488
Less accumulated depreciation	(1,760)	(1,542)
Property and equipment, net	2,692	2,661
Capitalized software	2,233	2,300
Less accumulated amortization	(915)	(1,022)
Capitalized software, net	1,318	1,278
Total property, equipment and capitalized software, net	$ 4,010	$ 3,939

Depreciation expense for property and equipment for the years ended December 31, 2013, 2012 and 2011 was $445 million, $449 million and $386 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2013, 2012 and 2011 was $411 million, $412 million and $377 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2012	$17,932	$2,113	$3,090	$840	$23,975
Acquisitions	6,557	705	98	—	7,360
Foreign currency effects and adjustments, net	(30)	—	(19)	—	(49)
Balance at December 31, 2012	24,459	2,818	3,169	840	31,286
Acquisitions	408	48	483	—	939
Dispositions	(5)	—	—	—	(5)
Foreign currency effects and adjustments, net	(611)	(6)	1	—	(616)
Balance at December 31, 2013	$24,251	$2,860	$3,653	$840	$31,604

In the fourth quarter of 2012, the Company purchased Amil, a health care company located in Brazil, providing health and dental benefits, hospital and clinical services, and advanced care management resources to nearly 7 million people. During 2013, the Company acquired all of Amil's remaining public shares for $1.5 billion, bringing the Company's ownership of Amil to 90%. The remaining stake in Amil is held by shareholders, including Amil's CEO, who has been a member of the Company's Board of Directors since October 2012, who have committed to retain the shares for at least five years, through October 2017. These shareholders have the right to put the shares to the Company and the Company has the right to call these shares upon expiration of the five year term, unless accelerated upon certain events, at fair market value. Related to this acquisition, Amil's CEO invested approximately $470 million in unregistered UnitedHealth Group common shares in the fourth quarter of 2012 and has committed to hold those shares for the same five year term, subject to certain exceptions.

The total consideration paid and fair value of the noncontrolling interest exceeded the estimated fair value of the net tangible assets acquired by $6.0 billion, of which $0.7 billion has been allocated to finite-lived intangible assets, $0.7 billion to indefinite-lived intangible assets and $4.6 billion to goodwill. In conjunction with the Amil share purchases, the Company generated Brazilian tax deductible goodwill of approximately R$8.9 billion ($3.8 billion in U.S. dollars at December 31, 2013).

For the years ended December 31, 2013, 2012 and 2011, aggregate consideration paid, net of cash assumed, for acquisitions other than Amil was $0.4 billion, $3.3 billion and $1.8 billion, respectively. These acquisitions were not material to the Company's Consolidated Financial Statements.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2013			December 31, 2012		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$4,821	$(2,028)	$2,793	$5,229	$(1,629)	$3,600
Trademarks and technology	433	(191)	242	445	(146)	299
Trademarks—indefinite-lived	589	—	589	611	—	611
Other	284	(64)	220	221	(49)	172
Total	$6,127	$(2,283)	$3,844	$6,506	$(1,824)	$4,682

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2013		2012	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$55	12 years	$1,530	8 years
Trademarks and technology	27	12 years	79	4 years
Other	—		111	15 years
Total acquired finite-lived intangible assets	$82	12 years	$1,720	9 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2014	$500
2015	478
2016	449
2017	411
2018	332

Amortization expense relating to intangible assets for 2013, 2012 and 2011 was $519 million, $448 million and $361 million, respectively.

7. Medical Costs and Medical Costs Payable

The following table provides details of the Company's net favorable medical cost development:

	For the Years Ended December 31,		
(in millions)	2013	2012	2011
Related to Prior Years	$680	$860	$720

The net favorable development for the years ended December 31, 2013, 2012, and 2011 was primarily driven by lower than expected health system utilization levels. The years ended December 31, 2012 and 2011 were also impacted by increased efficiency in claims processing and handling.

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2013	2012	2011
Medical costs payable, beginning of period	$ 11,004	$ 9,799	$ 9,220
Acquisitions	—	1,029	155
Reported medical costs:			
Current year	89,970	81,086	75,052
Prior years	(680)	(860)	(720)
Total reported medical costs	89,290	80,226	74,332
Claim payments:			
Payments for current year	(78,989)	(71,832)	(65,763)
Payments for prior year	(9,730)	(8,218)	(8,145)
Total claim payments	(88,719)	(80,050)	(73,908)
Medical costs payable, end of period	$ 11,575	$ 11,004	$ 9,799

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2013 Par Value	December 31, 2013 Carrying Value	December 31, 2013 Fair Value	December 31, 2012 Par Value	December 31, 2012 Carrying Value	December 31, 2012 Fair Value
Commercial Paper	$ 1,115	$ 1,115	$ 1,115	$ 1,587	$ 1,587	$ 1,587
4.875% notes due February 2013	—	—	—	534	534	536
4.875% notes due April 2013	—	—	—	409	411	413
4.750% notes due February 2014	172	173	173	172	178	180
5.000% notes due August 2014	389	397	400	389	411	414
Floating-rate notes due August 2014	250	250	250	—	—	—
4.875% notes due March 2015 (a)	416	431	436	416	444	453
0.850% notes due October 2015 (a)	625	624	628	625	623	627
5.375% notes due March 2016 (a)	601	641	657	601	660	682
1.875% notes due November 2016	400	398	408	400	397	412
5.360% notes due November 2016	95	95	107	95	95	110
6.000% notes due June 2017	441	479	506	441	489	528
1.400% notes due October 2017 (a)	625	613	617	625	622	626
6.000% notes due November 2017	156	168	178	156	170	191
6.000% notes due February 2018	1,100	1,116	1,271	1,100	1,120	1,339
1.625% notes due March 2019 (a)	500	489	481	—	—	—
3.875% notes due October 2020 (a)	450	435	474	450	442	499
4.700% notes due February 2021	400	416	436	400	417	466
3.375% notes due November 2021 (a)	500	472	494	500	512	533
2.875% notes due March 2022 (a)	1,100	981	1,046	1,100	998	1,128
0.000% notes due November 2022	15	9	10	15	9	11
2.750% notes due February 2023 (a)	625	563	572	625	619	631
2.875% notes due March 2023 (a)	750	729	698	—	—	—
5.800% notes due March 2036	850	845	935	850	845	1,025
6.500% notes due June 2037	500	495	593	500	495	659
6.625% notes due November 2037	650	645	786	650	645	860
6.875% notes due February 2038	1,100	1,084	1,370	1,100	1,084	1,510
5.700% notes due October 2040	300	298	329	300	298	364
5.950% notes due February 2041	350	348	397	350	348	440
4.625% notes due November 2041	600	593	567	600	593	641
4.375% notes due March 2042	502	486	459	502	486	521
3.950% notes due October 2042	625	611	530	625	611	622
4.250% notes due March 2043	750	740	673	—	—	—
Total U.S. dollar denominated debt	16,952	16,739	17,596	16,117	16,143	18,008
Cetip Interbank Deposit Rate (CDI) + 1.3% Subsidiary floating debt due October 2013	—	—	—	147	148	150
CDI + 1.45% Subsidiary floating debt due October 2014	—	—	—	147	149	150
110% CDI Subsidiary floating debt due December 2014	—	—	—	147	151	147
CDI + 1.6% Subsidiary floating debt due October 2015	—	—	—	74	76	76
Brazilian Extended National Consumer Price Index (IPCA) + 7.61% Subsidiary floating debt due October 2015	—	—	—	73	87	90
Total Brazilian real denominated debt (in U.S. dollars)	—	—	—	588	611	613
Total commercial paper and long-term debt	$16,952	$16,739	$17,596	$16,705	$16,754	$18,621

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

As of December 31, 2013, the Company's long-term debt obligations also included $121 million of other financing obligations, of which $34 million were current.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2014	$ 1,969
2015	1,086
2016	1,140
2017	1,266
2018	1,116
Thereafter	10,283

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2013, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.2%.

The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2018 and November 2014, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2013. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of December 31, 2013, the annual interest rates on both bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Debt Covenants

The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio of not more than 50%. The Company was in compliance with its debt covenants as of December 31, 2013.

Interest Rate Swap Contracts

The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are assumed to be highly effective hedges and all changes in fair value of the swaps are recorded as an adjustment to the carrying value of the related debt with no net impact recorded in the Consolidated Statements of Operations.

The following table summarizes the location and fair value of the interest rate swap fair value hedges on the Company's Consolidated Balance Sheet:

Type of Fair Value Hedge	Notional Amount (in billions)	Fair Value (in millions)	Balance Sheet Location
December 31, 2013			
Interest rate swap contracts	$6.2	$163	Other liabilities
December 31, 2012			
Interest rate swap contracts	$2.8	$ 14	Other assets
		11	Other liabilities

The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Consolidated Statements of Operations:

(in millions)	For the Years Ended December 31, 2013	2012	2011
Hedge — interest rate swap (loss) gain recognized in interest expense	$(166)	$ 3	$ 190
Hedged item — long-term debt gain (loss) recognized in interest expense	166	(3)	(190)
Net impact on the Company's Consolidated Statements of Operations	$ —	$ —	$ —

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2013	2012	2011
Current Provision:			
Federal	$3,004	$2,638	$2,608
State and local	237	150	150
Total current provision	3,241	2,788	2,758
Deferred provision	1	308	59
Total provision for income taxes	$3,242	$3,096	$2,817

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2013		2012		2011	
Tax provision at the U.S. federal statutory rate	$3,120	35.0%	$3,018	35.0%	$2,785	35.0%
State income taxes, net of federal benefit	126	1.4	143	1.7	136	1.7
Settlement of state exams, net of federal benefit	1	—	2	—	(29)	(0.4)
Tax-exempt investment income	(53)	(0.6)	(59)	(0.7)	(63)	(0.8)
Non-deductible compensation	39	0.5	22	0.2	10	0.1
Other, net	9	0.1	(30)	(0.3)	(22)	(0.2)
Provision for income taxes	$3,242	36.4%	$3,096	35.9%	$2,817	35.4%

The higher effective income tax rate for 2013 as compared to 2012 primarily resulted from the favorable resolution of various one-time tax matters in 2012.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2013	2012
Deferred income tax assets:		
Accrued expenses and allowances	$ 284	$ 306
U.S. federal and state net operating loss carryforwards	257	276
Share-based compensation	200	238
Long-term liabilities	170	160
Medical costs payable and other policy liabilities	155	149
Non-U.S. tax loss carryforwards	110	126
Unearned revenues	65	64
Unrecognized tax benefits	38	25
Other-domestic	57	93
Other-non-U.S.	89	142
Subtotal	1,425	1,579
Less: valuation allowances	(207)	(271)
Total deferred income tax assets	1,218	1,308
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(1,207)	(1,335)
Non-U.S. goodwill and intangible assets	(453)	(640)
Capitalized software	(481)	(482)
Net unrealized gains on investments	(31)	(296)
Depreciation and amortization	(268)	(249)
Prepaid expenses	(137)	(113)
Other-non-U.S.	(7)	(179)
Total deferred income tax liabilities	(2,584)	(3,294)
Net deferred income tax liabilities	$(1,366)	$(1,986)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $111 million expire beginning in 2021 through 2033, state net operating loss carryforwards expire beginning in 2014 through 2033. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2013, the Company had $359 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2013	2012	2011
Gross unrecognized tax benefits, beginning of period	$81	$129	$220
Gross increases:			
Current year tax positions	8	6	11
Prior year tax positions	5	18	10
Gross decreases:			
Prior year tax positions	—	(48)	(34)
Settlements	—	(10)	(25)
Statute of limitations lapses	(5)	(14)	(53)
Gross unrecognized tax benefits, end of period	$89	$ 81	$129

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During 2013, the Company recognized $4 million of interest expense. The Company recognized tax benefits from the net reduction of interest and penalties accrued of $20 million and $12 million during the years ended December 31, 2012 and 2011, respectively. The Company had $27 million and $23 million of accrued interest and penalties for uncertain tax positions as of December 31, 2013 and 2012, respectively. These amounts are not included in the reconciliation above. As of December 31, 2013, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $89 million.

The Company currently files income tax returns in the United States, various states and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2012 and prior. The Company's 2013 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to 2008. The Brazilian federal revenue service—Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed. Estimated taxes are paid monthly in Brazil with an annual return due on June 30 following the end of the taxable year.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $33 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2013, based on the 2012 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could have been paid by the Company's U.S. regulated subsidiaries to their parent companies was $4.3 billion. For the year ended December 31, 2013, the Company's regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $430 million of extraordinary dividends. For the year ended December 31, 2012, the Company's regulated subsidiaries paid their parent companies dividends of $4.9 billion, including $1.2 billion of extraordinary dividends. As of December 31, 2013, $1.0 billion of the Company's $7.3 billion of cash and cash equivalents was available for general corporate use.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $14.8 billion as of December 31, 2013. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $5.5 billion as of December 31, 2013.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2013, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. Repurchases may be made from time to time in open market purchases or other types of transactions (including structured share repurchase programs), subject to certain Board restrictions. In June 2013, the Board renewed and expanded the Company's share repurchase program with an authorization to repurchase up to 110 million shares of its common stock. During the year ended December 31, 2013, the Company repurchased 48 million shares at an average price of $65.52 per share and an aggregate cost of $3.2 billion. As of December 31, 2013, the Company had Board authorization to purchase up to an additional 83 million shares of its common stock.

Dividends

In June 2013, the Company's Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $1.12 per share, paid quarterly. Since June 2012, the Company had paid an annual cash dividend of $0.85 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2013	$1.0525	$1,056
2012	0.8000	820
2011	0.6125	651

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted stock and restricted stock units (collectively, restricted shares). As of December 31, 2013, the Company had 35 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and 14 million of awards in restricted shares. As of December 31, 2013, there were also 17 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2013 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	63	$45		
Granted	8	58		
Exercised	(28)	44		
Forfeited	(2)	55		
Outstanding at end of period	41	48	4.5	$1,121
Exercisable at end of period	30	46	3.1	879
Vested and expected to vest, end of period	40	48	4.5	1,110

Restricted Shares

Restricted share activity for the year ended December 31, 2013 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	9	$46
Granted	4	58
Vested	(1)	38
Forfeited	(1)	51
Nonvested at end of period	11	50

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2013	2012	2011
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 19	$ 18	$ 15
Total intrinsic value of stock options and SARs exercised	592	559	327
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	58	52	42
Total fair value of restricted shares vested	$ 31	$716	$113
Employee Stock Purchase Plan			
Number of shares purchased	3	3	3
Share-Based Compensation Items			
Share-based compensation expense, before tax	$331	$421	$401
Share-based compensation expense, net of tax effects	239	299	260
Income tax benefit realized from share-based award exercises	206	461	170

(in millions, except years)	December 31, 2013
Unrecognized compensation expense related to share awards	$310
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	2013	2012	2011
Risk-free interest rate	1.0% - 1.6%	0.7% - 0.9%	0.9% - 2.3%
Expected volatility	41.0% - 43.0%	43.2% - 44.0%	44.3% - 45.1%
Expected dividend yield	1.4% - 1.6%	1.2% - 1.7%	1.0% - 1.4%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.3	5.3 - 5.6	4.9 - 5.0

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for the years ended December 31, 2013, 2012 and 2011.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within Long-Term Investments with an approximately equal amount in Other Liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $441 million and $348 million as of December 31, 2013 and 2012, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates through 2028. Rent expense under all operating leases for 2013, 2012 and 2011 was $438 million, $334 million and $295 million, respectively.

As of December 31, 2013, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2014	$487
2015	452
2016	348
2017	299
2018	273
Thereafter	544

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of or for the years ended December 31, 2013, 2012 and 2011.

As of December 31, 2013, the Company had outstanding, undrawn letters of credit with financial institutions of $39 million and surety bonds outstanding with insurance companies of $499 million, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI has never issued a penalty in excess of $8 million, CDI has advocated a penalty of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a non-binding proposed decision recommending a penalty in an amount that is not material to the Company's results of operations, cash flows or financial condition. The matter is now before the California Insurance Commissioner, who has indicated that he will not adopt the administrative law judge's proposed decision and will issue his own decision. The Commissioner's decision is subject to challenge in court. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting regulatory fines and penalties, and the various remedies and levels of judicial review available to the Company in the event a fine or penalty is assessed.

Endoscopy Center of Southern Nevada Litigation. In April 2013, a Las Vegas jury awarded $24 million in compensatory damages and $500 million in punitive damages against a Company health plan and its parent corporation on the theory that they were negligent in their credentialing and monitoring of an in-network endoscopy center owned and operated by independent physicians who were subsequently linked by regulators to an outbreak of hepatitis C. In September 2013, the trial court reduced the overall award to $366 million following post-trial motions, and in December 2013, the Company filed a notice of appeal. Company plans are party to 41 additional individual lawsuits and two class actions relating to the outbreak. The Company cannot reasonably estimate the range of loss, if any, that may result from these matters given the likelihood of reversal on appeal, the availability of statutory and other limits on damages, the novel legal theories being advanced by the plaintiffs, the various postures of the remaining cases, the availability in many cases of federal defenses under Medicare law and the Employee Retirement Income Security Act, and the pendency of certain relevant legal questions before the Nevada Supreme Court. The Company is vigorously defending these lawsuits.

Government Investigations, Audits and Reviews

The Company has been, or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the Securities and Exchange Commission (SEC), the IRS, the SRF, the U.S. Department of Labor, the FDIC and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International because they have similar economic characteristics, products and services, customers, distribution methods and operational processes and operate in a similar regulatory environment. The U.S. businesses also share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide and active and retired military and their families through the TRICARE program (West Region). UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program, and other federal, state and community health care programs. UnitedHealthcare International is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.
- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling consumer health management and integrated care delivery through programs offered by employers, payers, government

entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, integrated care delivery services, consumer engagement and relationship management and sales distribution platform services and financial services.

- *OptumInsight* is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services, and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers pharmacy benefit management services and programs including retail pharmacy network management services, mail order and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing, and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and integrated care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 29%, 29%, and 28% for the years ended December 31, 2013, 2012 and 2011, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 95% and 99% of consolidated total revenues during the years ended December 31, 2013 and 2012, respectively. Substantially all revenue was U.S. generated revenue for the year ended December 31, 2011. Long-lived fixed assets located in the United States represented approximately 72% and 70% of the total long-lived fixed assets as of December 31, 2013 and 2012, respectively. The non-US revenues and fixed assets are primarily related to UnitedHealthcare International.

2014 Business Realignment

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, will be included in OptumInsight's results of operations. The Company's periodic filings with the SEC beginning with the first quarter 2014 Form 10-Q will include historical segment results restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

Corporate and intersegment elimination amounts are presented to reconcile the reportable segment results to the consolidated results. The following table presents the reportable segment financial information:

		Optum					
(in millions)	UnitedHealthcare	Optum Health	Optum Insight	OptumRx	Total Optum	Corporate and Intersegment Eliminations	Consolidated
2013							
Revenues — external customers:							
Premiums	$107,024	$2,533	$ —	$ —	$ 2,533	$ —	$109,557
Services	6,180	819	1,902	96	2,817	—	8,997
Products	8	19	92	3,071	3,182	—	3,190
Total revenues — external customers	113,212	3,371	1,994	3,167	8,532	—	121,744
Total revenues — intersegment	—	6,357	1,179	20,839	28,375	(28,375)	—
Investment and other income	617	127	1	—	128	—	745
Total revenues	$113,829	$9,855	$3,174	$24,006	$37,035	$(28,375)	$122,489
Earnings from operations	$ 7,309	$ 976	$ 603	$ 735	$ 2,314	$ —	$ 9,623
Interest expense	—	—	—	—	—	(708)	(708)
Earnings before income taxes	$ 7,309	$ 976	$ 603	$ 735	$ 2,314	$ (708)	$ 8,915
Total assets	$ 62,545	$9,329	$5,971	$ 4,525	$19,825	$ (488)	$ 81,882
Purchases of property, equipment and capitalized software	824	234	171	78	483	—	1,307
Depreciation and amortization	869	178	221	107	506	—	1,375
2012							
Revenues — external customers:							
Premiums	$ 97,985	$1,743	$ —	$ —	$ 1,743	$ —	$ 99,728
Services	4,867	767	1,720	83	2,570	—	7,437
Products	—	21	87	2,665	2,773	—	2,773
Total revenues — external customers	102,852	2,531	1,807	2,748	7,086	—	109,938
Total revenues — intersegment	—	5,503	1,075	15,611	22,189	(22,189)	—
Investment and other income	567	113	—	—	113	—	680
Total revenues	$103,419	$8,147	$2,882	$18,359	$29,388	$(22,189)	$110,618
Earnings from operations	$ 7,815	$ 561	$ 485	$ 393	$ 1,439	$ —	$ 9,254
Interest expense	—	—	—	—	—	(632)	(632)
Earnings before income taxes	$ 7,815	$ 561	$ 485	$ 393	$ 1,439	$ (632)	$ 8,622
Total assets	$ 63,591	$8,274	$5,463	$ 3,466	$17,203	$ 91	$ 80,885
Purchases of property, equipment and capitalized software	585	184	165	136	485	—	1,070
Depreciation and amortization	794	193	210	112	515	—	1,309
2011							
Revenues — external customers:							
Premiums	$ 90,487	$1,496	$ —	$ —	$ 1,496	$ —	$ 91,983
Services	4,291	628	1,616	78	2,322	—	6,613
Products	—	24	96	2,492	2,612	—	2,612
Total revenues — external customers	94,778	2,148	1,712	2,570	6,430	—	101,208
Total revenues — intersegment	—	4,461	958	16,708	22,127	(22,127)	—
Investment and other income	558	95	1	—	96	—	654
Total revenues	$ 95,336	$6,704	$2,671	$19,278	$28,653	$(22,127)	$101,862
Earnings from operations	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ —	$ 8,464
Interest expense	—	—	—	—	—	(505)	(505)
Earnings before income taxes	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ (505)	$ 7,959
Total assets	$ 52,618	$6,756	$5,308	$ 3,503	$15,567	$ (296)	$ 67,889
Purchases of property, equipment and capitalized software	635	168	175	89	432	—	1,067
Depreciation and amortization	680	154	195	95	444	—	1,124

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2013 and 2012 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	**March 31**	**June 30**	**September 30**	**December 31**
2013				
Revenues	$30,340	$30,408	$30,624	$31,117
Operating costs	28,201	28,007	27,993	28,665
Earnings from operations	2,139	2,401	2,631	2,452
Net earnings	1,240	1,436	1,570	1,427
Net earnings attributable to UnitedHealth Group common shareholders	1,192	1,436	1,570	1,427
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.17	1.42	1.56	1.43
Diluted	1.16	1.40	1.53	1.41
2012				
Revenues	$27,282	$27,265	$27,302	$28,769
Operating costs	24,965	25,039	24,692	26,668
Earnings from operations	2,317	2,226	2,610	2,101
Net earnings	1,388	1,337	1,557	1,244
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.34	1.30	1.52	1.22
Diluted	1.31	1.27	1.50	1.20

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2013. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2013.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control over Financial Reporting as of December 31, 2013

UnitedHealth Group Incorporated and Subsidiaries' (the "Company") management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2013. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (1992).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2013, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2013, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2013.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2013, based on criteria established in *Internal Control-Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2013. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control-Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2013 of the Company and our report dated February 12, 2014 expressed an unqualified opinion on those consolidated financial statements.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2014

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller, and persons performing similar functions. The code of ethics, entitled The Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2014 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2014 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2013, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	41	$48	52[3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	41	$48	52

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended, and the UnitedHealth Group 1993 ESPP, as amended.

(2) Excludes 48,000 shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average exercise price of $38 and an average remaining term of approximately 1.1 years. The options are administered pursuant to the terms of the plan under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 17 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2013, and 35 million shares available under the 2011 Stock Incentive Plan as of December 31, 2013. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 14 million of these shares are available for future grants of awards other than stock options or SARs.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2014 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2014 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2014 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2013 and 2012.
- Consolidated Statement of Operations for the years ended December 31, 2013, 2012, and 2011.
- Consolidated Statement of Comprehensive Income for the years ended December 31, 2013, 2012, and 2011.
- Consolidated Statement of Changes in Shareholders' Equity for the years ended December 31, 2013, 2012, and 2011.
- Consolidated Statement of Cash Flows for the years ended December 31, 2013, 2012, and 2011.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

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

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.3	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.5	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.6	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.12	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.14	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)

*10.15	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.16	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.17	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.18	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.19	Summary of Non-Management Director Compensation, effective as of October 1, 2013 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013)
*10.20	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10K for the year ended December 31, 2009)
*10.22	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.23	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.24	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.25	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.27	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.28	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)

*10.29	Amended and Restated Employment Agreement, dated as of August 8, 2011, between United HealthCare Services, Inc. and Gail K. Boudreaux (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)
*10.30	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.31	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.32	Amended and Restated Employment Agreement, dated as of March 26, 2012, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)
*10.33	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.34	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013, filed on February 12, 2014, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Shareholders' Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2013 and 2012, and for each of the three years in the period ended December 31, 2013, and the Company's internal control over financial reporting as of December 31, 2013, and have issued our reports thereon dated February 12, 2014; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2014

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	$ 822	$ 1,025
Short-term notes receivable from subsidiaries	11	2,889
Deferred income taxes and other current assets	214	225
Total current assets	1,047	4,139
Equity in net assets of subsidiaries	44,301	43,724
Long-term notes receivable from subsidiaries	4,215	—
Other assets	144	106
Total assets	$49,707	$47,969
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 335	$ 356
Note payable to subsidiary	215	175
Commercial paper and current maturities of long-term debt	1,935	2,541
Total current liabilities	2,485	3,072
Long-term debt, less current maturities	14,804	13,602
Deferred income taxes and other liabilities	269	117
Total liabilities	17,558	16,791
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 988 and 1,019 issued and outstanding	10	10
Additional paid-in capital	—	66
Retained earnings	33,047	30,664
Accumulated other comprehensive (loss) income	(908)	438
Total UnitedHealth Group shareholders' equity	32,149	31,178
Total liabilities and shareholders' equity	$49,707	$47,969

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2013	2012	2011
Revenues:			
Investment and other income	$ 252	$ 28	$ 3
Total revenues	252	28	3
Operating costs:			
Operating costs	(9)	(2)	25
Interest expense	618	566	451
Total operating costs	609	564	476
Loss before income taxes	(357)	(536)	(473)
Benefit for income taxes	130	192	167
Loss of parent company	(227)	(344)	(306)
Equity in undistributed income of subsidiaries	5,852	5,870	5,448
Net earnings	5,625	5,526	5,142
Other comprehensive (loss) income	(1,346)	(23)	209
Comprehensive income	$ 4,279	$5,503	$5,351

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2013	2012	2011
Operating activities			
Cash flows from operating activities	$ 5,099	$ 6,116	$ 5,560
Investing activities			
Issuance of notes to subsidiaries	(1,517)	(4,149)	—
Repayments of notes receivable from subsidiaries	275	—	—
Cash paid for acquisitions	(274)	(3,737)	(2,081)
Capital contributions to subsidiaries	(942)	(99)	(171)
Cash flows used for investing activities	(2,458)	(7,985)	(2,252)
Financing activities			
Common stock repurchases	(3,170)	(3,084)	(2,994)
Proceeds from common stock issuances	598	1,078	381
Cash dividends paid	(1,056)	(820)	(651)
(Repayments of) proceeds from commercial paper, net	(474)	1,587	(933)
Proceeds from issuance of long term debt	2,235	3,966	2,234
Repayments of long-term debt	(943)	(986)	(955)
Interest rate swap termination	—	—	132
Proceeds of note from subsidiary	40	30	15
Other	(74)	(383)	53
Cash flows used for financing activities	(2,844)	1,388	(2,718)
(Decrease) increase in cash and cash equivalents	(203)	(481)	590
Cash and cash equivalents, beginning of period	1,025	1,506	916
Cash and cash equivalents, end of period	$ 822	$ 1,025	$ 1,506
Supplemental cash flow disclosures			
Cash paid for interest	$ 618	$ 547	$ 418
Cash paid for income taxes	2,765	2,666	2,739

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements.

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Transactions with Subsidiaries. During 2013, the parent company issued intercompany notes of $1.5 billion that were used primarily to fund the purchase of Amil's remaining public shares. Additionally in 2013, the $2.6 billion term note issued in 2012 was reclassified to long-term. During 2012, the parent company completed a non-cash exchange of a $3.9 billion intercompany note to a subsidiary for a new term note of $2.6 billion and an equity interest of $1.3 billion.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.3 billion, $7.8 billion and $5.6 billion in 2013, 2012 and 2011, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements. Long-term debt obligations of the parent company do not include the other financing obligations at a subsidiary that totaled $121 million at December 31, 2013 or the Brazilian real denominated debt of a subsidiary with a total par value of $588 million at December 31, 2012 disclosed therein.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2014	$ 1,935
2015	1,055
2016	1,134
2017	1,260
2018	1,116
Thereafter	10,239

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 12, 2014

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director, President and Chief Executive Officer (principal executive officer)	February 12, 2014
/s/ DAVID S. WICHMANN **David S. Wichmann**	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations (principal financial officer)	February 12, 2014
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 12, 2014
* **William C. Ballard, Jr.**	Director	February 12, 2014
* **Edson Bueno**	Director	February 12, 2014
* **Richard T. Burke**	Director	February 12, 2014
* **Robert J. Darretta**	Director	February 12, 2014
* **Michele J. Hooper**	Director	February 12, 2014
* **Rodger A. Lawson**	Director	February 12, 2014
* **Douglas W. Leatherdale**	Director	February 12, 2014
* **Glenn M. Renwick**	Director	February 12, 2014
* **Kenneth I. Shine**	Director	February 12, 2014
* **Gail R. Wilensky**	Director	February 12, 2014

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 30, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on October 26, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.3	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan
*10.4	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.5	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.6	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.7	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

*10.9	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.10	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.12	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.14	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.15	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.16	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.17	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.18	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.19	Summary of Non-Management Director Compensation, effective as of October 1, 2013 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013)
*10.20	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10K for the year ended December 31, 2009)
*10.22	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.23	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)

*10.24	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.25	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.26	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.27	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.28	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.29	Amended and Restated Employment Agreement, dated as of August 8, 2011, between United HealthCare Services, Inc. and Gail K. Boudreaux (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011)
*10.30	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.31	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.32	Amended and Restated Employment Agreement, dated as of March 26, 2012, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012)
*10.33	Amended Employment Agreement, effective as of November 1, 2012, between Amil Assistência Médica Internacional S.A. and Dr. Edson de Godoy Bueno (incorporated by reference to Exhibit 10.32 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.34	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements")
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm

24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013, filed on February 12, 2014, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Shareholders' Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

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

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2012**

or

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

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Minnesota	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(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)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒ Accelerated filer ☐
Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2012 was $59,444,144,483 (based on the last reported sale price of $58.50 per share on June 30, 2012, on the New York Stock Exchange).*

As of January 31, 2013, there were 1,024,925,324 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we incorporate by reference certain information from our Definitive Proxy Statement for the 2013 Annual Meeting of Shareholders. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

* Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the Company have been excluded in determining this number.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company whose mission is to help people live healthier lives and help make health care work better (the terms "we," "our," "us," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries).

We are helping individuals access quality care at an affordable cost; simplifying health care administration and delivery; strengthening the physician/patient relationship; promoting evidence-based care; and empowering physicians, health care professionals, consumers, employers and other participants in the health system with actionable data to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides network-based health care benefits for a full spectrum of customers in the health benefits market. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, as well as students and other individuals, and will serve TRICARE West Region members beginning April 1, 2013. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare International includes Amil Participações S.A (Amil), a health care company providing health benefits and hospital and clinical services to individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, government, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that drive improved delivery, quality and cost effectiveness across eight business markets: integrated care delivery, care management, consumer engagement and support, distribution of benefits and services, health financial services, operational services and support, health care information technology and pharmacy.

Through UnitedHealthcare and Optum, in 2012, we managed nearly $150 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, see Note 13 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

UnitedHealthcare

UnitedHealthcare is advancing strategies to improve the way health care is delivered and financed, offering consumers a simpler, more affordable health care experience. Our market position is built on:

- a national scale;
- the breadth of our product offerings, which are responsive to many distinct market segments in health care;
- strong local market relationships;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- a commitment to innovation.

The financial results of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International have been aggregated in the UnitedHealthcare reportable segment due to their similar economic characteristics, products and services, customers, distribution methods, operational processes and regulatory environment. The domestic businesses also share significant common assets, including our contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx pharmacy benefit products and services, certain OptumHealth product offerings and care management and integrated care delivery services and OptumInsight health information and technology solutions, consulting and other services. UnitedHealthcare arranges for discounted access to care through networks that include a total of nearly 780,000 physicians and other health care professionals and approximately 5,900 hospitals and other facilities across the United States (UnitedHealthcare Network).

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual works closely with employers and individuals to provide health benefit plans that provide solutions to help members live healthier lives and achieve meaningful cost savings. UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide, providing nearly 27 million Americans access to health care as of December 31, 2012.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependants, UnitedHealthcare Employer & Individual receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependants, while UnitedHealthcare Employer & Individual provides customized services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision. Large employer groups, such as those serviced by UnitedHealthcare Employer & Individual National Accounts, typically use self-funded arrangements. As of December 31, 2012, UnitedHealthcare Employer & Individual National Accounts served 395 large employer groups under these arrangements, including 147 of the *Fortune 500* companies. Smaller employer groups are more likely to purchase risk-based products because they are less willing or able to bear a greater potential liability for health care expenditures. UnitedHealthcare Employer & Individual also offers a variety of non-employer based insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families.

As the commercial market becomes more consumer-oriented, individuals are assuming more personal and financial responsibility for their care, and they are demanding more affordable products, greater transparency and choice and personalized help navigating the complex system. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals. Individuals served by UnitedHealthcare Employer & Individual have access to 91% of the physicians and other health care professionals and 95% of the hospitals in the broad UnitedHealthcare Network; certain care providers are available only to those consumers served through Medicare and/or Medicaid products.

UnitedHealthcare Employer & Individual is engaging physicians and consumers and using information to promote well-informed health decisions, improved medical outcomes and greater efficiency. It offers consumers engaging and informative tools and resources that provide greater transparency around quality and cost, such as the Premium Designation® program and Health4Me for Apple® and Android® phones, myHealthcareCost Estimator, Health Care Lane and myuhc.com. These easy-to-use resources support better consumer decisions, affording members more control over their health care.

UnitedHealthcare Employer & Individual's distribution system consists primarily of producers (i.e., brokers and agents) and direct and internet sales in the individual market, producers in the small employer group market, and consultant-based or direct sales for larger employer and public sector segments. In recent years, the distribution model has been diversified to include professional employer organizations, associations, and private equity partners. UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs).

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, and allows the flexibility to meet the needs of employers of all sizes as well as individuals shopping for health benefits coverage. UnitedHealthcare Employer & Individual emphasizes local markets and leverages its national scale to adapt products quickly to meet specific market needs. UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans such as Choice and Options PPO to more traditional indemnity offerings. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products and Tools. Consumer engagement products couple plan design with financial accounts to increase employee ownership of their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer activation services such as personalized multi-channel activation messaging, behavioral incentive programs and consumer education information. During 2012, nearly 42,000 employer-sponsored benefit plans, including more than 200 employers in the large group self-funded market, purchased an HRA or HSA product. The consumer engagement tools provide members with online and/or mobile access to benefit, cost and quality information.

Value-Based Products. UnitedHealthcare Employer & Individual's suite of consumer incentive products increases individual awareness for heightened consumer responsibility and behavior change across diverse client segments and funding relationships. Examples include: Small Business Wellness, which is a packaged wellness and incentives product offering gym reimbursement and encouraging completion of important wellness activities. For mid-sized clients, SimplyEngaged is a scalable activity-based reward program that ties incentives to completion of health improvement activities, while SimplyEngaged Plus provides richer incentives for achieving health outcome goals. For large, self-funded customers, UnitedHealthcare Health Rewards program offers a flexible incentive design for employers to choose the right activities and biometric outcomes that best fit the needs of their population. Additionally, UnitedHealth Personal Rewards leverages a tailored approach to incentives by combining personalized scorecards with financial incentives for improving biometric scores, compliance with key health treatments and preventive care.

Essential Benefits Products. UnitedHealthcare Employer & Individual's portfolio of affordable products drives value to consumers with lower-cost products, innovative designs and unique network programs that guide people to physicians recognized for providing quality and cost efficient care to their patients. These approaches are designed to deliver sustainable health care costs, enabling employers to continue to offer their employees coverage at more affordable prices. Products such as Catalyst, Edge, Premium Tiered Benefit Plan, Navigate and CORE offer solutions for employers looking to achieve more affordable costs through tiered benefit plans that enhance benefits in the form of greater coinsurance coverage and/or lower copays for using UnitedHealth Premium designated providers.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefit management programs. The clinical and pharmacy benefit products complement the service offering by improving quality of care, engaging members and providing cost-saving options.

All UnitedHealthcare Employer & Individual members are provided access to clinical products with the goal of helping them make better health care decisions, and thus better use of their medical benefits, with the ultimate goal of improving health and decreasing medical expenses. Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured and self-funded), line of business (Individual, Small Business, Key Accounts, Public Sector, and National Accounts), and clinical need. The spectrum of clinical programs offered to all consumers, regardless of their health goals – staying healthy, getting healthy, living with a chronic condition includes: wellness, decision support, utilization management, case and disease management, and complex condition management, workplace on-site programs, including Know Your Numbers (biometrics) and flu shots, incentives to reinforce positive behavior change, mental health, substance use disorder management, employer assistance programs and well-being programs. The programs promote consumer engagement, health education, admission counseling before hospital stays, care advocacy to help avoid prolonged patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. Disease and condition management programs help individuals address significant, complex disease states, including disease-specific benefit offerings such as the Diabetes Health Plan.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to drive better unit costs, encouraging consumers to use drugs that offer better value and outcomes, and through physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

Specialty Offerings. UnitedHealthcare Employer & Individual also offers a comprehensive range of dental, vision, life, and disability product offerings delivered through an integrated approach that enhances efficiency and effectiveness and includes a network of nearly 55,000 vision professionals in private and retail settings, and nearly 210,000 dental providers.

UnitedHealthcare Military & Veterans. UnitedHealthcare Employer & Individual's Military & Veterans Services business unit has been awarded the Department of Defense's (DoD) TRICARE Managed Care Support contract to provide health care services for active duty and retired military service members and their families in the West Region. UnitedHealthcare Military & Veterans Services will be the Managed Care Support contractor serving more than 2.7 million TRICARE beneficiaries in 21 states. The contract includes a transition period and five one-year renewals at the government's option for health care operations. The first year of operations is anticipated to begin April 1, 2013.

UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration, and customer services. In partnership with government health programs, UnitedHealthcare Military & Veterans' mission is to improve the health and well-being of both those who currently serve in the military and have served in the military in the past, as well as their families, by providing innovative, high-quality and affordable health care solutions.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia, and most U.S. territories and has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to risk-based health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a wide spectrum of Medicare products which may be sold to individuals or on a group basis, including Medicare Advantage plans, Medicare Part D prescription drug coverage and Medicare Supplement/Medigap products that supplement traditional fee-for-service coverage. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 29% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2012, most of which were generated by UnitedHealthcare Medicare & Retirement under a number of contracts.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over; state and U.S. government agencies; and employer groups. Products are also offered through employer groups to retirees.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service (POS) plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS. Premium amounts vary based on the geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement had approximately 2.6 million members enrolled in its Medicare Advantage products as of December 31, 2012.

UnitedHealthcare Medicare & Retirement offers innovative care management and clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to proactively outreach to members to create individualized care plans and help members obtain the right care, in the right place, at the right time.

Prescription Drug Benefit (Part D). UnitedHealthcare provides Medicare prescription drug benefits (Part D) to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Part D plans. The portfolio of stand-alone Part D plans addresses a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. As of December 31, 2012, UnitedHealthcare had enrolled 6.8 million members in the Part D program, including 4.2 million members in the stand-alone Part D plans and 2.6 million members in its Medicare Advantage plans incorporating Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving approximately 4 million seniors through various Medicare Supplement products in association with AARP. We offer plans in all 50 states and most U.S. territories. These products cover varying levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to providing diversified solutions to states' programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage in exchange for a monthly premium per member from the applicable state. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program (CHIP), and other federal, state and community health care programs. States using managed care services for Medicaid beneficiaries select health plans using either a formal bid process, or award individual contracts. As of December 31, 2012, UnitedHealthcare Community & State participates in programs in 25 states and the District of Columbia, serving approximately 3.8 million beneficiaries. UnitedHealthcare Community & State serves populations that range in size from 9,000 people to more than 600,000 people. For those states or counties that choose not to enter into risk arrangements, UnitedHealthcare Community & State offers a variety of management services that leverage its infrastructure and experience, as well as the considerable health care system assets of UnitedHealth Group.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State include Temporary Assistance for Needy Families (TANF), CHIP, Aged Blind and Disabled, SNPs, Long-Term Care, Childless Adults & Programs, Dual Medicare-Medicaid Eligible (dually eligible) beneficiaries and other federal and state health care programs (e.g., Developmentally Disabled, Rehabilitative Services). The health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with higher risk medical, behavioral and social conditions. UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group, delivering them at the local market level to support effective care management, regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care. For example, the Personal Care Model establishes an ongoing relationship between health care professionals and individuals who have serious and chronic health conditions to help them maintain the best possible health and functional status, whether care is delivered in an acute care setting, long-term care facility or at home. Programs for families and children focus on high-prevalence and debilitating chronic illnesses such as hypertension and cardiovascular disease, asthma, sickle cell disease, diabetes, HIV/AIDS and high-risk pregnancies. Programs for the long-term care population focus on dementia, depression, coronary disease and functional-use deficiencies that impede daily living.

Additionally, there are more than nine million dually eligible beneficiaries who typically have complex conditions with costs of care that are far higher than a typical Medicare or Medicaid beneficiary. While these individuals' health needs are more complex and more costly, they have historically been in unmanaged environments. As of December 31, 2012, UnitedHealthcare serves more than 250,000 members in legacy dually eligible programs through Medicare Advantage and SNPs. In 2013, UnitedHealthcare Community & State will help implement Ohio's Integrated Medicare-Medicaid Eligible (MME) program, one of the first in the country under the new CMS design.

UnitedHealthcare International

UnitedHealthcare International provides solutions for consumers of domestic or cross-border health care management, insurance, and administration services; regardless of their geographic location, language or cultural origins. UnitedHealthcare International's goal is to create business solutions that are based on local infrastructure, culture and needs, and that blend local expertise with experiences from the U.S. health care industry.

Amil. In 2012, UnitedHealthcare International acquired Amil, which provides health and dental benefits to over five million people and also operates 22 acute hospitals, as well as specialty clinics, primary care, and emergency services across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of 45,000 physicians and other health care professionals, 3,300 hospitals and 12,000 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and values, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare International also includes other diversified global health services business with a variety of offerings for international customers, including:

- Network access and care coordination in the U.S. and overseas;
- TPA products and services for health plans and TPAs;
- Brokerage services;
- Practice management services for care providers;
- Government and corporate consulting services for improving quality and efficiency; and
- Global expatriate insurance solutions.

See Note 13 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for additional information related to the revenues and long-lived assets of the UnitedHealthcare International operations.

Optum

Optum is a health services business serving the broad health care marketplace including:

- Those who need care: the consumers and patients who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: physicians and other care providers, hospitals and clinical facilities seeking to modernize in ways that enable the best patient care and experience possible, delivered cost-effectively.
- Those who pay for care: insurers, employers and government agencies devoted to ensuring that those they sponsor receive high-quality care, administered and delivered efficiently.
- Those who innovate for care: life sciences and research focused organizations dedicated to developing more effective approaches, enabling technologies and medicines that improve the delivery and quality of care.

Using advanced data, analytics and technology, Optum helps improve overall health system performance: optimizing care quality, reducing costs and improving the consumer experience and care provider performance. Optum is organized in three segments:

- OptumHealth focuses on care management, integrated care delivery, and consumer solutions, including financial services;
- OptumInsight delivers operational services and support and health information technology services; and
- OptumRx specializes in pharmacy services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and financial needs of more than 61 million unique individuals and enabling consumer health management and integrated care delivery

through programs offered by employers, payers, government entities and, increasingly, directly through the care delivery system. OptumHealth's products and services can be deployed individually or integrated to provide comprehensive solutions, addressing a broad base of needs within the health care system. OptumHealth's solutions reduce costs for customers, improve workforce productivity and consumer satisfaction and optimize the overall health and well-being of populations.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served, and on an administrative fee basis whereby it manages or administers delivery of the products or services in exchange for a fixed fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, Veterans Administration and other federal procurement). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and integrated care delivery businesses.

OptumHealth is organized into three major operating groups: Care Management, Integrated Care Delivery and Consumer Solutions.

Care Management. Care Management includes Specialty Networks and Health Management Solutions.

- Specialty Networks: Within Specialty Networks, OptumHealth serves over 55 million people in two primary ways: 1) creating access to networks of provider specialists in the areas of behavioral health management (e.g., mental health, substance abuse), global well-being (e.g., international work/life solutions), chronic physical health management (e.g., chiropractic, physical therapy), and complex medical conditions (e.g., transplant, infertility); and 2) managing the care and health needs for consumers through a variety of programs utilizing predictive modeling, evidence-based clinical outcomes management and peer support. Specialty Networks addresses areas likely to have significant variation in clinical practice, where a disciplined, evidence-based approach can drive improved health outcomes and reduced costs. These range from relatively commonly accessed services (e.g., behavioral health and chiropractic) to less common procedures such as transplant, infertility, bariatric surgery and kidney disease/end stage renal disease.
- Health Management Solutions: OptumHealth serves more than 40 million people with population health management solutions (e.g., care management and advocacy, health and wellness, and complex conditions including cancer, neonatal and maternity) and decision support solutions (e.g., insurance choices and treatment and health care provider options). This comprehensive solution set empowers consumers to take more control of their health and well-being and enables their collaboration with specialty care providers, which is critical to decisions that drive medical costs, including hospitalization and surgery.

Integrated Care Delivery. Integrated Care Delivery is defined by the types of care delivery support services provided within OptumHealth's two businesses: Collaborative Care and Logistics Health, Inc. (LHI). Collaborative Care is driven by the recognition that the market is moving to a collaborative network aligned around the concept of total population health management and outcomes based reimbursement. Collaborative Care's local care delivery systems deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. Collaborative Care's complex population management services augment primary care physicians to deliver services outside of hospitals to vulnerable, chronically ill populations. Collaborative Care also delivers care to approximately 1 million people through a spectrum of models ranging from medical clinics to contracts with individual practice association networks. LHI designs and implements mobile care delivery solutions, providing occupational health, medical and dental readiness services, treatments and immunization programs for the U.S. military and U.S. Department of Health and Human Services (HHS), as well as for many commercial companies.

Consumer Solutions. Consumer Solutions includes consumer and marketing capabilities, such as distribution and financial services.

- Distribution: Connextions is a growth, retention and service solutions company meeting consumer distribution needs in the health care market. Through a combination of technology, campaign management and customer service, Connextions has developed a consumer relationship management and sales distribution platform. Services offered include call center support, software, data analysis, certified insurance brokers and trained nurses, which allow health care payers and providers to acquire, retain, schedule, refer and manage large populations of individual health care consumers. Connextions is also an enabler of health insurance exchange solutions, with private exchange business today.
- Financial Services: Dedicated solely to providing financial solutions for the health care market, OptumHealth Financial Services helps organizations and individuals optimize their health care finances. As a leading provider of consumer health care accounts (e.g., HSAs, flexible spending accounts), OptumHealth's tax-favored accounts enable individuals to save money today and build health savings for the future. Organizations rely upon OptumHealth to manage and improve their cash flows through turnkey electronic payment solutions (e.g., remittance advices, funds transfers), health care-related lending and credit (e.g., financing of care provider medical equipment acquisitions) and financial risk protection for third party payers and self-funded employers (e.g., comprehensive stop loss insurance coverage). Financial services includes Optum Bank. As of December 31, 2012, Financial Services had $1.8 billion in customer assets under management and during 2012 processed $66 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services, and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system work with OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape. As of December 31, 2012, OptumInsight's products and services are used by four out of five hospitals, tens of thousands of physician practices and other health care facilities, approximately 300 health plans, nearly 400 global life sciences companies, and many government agencies, as well as other UnitedHealth Group businesses.

Many of OptumInsight's software and information products, advisory consulting arrangements, and outsourcing contracts are performed over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. OptumInsight's aggregate backlog at December 31, 2012 was $4.6 billion, of which $2.7 billion is expected to be realized within the next 12 months. This includes $1.0 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services, the potential for cancellation, non-renewal, or early termination of service arrangements. OptumInsight's aggregate backlog at December 31, 2011 was $4.0 billion.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

OptumInsight's technology products and services solutions are offered through four integrated market groups. These market groups are care providers (e.g., physician practices and hospitals), commercial payers, governments and life sciences.

Care Providers. The Provider Solutions businesses combine a comprehensive range of technology and information products, advisory consulting, and outsourcing services focused on hospitals, integrated delivery networks, and physician practices. These solutions help drive financial performance, meet compliance requirements and deliver health intelligence and are organized around hospital and physician practice needs for:

- Financial Performance Improvement: Provides comprehensive revenue cycle management technology and services, claims integrity and coding solutions, and full business process outsourcing for hospitals and physicians practices to drive higher net patient revenue and lower operational costs;
- Quality Measurements and Compliance: Delivers real-time medical necessity reviews and retrospective appeals management services to more than 2,400 hospitals in all 50 states;
- Clinical Workflow and Connectivity: Provides high-acuity and ambulatory clinical workflow, clinical cost and performance analytics and benchmarks and electronic medical records software that makes hospital departments and physician practices more efficient, improves patient experience, and enables sharing of clinical data in integrated care settings; and
- Accountable Care Solutions: Working with early adopters of Accountable Care Organization models to build the administrative, analytics, compliance, and care management infrastructure to succeed in outcomes-based payment models.

Commercial Payers. OptumInsight's Payer Solutions group serves clients that offer commercial health insurance or privately administer health insurance programs on behalf of federal or state governments (e.g., Medicare Advantage or Managed Medicaid). The business offers technology, services and consulting capabilities that supplement OptumInsight's clients' existing operations, as well as fully outsourced solutions. The business addresses diverse needs for payer clients, serving four primary areas:

- Network Performance: Comprehensive offerings to enhance performance of provider networks and improve population health, including network design, management and operation services, as well as analytical tools that support care management;
- Clinical Performance and Compliance: Services that align clinical quality and performance with financial outcomes for payers, such as Medicare risk adjustment and CMS star rating system services and quality improvement consulting;
- Operational Efficiency and Payment Integrity: A spectrum of offerings focused on improving the efficiency and cost-effectiveness of payer operations. Solutions assist in addressing a wide variety of operational improvement opportunities such as process improvement and automation, fraud and abuse, claims payment accuracy and coordination of benefits; and
- Risk Optimization: Solutions help payers to grow and improve financial performance through predictive analytics and risk management services. Offerings include actuarial services, rating and underwriting products, and membership population modeling, as well as analytics and consulting.

Governments. OptumInsight Government Solutions helps state and federal governments improve the efficiency and quality of health and human services programs by offering a broad range of solutions including:

- Financial Management and Program Integrity: Improves the accuracy and efficiency of provider payments through prospective and retrospective analysis of claims transactions, driving detection of fraud and abuse and checking payment accuracy;
- Consulting: Provides policy and compliance consulting including health policy advisory services; and
- Data and Analytics Technology and Systems Integration: Measures and identifies opportunities for improvement in cost, network performance, and care management for populations of covered members. Government Solutions builds and manages health care specific data model and warehouse solutions for Federal and State based programs and applies business intelligence to analyze and drive decision making to improve cost, clinical outcomes, and member satisfaction.

Life Sciences. OptumInsight's Life Sciences business addresses the changing global economic and regulatory competitive landscape by assisting life sciences clients in identifying, analyzing and measuring the value of their products. Life Sciences provides expertise in using real-world evidence to support market access and positioning of products, to deliver strategic regulatory services, to provide insights into patient reported outcomes and to optimize and manage risk to Life Sciences' clients. Products include:

- Market Access and Reimbursement: Utilizes real-world evidence to drive increased drug revenues and pricing and reimbursements strategies;
- Health Economics Outcomes and Late Phase Research: decreased commercialization costs through health economics and outcomes research and late phase/Phase IV research studies;
- Data and Informatics Services;
- Regulatory Consulting: Focuses on design and execution of multi-national regulatory strategies to help clients speed regulatory approval and maintain compliance with dynamic regulations across geographies;
- Epidemiology and Drug Safety: Designs and executes epidemiology studies to understand detailed drug safety profiles and build integrated plans to address safety issues with regulators, providers, and patients; and
- Patient-Reported Outcomes: Drives collection and understanding of patient reported outcomes to inform comparative effectiveness research, patient engagement and adherence, and population health management.

OptumRx

OptumRx provides a full range of pharmacy benefit management (PBM) services to more than 14 million people nationwide, processing over 350 million adjusted retail, mail and specialty drug prescriptions and managing more than $25 billion in pharmaceutical spending annually. Its PBM services include benefit plan design and consultation, claims processing, manufacturer rebate contracting and administration, retail pharmacy network management services, mail order and specialty pharmacy services, Medicare Part D services, and a variety of clinical services, such as formulary management and compliance, drug utilization review and disease and drug therapy management services. The mail order and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component of its business, providing patients with convenient access to maintenance medications, offering a broad range of complex drug therapies and patient management services for individuals with chronic health conditions, and enabling OptumRx to manage its clients' drug costs through operating efficiencies and economies of scale.

OptumRx provides PBM services to nearly all members enrolled in the benefit plans that offer pharmacy benefits of UnitedHealthcare's Medicare & Retirement and Community & State businesses and also serves a portion of UnitedHealthcare's Employer & Individual's commercial members. In 2013, OptumRx will in-source approximately 12 million of UnitedHealthcare's commercial members who currently receive PBM services from Express Scripts' subsidiary, Medco Health Solutions, Inc. OptumRx also provides PBM services to non-affiliated external clients, including public and private sector employer groups, insurance companies, Taft-Hartley Trust Funds, TPAs, managed care organizations, Medicare-contracted plans, Medicaid plans and other sponsors of health benefit plans and individuals throughout the U.S. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated by U.S. federal and state as well as non-U.S. regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Reform Legislation, were signed into law in the first quarter of 2010 and, after being challenged, were substantially

upheld in a U.S. Supreme Court decision in the second quarter of 2012. The Health Reform Legislation, portions of which are summarized below, alters the regulatory environment in which we operate, in some cases to a significant degree. U.S. federal and state governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, as well as a result of changes in the political climate, could adversely affect our business.

In the event we fail to comply with, or we fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal, state and international laws and regulations.

Health Care Reforms

The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system. Certain provisions of the Health Reform Legislation have already taken effect and other provisions become effective at various dates over the next several years. The U.S. Department of Labor (DOL), HHS and the U.S. Treasury Department have issued or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance on other key aspects of the legislation remain pending.

The following outlines certain provisions of the Health Reform Legislation that are currently effective, currently effective with phased implementation or are expected to take effect in the coming years.

- *Currently Effective*: The Health Reform Legislation mandated the expansion of dependant coverage to include adult children until age 26; eliminated certain annual and lifetime caps on the dollar value of certain essential health benefits; eliminated pre-existing condition limits for enrollees under age 19; prohibited certain policy rescissions; prohibited plans and issuers from charging higher cost sharing (copayments or coinsurance) for emergency services that are obtained outside of a plan's network; and included a requirement to provide coverage for preventive services without cost to members (for non-grandfathered plans).

  Commercial fully insured health plans in the large employer group, small employer group and individual markets with medical loss ratios below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals, as calculated under the definitions in the Health Reform Legislation and regulations, subject to state specific exceptions) are required to rebate ratable portions of their premiums to their customers annually.

  The Health Reform Legislation also mandated certain changes to coverage determination and appeals processes, including: expanding the definition of "adverse benefit determination" to include rescissions; extending external review rights of adverse benefit determinations to insured and self-funded plans; and improving the clarity of and expanding the types of information in adverse benefit determination notices.

- *Currently Effective with Phased Implementation*: The Health Reform Legislation also mandated consumer discounts on brand name and generic prescription drugs for Part D plan participants in the coverage gap. These consumer discounts will gradually increase over the next several years, which will decrease consumer out-of-pocket drug spending within the coverage gap, shifting a portion of these costs to the plan sponsor. In 2012, the discount on brand name prescription drugs was 50% while the discount on generic prescription drugs was 14%.

  In addition, as required under the Health Reform Legislation, HHS established a federal premium rate review process, which generally applies to proposed rate increases equal to or exceeding 10%. The regulations further require commercial health plans to provide to the states and HHS extensive information supporting any rate increases subject to the new federal rate review process. The regulations clarify that HHS review will not supersede existing state review and approval processes, but plans deemed to have a

history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that are scheduled to become active under the Health Reform Legislation in 2014. Under current regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

CMS reduced or froze benchmarks which affect our Medicare Advantage reimbursements from CMS between 2009 and 2011, and in 2012, additional cuts to Medicare Advantage benchmarks began to take effect (benchmarks will ultimately range from 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), with changes continuing to be phased-in over the next one to five years, depending on the level of benchmark reduction in a county. In addition to other measures, quality bonuses may partially offset these anticipated benchmark reductions. CMS quality rating bonuses are paid to certain qualifying plans for a three year period that began in 2012. Quality bonuses are based upon STAR ratings at the local plan level, as determined by CMS, and are dependent on numerous factors, including member satisfaction and member behavior in the context of obtaining preventive screens.

- *Effective 2013*: Effective beginning in 2013 with respect to services performed after 2009, the Health Reform Legislation limits the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code for insurance providers if at least 25% of the insurance provider's gross premium revenue from health business is derived from health insurance plans that meet the minimum creditable coverage requirements.

- *Effective 2013/2014:* The Health Reform Legislation provides for an increase in Medicaid fee-for-service and managed care program reimbursements for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014, and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009.

- *Effective 2014*: A number of the provisions of the Health Reform Legislation are scheduled to take effect in 2014, including: an annual insurance industry assessment ($8 billion to be levied on the insurance industry in 2014 increasing to $14.3 billion by 2018 with increasing annual amounts thereafter), which is not deductible for income tax purposes; a transitional reinsurance program ($25 billion over a three-year period), which will be funded by a $5.25 per member per month fee (as currently estimated by HHS), on all comprehensive lines of business (including risk-based and self-insured) with only insurance plans for individuals eligible for reinsurance recoveries; a permanent risk adjustment program designed to promote stability in the individual and small employer group marketplace by transferring funds among competing plans based on variance in risk populations; all individual and group health plans must offer coverage on a guaranteed issue and guaranteed renewal basis during annual open enrollment and special enrollment periods and cannot apply pre-existing condition exclusions or health status rating adjustments; all individual and small group plans must provide certain essential health benefits, with member cost-sharing limitations and no annual limits on essential benefits coverage; establishment of state-based exchanges for individuals and small employers as well as certain CHIP eligibles; a temporary risk corridor program that limits the losses and gains of insurers that offer products on exchanges; introduction of plan designs based on set actuarial values to increase comparability of competing products on the exchanges and limit member cost-sharing obligations; and establishment of minimum medical loss ratio of 85% for Medicare Advantage plans, as calculated under rules that have not yet been issued.

The Health Reform Legislation and the related federal and state regulations will impact how we do business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase our medical and administrative costs, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business. In addition, our results of operations, financial position, including our ability to maintain the value of our goodwill, and cash flows could be materially and adversely affected by such changes. The Health Reform Legislation may also create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform

Legislation remains difficult to predict and is not yet fully known. See also Item 1A, “Risk Factors” for a discussion of the risks related to the Health Reform Legislation and related matters.

Other Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses, and certain aspects of our Optum businesses. Our UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and OptumHealth businesses submit information relating to the health status of enrollees to CMS (or state agencies) for purposes of determining the amount of certain payments to us. CMS also has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care given to Medicare beneficiaries. Beginning in 2014, our commercial business may be subject to audit related to the risk adjustment and reinsurance data. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” and Item 1A, “Risk Factors” for a discussion of audits by CMS.

Our UnitedHealthcare reportable segment, through UnitedHealthcare Community & State, also has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance, and the regulatory environment with respect to these programs has become and will continue to become increasingly complex as a result of the Health Reform Legislation. In addition, our UnitedHealthcare Military & Veterans business and certain of Optum’s businesses hold contracts with federal agencies including the DoD and we are subject to federal law and regulations relating to the administration of these contracts.

Certain of UnitedHealthcare’s and Optum’s businesses, such as UnitedHealthcare’s eyeglass manufacturing activities and Optum’s high acuity clinical workflow software, hearing aid products, and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration (FDA), and the clinical research activities are also subject to laws and regulations outside of the United States that regulate clinical trials. Laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust also affect us.

HIPAA, GLBA and Other Privacy and Security Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. HIPAA requires guaranteed health care coverage for small employers and certain eligible individuals. It also requires guaranteed renewability for employers and individuals and limits exclusions based on pre-existing conditions. Federal regulations related to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may also apply to us.

Federal privacy and security requirements change frequently because of legislation, regulations and judicial or administrative interpretation. For example, the U.S. Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), which significantly amends, and adds new privacy and security provisions to HIPAA and imposes additional requirements on uses and disclosures of health information. ARRA includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In January 2013, HHS issued its final regulations implementing the ARRA amendments to HIPAA and updating the HIPAA privacy, security and

enforcement rules. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information. The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with HIPAA, GLBA and other privacy-related regulations.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the DOL as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL provide additional rules for claims payment and member appeals under health care plans governed by ERISA. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, when implemented by states would require certain governance practices substantially similar to the Sarbanes-Oxley Act of 2002 and expand insurance company and HMO risk and solvency assessment reporting. We expect that states will adopt these or similar measures over the next few years, expanding the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Certain states have also adopted their own regulations for minimum medical loss ratios with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the Health Reform Legislation. We expect the states to continue to introduce and pass similar laws in 2013, and this will affect our operations and our financial results.

Health plans and insurance companies are also regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

In addition, some of our business and related activities may be subject to other health care-related regulations and requirements, including PPO, managed care organization (MCO), utilization review (UR) or TPA-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practice and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide

range of activities, including kickbacks for referral of members, billing unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker, and sales distributions laws and regulations. Our UnitedHealthcare Community & State, UnitedHealthcare Medicare & Retirement and certain Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies (and HMOs in some states), including those issuing health, long-term care, life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Assessments generally are based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets.

Pharmacy Regulation. OptumRx's mail order pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, "Risk Factors" for a discussion of the risks related to our PBM businesses.

Privacy and Security Laws. States have adopted regulations to implement provisions of the GLBA. Like HIPAA, GLBA allows states to adopt more stringent requirements governing privacy protection. A number of states have also adopted other laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security-related regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct service providers to care delivery systems and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit certain entities from practicing medicine or employing physicians to practice medicine. Additionally, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be a matter of judicial or regulatory interpretation. These laws, regulations and interpretations have, in certain states, been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation (FDIC), which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could be subjected to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses and operations are international in nature and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass tax, licensing, tariffs, intellectual property, investment, management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary from jurisdiction to jurisdiction, among other matters. We have recently acquired and may in the future acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our acquisition of Amil subjects us to Brazilian laws and regulations affecting the managed care and insurance industries and regulation by Brazilian regulators including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar (ANS), whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. For more information about the Amil acquisition, see Note 6 of Notes to the Consolidated Financial Statement included in Item 8, "Financial Statements." In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act.

Audits and Investigations

We have been and may in the future become involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, the FTC, U.S. Congressional committees, the U.S. Department of Justice (DOJ), U.S. Attorneys, the Securities and Exchange Commission (SEC), the Brazilian securities regulator, the Comissão de Valores Mobiliários (CVM), the Internal Revenue Service (IRS), the Brazilian federal revenue service — the Secretaria da Receita Federal (SRF), the DOL, the FDIC and other governmental authorities. Certain of our businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model. Such government investigations, audits and reviews can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. In addition, disclosure of any adverse investigation, audit results or sanctions could adversely affect our reputation in various markets and make it more difficult for us to sell our products and services while retaining our current business.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to directly contract with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various

health information and consulting companies. For our UnitedHealthcare businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association, and, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. Our OptumHealth and OptumInsight reportable segments also compete with a broad and diverse set of businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, "Risk Factors," for additional discussion of our risks related to competition.

EMPLOYEES

As of December 31, 2012, we employed approximately 133,000 individuals. We believe our employee relations are generally positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 6, 2013, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	60	President and Chief Executive Officer
David S. Wichmann	50	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations
Gail K. Boudreaux	52	Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare
Eric S. Rangen	56	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	59	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum
Marianne D. Short	61	Executive Vice President and Chief Legal Officer
Lori Sweere	54	Executive Vice President of Human Capital

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since January 2008, and has been a member of the Board of Directors since February 2000.

Mr. Wichmann is Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since January 2011. Mr. Wichmann has served as Executive Vice President and President of UnitedHealth Group Operations since April 2008. From January 2008 to April 2008, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of the Commercial Markets Group (now UnitedHealthcare Employer & Individual).

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since January 2011. Ms. Boudreaux has overall responsibility for all UnitedHealthcare health benefits businesses. Ms. Boudreaux served as Executive Vice President of UnitedHealth Group and President of UnitedHealthcare from May 2008 to January 2011. Prior to joining UnitedHealth Group, Ms. Boudreaux served as Executive Vice President of Health Care Services Corporation (HCSC) from January 2008 to April 2008.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since January 2008.

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations (now UnitedHealthcare Medicare & Retirement). Prior to joining UnitedHealth Group, Mr. Renfro served as President of Fidelity Developing Businesses at Fidelity Investments and as a member of the Fidelity Executive Committee from June 2008 to January 2009. From January 2008 to May 2008, Mr. Renfro held several senior positions at AARP Services Inc., including President and Chief Executive Officer of AARP Services Inc., Chief Operating Officer of AARP Services Inc., President and Chief Executive Officer of AARP Financial and President of the AARP Funds.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP from 2008 to 2012.

Ms. Sweere is Executive Vice President of Human Capital of UnitedHealth Group and has served in that capacity since January 2008.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "plan," project," "should" or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. 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 cautionary statements regarding our business that investors and others should consider. We do not undertake to address or update forward-looking statements in future filings or communications regarding our business or results of operations, 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 past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or 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. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in this report or any of our prior communications.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Under our risk-based benefit product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of these products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, the Health Reform Legislation established minimum medical loss ratios for certain health plans and authorized HHS to maintain an annual price increase review process for commercial health plans, which could make it more difficult for us to price our products competitively. See the risk factor below relating to health care reform for further discussion of these provisions. In addition, our OptumHealth Collaborative Care business negotiates capitation arrangements with commercial third party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to accurately predict, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue on commercial policies is typically at a fixed rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. We base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period; however, many factors may cause actual costs to exceed what was estimated and reflected

in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2012 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2012 would have been reduced by approximately $215 million, excluding any offsetting impact from premium rebates.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, our results of operations could be materially and adversely affected.

Our business activities are highly regulated; new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our results of operations, financial position and cash flows.

Our business is regulated at the federal, state, local and international levels. Our insurance and HMO subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, utilization review and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims, debt collection and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty fund laws, certain health, life and accident insurance companies and, in certain cases, HMOs can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business in these states, which would expose our business to the risk of insolvency of a competitor in these states.

Certain of our Optum businesses are also subject to regulatory and other risks and uncertainties, some of which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, FDA regulations, state telemedicine regulations and state corporate practice of medicine doctrines and fee-splitting rules, some of which could impact our relationships with physicians, hospitals and customers. Additionally, OptumHealth participates in the emerging private exchange markets and it is not yet known to what extent the states will issue new regulations that apply to private exchanges. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products, increase prices for certain regulated products and complete certain acquisitions and dispositions or integrate certain acquisitions. For

example, premium rates for our health insurance and/or managed care products are subject to regulatory review or approval in many states and by the federal government, and a number of states have enhanced (or are proposing to enhance) their rate review processes. In addition, geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Some of our businesses and operations are international in nature and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, management control, labor relations, fraud and corruption present compliance requirements and uncertainties for us that are different from those faced by U.S.-based businesses. We have recently acquired and may in the future acquire or commence additional businesses based outside of the United States. For example, our acquisition of Amil in October 2012 subjects us to Brazilian laws and regulations affecting the managed care and insurance industries, which vary from comparable U.S. laws and regulations, and regulation by Brazilian regulators, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. For more information about the Amil acquisition, see Note 6 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements.” In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price, damage our reputation in various markets or foster an increasingly active regulatory environment, which, in turn, could further increase the regulatory burdens under which we operate and our costs of doing business.

For a discussion of various laws and regulations that impact our businesses, see Item 1, “Business — Government Regulation.”

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system. Among other things, the Health Reform Legislation includes guaranteed coverage and expanded benefit requirements, eliminates pre-existing condition exclusions and annual and lifetime maximum limits, restricts the extent to which policies can be rescinded, establishes minimum medical loss ratios, creates a federal premium review process, imposes new requirements on the format and content of communications (such as explanations of benefits, or EOBs) between health insurers and their members, grants to members new and additional appeal rights, imposes new and significant taxes on health insurers and health care benefits, reduces the Medicare Part D coverage gap and reduces payments to private plans offering Medicare Advantage.

Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. HHS, the DOL and the Treasury Department have issued or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance

on other key aspects of the legislation remain pending. Due to the complexity of the Health Reform Legislation, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known. For example, effective in 2011, the Health Reform Legislation established minimum medical loss ratios for all commercial health plans in the large employer group, small employer group and individual markets (85% for large employer groups, 80% for small employer groups and 80% for individuals, calculated under the definitions in the Health Reform Legislation and regulations), subject to state specific exceptions. Companies with medical loss ratios below these targets are required to rebate ratable portions of their premiums to their customers annually. The medical loss ratios that determine the size of the rebates will be measured by state, by group size and by licensed subsidiary. This disaggregation of insurance pools into much smaller pools will likely decrease the predictability of results for any given pool and could lead to variation over time in the estimates of rebates owed in total. Effective in 2014, Medicare Advantage plans will be required to maintain a minimum medical loss ratio of 85%, although the rules expected to set forth the basis for calculating this medical loss ratio have not yet been issued. Some state Medicaid programs are also imposing medical loss ratio requirements on Medicaid managed care organizations, which generally require such plans to rebate ratable portions of their premiums to their state customers if they cannot demonstrate they have met the minimum medical loss ratios. Depending on our calculations of the medical loss ratios for each of our plans and the manner in which we adjust our business model in light of these requirements, there could be meaningful disruptions in local health care markets, and our market share, results of operations, financial position and cash flows could be materially and adversely affected.

In addition, the Health Reform Legislation requires the establishment of state-based health insurance exchanges for individuals and small employers by 2014. The types of exchange participation requirements ultimately enacted by each state, the availability of federal subsidies for premiums and cost-sharing reductions within exchanges, the potential for differential imposition of state benefit mandates inside and outside the exchanges, the operation of reinsurance, risk corridors and risk adjustment mechanisms inside and outside the exchanges and the possibility that certain states may restrict the ability of health plans to continue to offer coverage to individuals and small employers outside of the exchanges could result in disruptions in local health care markets and our results of operations, financial position and cash flows could be materially and adversely affected.

The Health Reform Legislation also includes specific reforms for the individual and small group marketplace, scheduled to take effect in January 2014, including adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (expected to result in benefit changes for many members) and actuarial value requirements likely to result in expanded benefits or reduced member cost sharing (or a combination of both) for some policyholders. Although HHS issued proposed regulations related to these provisions in late 2012, the federal regulations are not yet final and most states have not issued implementing regulations or guidance with respect to these provisions. Depending on the timing and outcome of the final federal regulations and required state regulations or guidance, there could be disruptions in local health care markets and our results of operations, financial position and cash flows could be materially and adversely affected.

The Health Reform Legislation includes a “maintenance of effort” (MOE) provision that requires states to maintain their eligibility rules for adults covered by Medicaid, until the Secretary of HHS determines that an insurance exchange is operational in a given state, scheduled for January 2014, and for children covered by Medicaid or CHIP, through federal fiscal year 2019. States with, or projecting, a budget deficit may apply for an exception to the MOE provision. If states are successful in obtaining MOE waivers and allow certain Medicaid programs to expire, we could experience reduced Medicaid enrollment, which could materially and adversely affect our results of operations, financial position and cash flows.

Under the U.S. Supreme Court’s June 2012 decision, state participation in the Health Reform Legislation’s Medicaid expansion is voluntary. Several states have indicated they may not expand their Medicaid programs based on concerns over costs when expanded federal funding pares down, starting in 2017. The extent to which states expand their Medicaid programs, or discontinue current expansion programs, could adversely impact our Medicaid enrollment levels, which could in turn materially and adversely affect our results of operations, financial position and cash flows.

Several of the provisions in the Health Reform Legislation will likely increase our medical cost trends. Examples of these provisions are the excise tax on medical devices, annual fees on prescription drug manufacturers, enhanced coverage requirements (including essential health benefit requirements and phased-in closing of the coverage gap for Medicare Part D participants), the prohibition of pre-existing condition exclusions and the implementation of adjusted community rating requirements. The annual insurance industry assessment ($8 billion to be levied on the insurance industry in 2014 increasing to $14.3 billion by 2018 with increasing annual amounts thereafter), which is not deductible for income tax purposes, and the temporary reinsurer's fee ($25 billion to be levied on all commercial lines of business including insured and self-funded arrangements, over a three-year period starting in 2014), will increase our operating costs. Premium increases or benefit reductions will be necessary to offset the impact these and other provisions will have on our medical and operating costs. These premium increases are often subject to state regulatory approval, and the Federal government is encouraging states to intensify their reviews of requests for rate increases by commercial health plans and providing funding to assist in those state-level reviews. We have begun to experience greater regulatory challenges to appropriate premium rate increases in several states, including California and New York. In addition, as required under the Health Reform Legislation, HHS established a federal premium rate review process, which became effective in September 2011 and generally applies to proposed rate increases equal to or exceeding 10%. The regulations further require commercial health plans in the individual and small group markets to provide to the states and HHS extensive information supporting rate increases. If we are not able to secure approval for adequate premium increases to offset increases in our cost structure or if consumers forego coverage as a result of such premium increases, our margins, results of operations, financial position and cash flows could be materially and adversely affected. In addition, plans deemed to have a history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that become active under the Health Reform Legislation in 2014. Under the regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

We also expect that implementation of the Health Reform Legislation will increase the demand for products and capabilities offered by our Optum businesses. We have made and will continue to make strategic decisions and investments based, in part, on these assumptions, and our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under the Health Reform Legislation than we expect or we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for our Optum businesses does not increase.

Future regulatory or legislative action could further impact the implementation of Health Reform Legislation. For example, Congress may attempt to amend or withhold the funding necessary to implement the Health Reform Legislation. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the Health Reform Legislation. New federal or state laws and regulations could force us to materially change how we do business and any amendment, withholding of funding, extended delays in the issuance of necessary federal and state implementing regulations or guidance or other uncertainty regarding the Health Reform Legislation could materially and adversely impact our ability to capitalize on the opportunities presented by the legislation or cause us to incur additional costs of compliance or reverse some of the changes we have already implemented. In addition, our market share, our results of operations, our financial position, including our ability to maintain the value of our goodwill, and our cash flows could be materially and adversely affected by legislative and regulatory changes.

For additional information regarding the Health Reform Legislation, see Item 1, "Business — Government Regulation" and Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations — Executive Overview — Regulatory Trends and Uncertainties."

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs, CHIP and our TRICARE West contract with the DoD, and receive substantial revenues from these programs. We also provide services to payers through our Optum businesses. These programs generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs are dependent upon periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs is dependent upon many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level, and general political issues and priorities. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are expected in the next few years. Although we have adjusted members' benefits and premiums on a selective basis, terminated benefit plans in certain counties, and intensified both our medical and operating cost management in response to these benchmark reductions, there can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage program. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies may materially and adversely affect our results of operations, financial position and cash flows.

Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and we will not have additional members auto-assigned to us. For example, we lost approximately 470,000 of our auto-enrolled low-income subsidy members in 2012 because certain of our bids exceeded thresholds set by the government. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Medicare program or other programs on which we bid, or our competitors submit bids at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the Health Reform Legislation, CMS has developed a system entitling plans that meet certain quality ratings at the local plan level to various quality bonus payments. In addition, under the Health Reform Legislation, Congress authorized CMS and the states to implement MME managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MME demonstration programs for dually eligible beneficiaries, or our inability to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been audited. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the "error rate" identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service (FFS) "error rate" adjuster that will be used in determining the payment adjustment. Depending on the plans selected for audit, if any, and the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been and may in the future become involved in various governmental investigations, audits, reviews and assessments. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the OIG, the Office of Personnel Management, the Office of Civil Rights, the FTC, U.S. Congressional committees, the DOJ, U.S. Attorneys, the SEC, the CVM, the IRS, the SRF, the DOL, the FDIC and other governmental authorities. Certain of our businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model. Such investigations, audits or reviews sometimes arise out of or prompt claims by private litigants or whistleblowers that, among other things, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could expand to subjects beyond those targeted by the original investigation, audit, review, assessment or private action and could lead to government actions, which could result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for a discussion of certain of these matters.

If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, or if we fail to address emerging security threats or detect and prevent privacy and security incidents, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Further, many of our businesses are subject to the Payment Card Industry Data Security Standards (PCI DSS), which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. See Item 1, "Business — Government Regulation" for additional information. HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. Even though we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we still have limited oversight or control over their actions and practices.

Our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations.

Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. For example, final HHS regulations released in January 2013 implementing the ARRA amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern their relationships with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business as a mail order pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices. See Item 1, “Business — Government Regulation” for a discussion of various federal and state laws and regulations governing our PBM businesses.

Our PBM businesses would also be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to timely process and dispense prescriptions and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or entering into certain prohibited transactions.

UnitedHealthcare Employer & Individual recently began to transition pharmacy benefit management for approximately 12 million of its commercial members, including pharmacy claims adjudication and customer service, from Express Scripts' subsidiary, Medco Health Solutions, Inc., to OptumRx. If our customers are not satisfied with our pharmacy benefit management services as a result of this transition, UnitedHealthcare Employer & Individual could face loss of business, which could adversely impact our results of operations, financial position and cash flows.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States and face significant competition in all of the geographic markets in which we operate. We compete with other companies on the basis of many factors, including price of benefits offered and cost and risk of alternatives, location and choice of health care providers, quality of customer service, comprehensiveness of coverage offered, reputation for quality care, financial stability and diversity of product offerings. For our UnitedHealthcare businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association, and, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. Our OptumHealth and OptumInsight reportable segments also compete with a broad and diverse set of businesses.

In particular markets, competitors may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; or other factors that give such competitors a competitive advantage. In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products, our business, results of operations, financial position and cash flows could be materially and adversely affected.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be materially and adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for services. Our results of operations and prospects are substantially dependent on our continued ability to contract for these services at competitive prices. Failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, accountable care organizations (ACOs), practice management companies, which aggregate physician practices

for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationships with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our results of operations, financial position and cash flows could be adversely affected. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. There can be no assurance that health care providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, it is either not defined or it is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example, we are involved in litigation with out-of-network providers, as described in more detail in “Litigation Matters” in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements.”

The success of certain Optum businesses, particularly Collaborative Care, depends on maintaining satisfactory physician relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. If we are unable to maintain satisfactory relationships with primary care physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. If our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or to adequately price their contracts with these third party payers, our results of operations, financial position and cash flows could be materially and adversely affected.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

Because of the nature of our business, we are routinely subject to various litigation actions, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties and/or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

Because of the nature of our business, we are routinely made party to a variety of legal actions related to, among other things, the design, management and delivery of our product and service offerings. These matters have

included or could in the future include claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort (including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we periodically acquire businesses or commence operations in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters; however, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

A description of significant legal actions in which we are currently involved is included in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements.” We cannot predict the outcome of these actions with certainty, and we are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in select markets and businesses.

Any failure by us to successfully manage our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to both AARP members and non-members. If we fail to meet the needs of AARP and its members, including by developing additional products and services, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliance with the AARP could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations. We are required to integrate these businesses into our internal control environment, which may present challenges that are different than those presented by organic growth and that may be difficult to manage. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we continue to expand our business outside the United States, acquired foreign businesses, such as Amil, will present challenges that are different from those presented by acquisitions of domestic businesses, including adapting to new markets, business, labor and cultural practices and regulatory environments that are materially different from what we have experienced in our U.S. operations. For more information on the Amil acquisition, see Note 6 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements.” Adapting to these challenges could require us to devote significant senior management and other resources to the

acquired businesses before we realize anticipated benefits or synergies from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation, and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to successfully manage our foreign acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Additionally, foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and the future costs of or revenues and cash flows from our international operations, and any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of independent producers and consultants.

Our products are sold in part through independent producers and consultants who assist in the production and servicing of business. We typically do not have long-term contracts with our producers and consultants, who generally are not exclusive to us and who typically also recommend and/or market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be materially and adversely affected if we were unable to attract or retain independent producers and consultants or if we do not adequately provide support, training and education to them regarding our product portfolio, or if our sales strategy is not appropriately aligned across distribution channels.

Because producer commissions are included as administrative expenses under the medical loss ratio requirements of the Health Reform Legislation, these expenses will be under the same cost reduction pressures as other administrative costs. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

In addition, there have been a number of investigations regarding the marketing practices of producers selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and producers marketing and selling these companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment rates have caused and could continue to cause lower enrollment or lower rates of renewal in our employer group plans and our non-employer individual plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. All of these could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to payments already negotiated and/or received from the government

and could materially and adversely affect our results of operations, financial position and cash flows. In addition, the state and federal budgetary pressures could cause the government to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and health maintenance organizations and surcharges or fees on select fee-for-service and capitated medical claims, and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, a prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2012. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and a prolonged low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal and/or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and we may be required to write down the value of our investments, which could materially and adversely affect our profitability and shareholders' equity.

We also allocate a small proportion of our portfolio to equity investments, which are subject to greater volatility than fixed income investments. General economic conditions, stock market conditions, and many other factors beyond our control can materially and adversely affect the value of our equity investments and may result in investment losses.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and debt ratings could be materially and adversely affected.

Goodwill and other intangible assets were $36.0 billion as of December 31, 2012, representing 44% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the manner in or the extent to which the Health Reform Legislation is implemented may impact our ability to maintain the value of our goodwill and other intangible assets in our business. Similarly, the value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, adversely impact our debt ratings or potentially impact our compliance with our debt covenants.

If we fail to properly maintain the integrity or availability of our data or to strategically implement new or upgrade or consolidate existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to adequately price our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to accurately report our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we periodically consolidate, integrate, upgrade and expand our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, emerging cybersecurity risks and threats, and changing customer patterns. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, have regulatory sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, protecting our systems against cybersecurity risks and threats, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install hardware and software products, and these products may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

In addition, uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations and financial position could be materially and adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations and financial position could be materially and adversely affected.

Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically and there can be no assurance that current credit ratings will be maintained in the future. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. Downgrades in our credit ratings, should they occur, may adversely affect our results of operations, financial position and cash flows.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

ITEM 4. MINE SAFETY DISCLOSURES

N/A

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2013, there were 15,204 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE were as follows:

	High	Low	Cash Dividends Declared
2013			
First quarter (through February 6, 2013)	$57.83	$51.36	$0.2125
2012			
First quarter	$59.43	$49.82	$0.1625
Second quarter	$60.75	$53.78	$0.2125
Third quarter	$59.31	$50.32	$0.2125
Fourth quarter	$58.29	$51.09	$0.2125
2011			
First quarter	$45.75	$36.37	$0.1250
Second quarter	$52.64	$43.30	$0.1625
Third quarter	$53.50	$41.27	$0.1625
Fourth quarter	$51.71	$41.32	$0.1625

DIVIDEND POLICY

In June 2012, our Board of Directors increased our cash dividend on common stock to an annual dividend rate of $0.85 per share, paid quarterly. Since May 2011, we had paid an annual cash dividend on common stock of $0.65 per share, distributed quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2012

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
October 31, 2012	—	$ —	—	94
November 30, 2012	—	—	—	94
December 31, 2012	9	54	9	85
Total	9	$ 54	9	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2012, the Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs). There is no established expiration date for the program.

UNREGISTERED SALE OF EQUITY SECURITIES

On November 2, 2012, we issued and sold, in reliance on Section 4(a)(2) of the Securities Act of 1933, as amended, 8 million shares of our common stock to CSHG 1122 FUNDO DE INVESTIMENTO MULTIMERCADO — CRÉDITO PRIVADO INVESTIMENTO NO EXTERIOR, a fund wholly beneficially owned by Dr. Edson de Godoy Bueno, a member of our Board of Directors. We received net proceeds of approximately $470 million in cash and did not pay underwriting or placement discounts or fees in the transaction. Dr. Bueno has agreed to hold the shares for five years from the date of sale, subject to certain exceptions.

PERFORMANCE GRAPHS

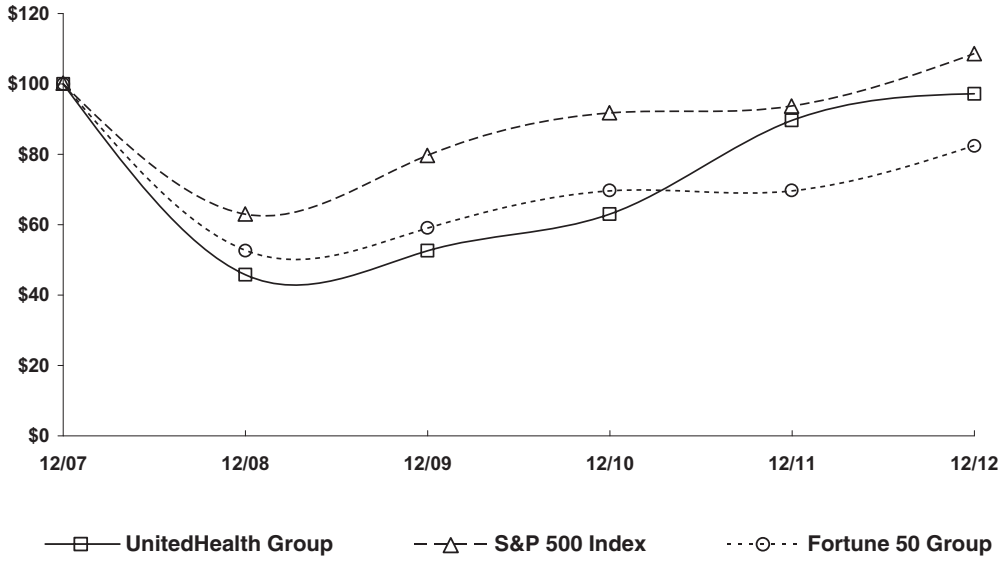
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group"), for the five-year period ended December 31, 2012. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2012. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2007 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and Fortune 50 Group



	12/07	12/08	12/09	12/10	12/11	12/12
UnitedHealth Group	**$100.00**	**$45.74**	**$52.49**	**$62.93**	**$89.48**	**$ 97.17**
S&P 500 Index	**100.00**	**63.00**	**79.67**	**91.67**	**93.61**	**108.59**
Fortune 50 Group	**100.00**	**52.66**	**58.88**	**69.57**	**69.55**	**82.41**

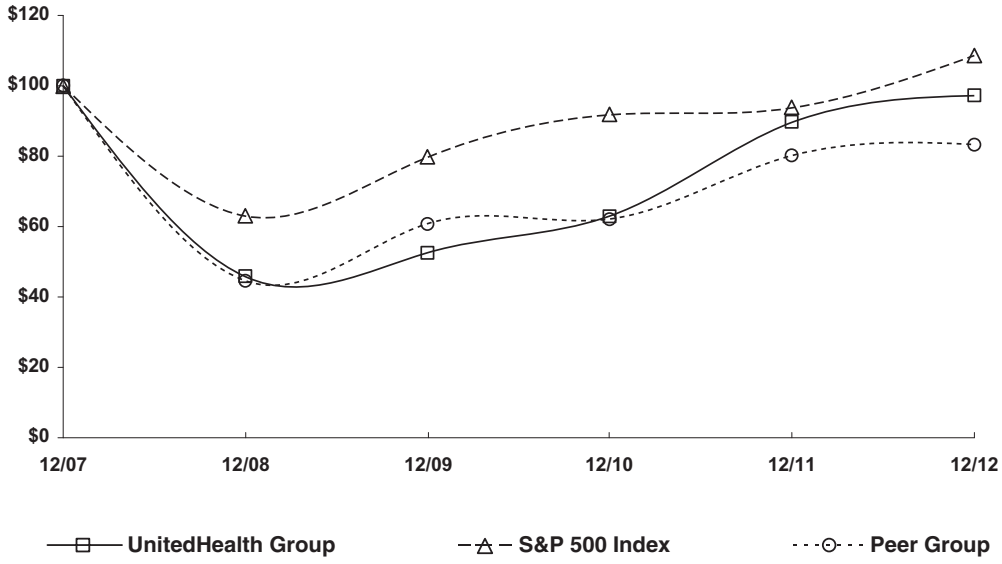
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc. and WellPoint, Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index,
and a Peer Group



	12/07	12/08	12/09	12/10	12/11	12/12
UnitedHealth Group	**$100.00**	**$45.74**	**$52.49**	**$62.93**	**$89.48**	**$ 97.17**
S&P 500 Index	**100.00**	**63.00**	**79.67**	**91.67**	**93.61**	**108.59**
Peer Group	**100.00**	**44.58**	**60.73**	**62.11**	**80.06**	**83.33**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(In millions, except percentages and per share data)	For the Year Ended December 31, 2012	2011	2010	2009	2008
Consolidated operating results					
Revenues	$110,618	$101,862	$94,155	$87,138	$81,186
Earnings from operations	9,254	8,464	7,864	6,359	5,263
Net earnings	5,526	5,142	4,634	3,822	2,977
Return on shareholders' equity (a)	18.7%	18.9%	18.7%	17.3%	14.9%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 5.38	$ 4.81	$ 4.14	$ 3.27	$ 2.45
Diluted earnings per share attributable to UnitedHealth Group common shareholders	5.28	4.73	4.10	3.24	2.40
Cash dividends declared per common share	0.8000	0.6125	0.4050	0.0300	0.0300
Consolidated cash flows from (used for)					
Operating activities	$ 7,155	$ 6,968	$ 6,273	$ 5,625	$ 4,238
Investing activities	(8,649)	(4,172)	(5,339)	(976)	(5,072)
Financing activities	471	(2,490)	(1,611)	(2,275)	(605)
Consolidated financial condition					
(As of December 31)					
Cash and investments	$ 29,148	$ 28,172	$25,902	$24,350	$21,575
Total assets	80,885	67,889	63,063	59,045	55,815
Total commercial paper and long-term debt	16,754	11,638	11,142	11,173	12,794
Shareholders' equity	31,178	28,292	25,825	23,606	20,780
Debt to debt-plus-equity ratio	35.0%	29.1%	30.1%	32.1%	38.1%

(a) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

Financial Highlights should be read with the accompanying Management's Discussion and Analysis of Financial Condition and Results of Operations in Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. 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. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making health care work better. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services. Further information on our business is included in Item 1, "Business" and additional information on the our segments can be found in this Item 7 and in Note 13 to the Consolidated Financial Statements in Item 8, "Financial Statements."

Revenues

Our revenues are primarily comprised of premiums derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and we assume the economic risk of funding our customers' health care benefits and related administrative costs. We also generate revenues from fee-based services performed for customers that self-insure the health care costs of their employees and employees' dependants. For both risk-based and fee-based health care benefit arrangements, we provide coordination and facilitation of medical services; transaction processing; health care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. We also generate service revenues from our Optum businesses relating to care management, consumer engagement and support, distribution of benefits and services, health financial services, operational services and support, health care information technology and pharmacy services. Product revenues are mainly comprised of products sold by our pharmacy benefit management business. We derive investment income primarily from interest earned on our investments in debt securities; investment income also includes gains or losses when investment securities are sold, or other-than-temporarily impaired.

Pricing Trends. We seek to price our products consistent with anticipated underlying medical trends, while balancing growth, margins, competitive dynamics, cost increases for the industry fees and tax provisions of Health Reform Legislation and premium rebates at the local market level. We endeavor to sustain a commercial medical care ratio in a stable range for an equivalent mix of business. Changes in business mix and Health Reform Legislation may impact our premiums, medical costs and medical care ratio. Further, we continue to expect premium rates to be under pressure through continued market competition in commercial products and government payment rates. Aggregating UnitedHealthcare's businesses, we expect the medical care ratio to rise over time as we continue to grow in the senior and public markets and participate in the health benefit exchange market in 2014.

In the commercial market segment, we expect pricing to continue to be highly competitive in 2013. We plan to hold to our pricing disciplines and, considering the competitive environment and persistently weak employment and new business formation rates, we expect continued pressure on our commercial risk-based product membership in 2013. Additionally, self-insured membership as a percent of total commercial membership is expected to continue to increase at a modest pace in 2013 and beyond, due in part to the emerging popularity of midsize employers moving to self-funded arrangements.

In government programs, we are seeing continuing rate pressures, and rate changes for some Medicaid programs are slightly negative. Unlike in prior years, recent Medicaid reductions have generally not been mitigated by corresponding benefit reductions or care provider fee schedule reductions by the state sponsor. We continue to take a prudent, market-sustainable posture for both new bids and maintenance of existing Medicaid contracts. Medicare funding is similarly pressured; see further discussion below in "Regulatory Trends and Uncertainties." We expect these factors to result in pressure on gross margin percentages for our Medicare and Medicaid programs in 2013.

In 2013, UnitedHealthcare created a new affordable "Basic Plan" for Medicare Part D consumers and reclassified its large 4 million member Medicare Part D plan to an "Enhanced Plan" status with CMS. The change to Enhanced Plan status changes the seasonal pattern of earnings to later in the year with no material impact expected on full year profitability.

Operating Costs

Medical Costs. Medical costs represent the costs of our obligations for claims and/or benefits of our risk-based insurance arrangements. Our operating results depend in large part on our ability to effectively estimate, price for and manage our medical costs through underwriting criteria, product design, negotiation of favorable care provider contracts and care coordination programs. Controlling medical costs requires a comprehensive and integrated approach to organize and advance the full range of interrelationships among patients/consumers, health professionals, hospitals, pharmaceutical/technology manufacturers and other key stakeholders.

Medical costs include estimates of our obligations for medical care services rendered on behalf of insured consumers for which we have not yet received or processed claims, and our estimates for physician, hospital and other medical cost disputes. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Our medical care ratio, calculated as medical costs as a percentage of premium revenues, reflects the combination of pricing, rebates, benefit designs, consumer health care utilization and comprehensive care facilitation efforts.

Medical Cost Trends. In 2012, we managed our commercial medical cost trend to a level under 5.5 percent. In 2013, we expect a slight increase in trend from 2012, albeit with relatively consistent unit cost and utilization trends compared to 2012. We expect our total trend will be driven primarily by continued unit cost pressure from health care providers as they try to compensate for soft utilization trends and cross-subsidization pressure due to their government reimbursement levels.

Underlying utilization trends declined significantly in 2010 and increased modestly in 2011 and 2012. Use of outpatient services has been the primary driver of utilization trend increase, with inpatient utilization declining. We also experienced an increase in prescription drug costs in 2012 and expect that trend to continue due to unit cost pressure and a trend towards expensive new specialty drugs. As we move into 2013, we believe current utilization trends are slightly below what we believe to be normal utilization levels. The weak economic environment, combined with our medical cost management, has had a favorable impact on utilization trends. We believe our alignment of progressive benefit designs, consumer engagement, clinical management, pay-for-performance reimbursement programs for care providers and network resources is favorably controlling medical and pharmacy costs, enhancing affordability and quality for our customers and members and helping to drive strong market response and growth.

Operating Costs. Operating costs are primarily comprised of costs related to employee compensation and benefits, agent and broker commissions, premium taxes and assessments, professional fees, advertising and occupancy costs. We seek to improve our operating cost ratio, calculated as operating costs as a percentage of total revenues, for an equivalent mix of business. However, changes in business mix, such as increases in the size of our health services businesses or an increase in the delivery of medical services on an integrated basis may impact our operating costs and operating cost ratio.

Other Business Trends

Our businesses participate in the U.S., Brazilian and certain other health economies. In the U.S., health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, including in the U.S. enacted health care reforms, which could also impact our results of operations.

Delivery System and Payment Modernization. The market is changing based on demographic shifts, new regulations, political forces and both payer and patient expectations. These factors are creating market pressures to change from fee-for-service models to new delivery models focused on the holistic health of the consumer, integrated care across care providers and pay-for-performance payment structures. Health plans and care providers are being called upon to work together to close gaps in care and improve the overall care for people, improve the health of a population and reduce the cost of care. The focus on delivery system modernization and payment reform is critical and the alignment of incentives between key constituents remains an important theme. We have seen increased participation in incentive-based payment models such as pay for performance, shared savings, bundled/episode payment and Patient-Centered Medical Home models (PCMHs). We also have seen continued development and deployment of risk-based accountable care models designed to modernize local delivery systems by better coordinating care, reducing the fragmentation of treatments between multiple care providers in the current system, limiting unnecessary hospital admissions and readmissions, focusing on preventive care, breaking down reimbursement and treatment “silos,” and improving quality and outcomes.

This trend is creating the need for health management services that can coordinate care around the primary care physician and for investment in new clinical and administrative information and management systems, providing growth opportunities for our Optum business platform.

Government Reliance on Private Sector. The government, as a benefit sponsor, has been increasingly relying on private sector solutions. We expect this trend to continue as we believe the private sector provides a more flexible, better managed, higher quality health care experience than do traditional passive indemnity programs typically used in governmental benefit programs.

States are struggling to balance unprecedented budget pressures with increases in their Medicaid expenditures. At the same time, many are expanding their interest in managed care with particular emphasis on consumers who have complex and expensive health care needs. More and more, Medicaid managed care is being viewed as an effective method to improve quality and manage costs. Additionally, there are more than nine million individuals eligible for both Medicare and Medicaid. Dually eligible beneficiaries typically have complex conditions with costs of care that are far higher than a typical Medicare or Medicaid beneficiary. While these individuals’ health needs are more complex and more costly, they have historically been in unmanaged environments. This provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid financing to fund efforts to optimize the health status of this frail population through close coordination of care. As of December 31, 2012, UnitedHealthcare served more than 250,000 members in legacy dually eligible programs through Medicare Advantage and SNPs. In 2013, UnitedHealthcare Community & State will help implement Ohio’s MME program, one of the first in the country under the new CMS design.

Regulatory Trends and Uncertainties

Following is a summary of management’s view of the trends and uncertainties related to some of the key provisions of the Health Reform Legislation and other regulatory items; for additional information regarding the Health Reform Legislation and Regulatory Trends and Uncertainties, see Item 1, “Business — Government Regulation” and Item 1A, “Risk Factors.”

Commercial Rate Increase Review. The Health Reform Legislation requires HHS to maintain an annual review of "unreasonable" increases in premium rates for commercial health plans. HHS established a review threshold of annual premium rate increases generally at or above 10% and clarified that HHS review will not supersede existing state review and approval procedures. Premium rate review legislation (ranging from new or enhanced rate filing requirements to prior approval requirements) has been introduced or passed in more than half of the states as of the date of this report.

The competitive forces common in our markets do not support unjustifiable rate increases. We have experienced and expect to continue to experience a tight, competitive commercial pricing environment. Further, our rates and rate filings are developed using methods consistent with the standards of actuarial practices. We anticipate requesting rate increases above 10% in a number of markets due to the combination of medical cost trends and the incremental costs of health care reform. We have begun to experience greater regulatory challenges to appropriate premium rate increases in several states, including California and New York. Depending on the level of scrutiny by the states, there is a broad range of potential business impacts. For example, it may become more difficult to price our commercial risk business consistent with expected underlying cost trends, leading to the risk of operating margin compression in the commercial health benefits business.

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage pricing benchmarks have been cut over the last several years and additional cuts were implemented in 2012, with changes to continue to be phased in over the next one to five years (benchmarks will ultimately range from 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), depending on the level of benchmark reduction in a county. Additionally, Congress passed the Budget Control Act of 2011, which as amended by the American Taxpayer Relief Act of 2012, would trigger automatic across-the-board budget cuts (sequestration), including a reduction in outlays for Medicare starting in March 2013, absent further Congressional action. Further, beginning in 2014, Medicare Advantage plans will be required to have a minimum medical loss ratio of 85%. CMS has not yet issued guidance as to how this requirement will be calculated for Medicare Advantage plans.

A significant portion of our network contracts are tied to Medicare reimbursement levels. However, future Medicare Advantage rates may be outpaced by underlying medical cost trends, placing continued importance on effective medical management and ongoing improvements in administrative costs. There are a number of annual adjustments we can and are making to our operations, which may partially offset any impact from these rate reductions. For example, we seek to intensify our medical and operating cost management, adjust members' benefits and decide on a county-by-county basis in which geographies to participate. Additionally, achieving high quality scores from CMS for improving upon certain clinical and operational performance standards will impact future quality bonuses that may offset these anticipated rate reductions. The expanded stars bonus program is set to expire in 2014. In 2015, quality bonus payments will only be paid to 4 and 5 star plans per PPACA (compared to current bonuses that are available to certain qualifying plans rated 3 stars or higher). Approximately 60% and 10% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and 4 stars or higher, respectively for the 2014 payment year based on scoring released by CMS in October 2012. Updated scores, to be released in October 2013, will determine what portion of our Medicare Advantage membership will reside in a 4 star or 5 star plan and qualify for quality bonus payments in 2015. Although we are dedicating substantial resources to improving our quality scores and star ratings, if we are unable to significantly increase the level of membership in plans with a rating of 4 stars or higher for the 2015 payment year, our 2015 results of operations and cash flows could be adversely impacted.

We also may be able to mitigate the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. Compared to 2011, our 2012 Medicare Advantage membership has increased by 400,000 consumers, or 18%, including acquisitions. Longer term, market wide decreases in the availability or relative quality of Medicare Advantage products may increase demand for other senior health benefits products such as our Medicare Supplement and Medicare Part D insurance offerings.

Industry Fees and Taxes. The Health Reform Legislation includes an annual, non-deductible insurance industry tax to be levied proportionally across the insurance industry for risk-based products, beginning January 1, 2014. The amount of the annual tax is $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will be equal to the annual tax for the preceding year increased by the rate of premium growth for the preceding year. The annual tax will be allocated based on the ratio of an entity's net premiums written during the preceding calendar year to the total health insurance industry's net premiums written for any U.S. health risk-based products during the preceding calendar year, subject to certain exceptions. This tax will first be paid and expensed in 2014; however, because our policies are annual, we have included the tax and other Health Reform Legislation cost factors in our 2013 rate filings relating to 2014 rate periods and any related premium increases for 2013 policies that have coverage into 2014 will increase the amount of premium recognized in 2013. Our effective income tax rate will increase significantly in 2014 as a result of the non-deductibility of these taxes.

With the introduction of state health insurance exchanges in 2014, the Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs are: a transitional reinsurance program; a temporary risk corridors program; and a permanent risk adjustment program. The transitional reinsurance program is a temporary program which will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements ($25 billion over a three-year period beginning in 2014 of which $20 billion (subject to increases based on state decisions) will fund the state reinsurance pools and $5 billion funds the U.S. Treasury). The terms of the specific reinsurance programs to be used in each state are not yet known.

It is our intention to pass these taxes and fees on to customers through increases in rates and/or decreases in benefits, subject to regulatory approval.

State-Based Exchanges and Coverage Expansion. Effective in 2014, state-based exchanges are required to be established for individuals and small employers with enrollment processes scheduled to commence in October of 2013. We expect to selectively respond and participate in exchanges as they are introduced to the market. Our level of participation in state-based exchanges will be driven by how we assess each local market's current and future prospects, including how the exchange and its rules are set up state-by-state and, our market position relative to others in the market. Our participation will likely evolve and change over time as the exchange markets mature. Exchanges will create new market dynamics that could impact our existing businesses, depending on the ultimate member migration patterns for each market, its pace and its impact on our established membership. For example, certain small employers may no longer offer health benefits to their employees and larger employers may elect to convert their benefit plans from risk-based to self-funded programs.

The Health Reform Legislation also provides for expanded Medicaid coverage effective in January 2014. These measures remain subject to implementation at the state level.

Individual & Small Group Market Reforms. The Health Reform Legislation includes several provisions that will take effect on January 1, 2014 and are expected to alter the individual and small group marketplace. Although HHS issued proposed regulations in late 2012, these regulations are not yet final. Key provisions include: (1) adjusted community rating requirements, which will change how individual and small group plans are rated in many states and are expected to result in significant adjustments in some policyholders' rates during the transition period; (2) essential health benefit requirements, which will result in benefit changes for many individual and small group policyholders and will also impact rates; and (3) actuarial value requirements, which will significantly impact benefit designs (e.g. member cost sharing requirements) and could also significantly impact rates for some policyholders.

RESULTS SUMMARY

(in millions, except percentages and per share data)	For the Years Ended December 31, 2012	2011	2010	Increase/ (Decrease) 2012 vs. 2011		Increase/ (Decrease) 2011 vs. 2010	
Revenues:							
Premiums	$ 99,728	$ 91,983	$85,405	$7,745	8%	$6,578	8%
Services	7,437	6,613	5,819	824	12	794	14
Products	2,773	2,612	2,322	161	6	290	12
Investment and other income	680	654	609	26	4	45	7
Total revenues	110,618	101,862	94,155	8,756	9	7,707	8
Operating costs:							
Medical costs	80,226	74,332	68,841	5,894	8	5,491	8
Operating costs	17,306	15,557	14,270	1,749	11	1,287	9
Cost of products sold	2,523	2,385	2,116	138	6	269	13
Depreciation and amortization	1,309	1,124	1,064	185	16	60	6
Total operating costs	101,364	93,398	86,291	7,966	9	7,107	8
Earnings from operations	9,254	8,464	7,864	790	9	600	8
Interest expense	(632)	(505)	(481)	127	25	24	5
Earnings before income taxes	8,622	7,959	7,383	663	8	576	8
Provision for income taxes	(3,096)	(2,817)	(2,749)	279	10	68	2
Net earnings	$ 5,526	$ 5,142	$ 4,634	$ 384	7%	$ 508	11%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 5.28	$ 4.73	$ 4.10	$ 0.55	12%	$ 0.63	15%
Medical care ratio (a)	80.4%	80.8%	80.6%	(0.4)%		0.2%	
Operating cost ratio	15.6	15.3	15.2	0.3		0.1	
Operating margin	8.4	8.3	8.4	0.1		(0.1)	
Tax rate	35.9	35.4	37.2	0.5		(1.8)	
Net margin	5.0	5.0	4.9	—		0.1	
Return on equity (b)	18.7%	18.9%	18.7%	(0.2)%		0.2%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2012 year-over-year operating comparisons to 2011 and other 2012 significant items.

- Consolidated revenues increased 9% and UnitedHealthcare revenues increased 8%.
- UnitedHealthcare medical enrollment grew by 6.4 million people, including 4.4 million people served in Brazil as a result of the Amil acquisition; Medicare Part D stand-alone membership decreased by 0.6 million people.
- The consolidated medical care ratio of 80.4% decreased 40 basis points.
- Earnings from operations increased 8% at UnitedHealthcare and 14% at Optum.
- Net earnings of $5.5 billion and diluted earnings per share of $5.28 increased 7% and 12%, respectively.

- $1.1 billion in cash was held by non-regulated entities as of December 31, 2012.
- 2012 debt offerings amounted to $4 billion, including the August debt exchange.
- Cash paid for acquisitions in 2012, net of cash assumed, totaled $6.5 billion, including the fourth quarter acquisition of approximately 65% of the outstanding shares of Amil. We also plan to acquire an additional 25% of Amil in the first half of 2013. See Note 6 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” for further detail on Amil.
- We repurchased 57 million shares for $3.1 billion and paid dividends of $0.8 billion.

2012 RESULTS OF OPERATIONS COMPARED TO 2011 RESULTS

Consolidated Financial Results

Revenues

Revenue increases in 2012 were driven by growth in the number of individuals served and premium rate increases related to underlying medical cost trends in our UnitedHealthcare businesses and growth in our Optum health service and technology offerings.

Medical Costs

Medical costs increased in 2012 due to risk-based membership growth in our public and senior markets businesses, unit cost inflation across all businesses and continued moderate increases in health system use, partially offset by an increase in favorable medical reserve development. Unit cost increases represented the primary driver of our medical cost trend, with the largest contributor being price increases to hospitals.

Operating Costs

The increases in our operating costs for 2012 were due to business growth, including increases in revenues from UnitedHealthcare fee-based benefits and Optum services, which carry comparatively higher operating costs, as well as investments in the OptumRx pharmacy management services and UnitedHealthcare Military & Veterans businesses.

Income Tax Rate

The increase in our effective income tax rate for 2012 was due to the favorable resolution of various tax matters in 2011, which lowered the 2011 effective income tax rate.

Reportable Segments

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

See Note 13 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” and Item 1, “Business” for a description of how each of our reportable segments derives its revenues.

Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and integrated care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management’s estimate of fair value. Intersegment transactions are eliminated in consolidation.

The following table presents reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2012	2011	2010	Increase/ (Decrease) 2012 vs. 2011		Increase/ (Decrease) 2011 vs. 2010	
Revenues							
UnitedHealthcare	$103,419	$ 95,336	$ 88,730	$8,083	8%	$6,606	7%
OptumHealth	8,147	6,704	4,565	1,443	22	2,139	47
OptumInsight	2,882	2,671	2,342	211	8	329	14
OptumRx	18,359	19,278	16,724	(919)	(5)	2,554	15
Total Optum	29,388	28,653	23,631	735	3	5,022	21
Eliminations	(22,189)	(22,127)	(18,206)	62	—	3,921	22
Consolidated revenues	$110,618	$101,862	$ 94,155	$8,756	9%	$7,707	8%
Earnings from operations							
UnitedHealthcare	$ 7,815	$ 7,203	$ 6,740	$ 612	8%	$ 463	7%
OptumHealth	561	423	511	138	33	(88)	(17)
OptumInsight	485	381	84	104	27	297	354
OptumRx	393	457	529	(64)	(14)	(72)	(14)
Total Optum	1,439	1,261	1,124	178	14	137	12
Consolidated earnings from operations	$ 9,254	$ 8,464	$ 7,864	$ 790	9%	$ 600	8%
Operating margin							
UnitedHealthcare	7.6%	7.6%	7.6%	— %		— %	
OptumHealth	6.9	6.3	11.2	0.6		(4.9)	
OptumInsight	16.8	14.3	3.6	2.5		10.7	
OptumRx	2.1	2.4	3.2	(0.3)		(0.8)	
Total Optum	4.9	4.4	4.8	0.5		(0.4)	
Consolidated operating margin	8.4%	8.3%	8.4%	0.1%		(0.1)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenue by business:

(in millions, except percentages)	For the Years Ended December 31, 2012	2011	2010	Increase/ (Decrease) 2012 vs. 2011		Increase/ (Decrease) 2011 vs. 2010	
UnitedHealthcare Employer & Individual	$ 46,596	$45,404	$42,550	$1,192	3%	$2,854	7%
UnitedHealthcare Medicare & Retirement (a)	39,257	34,933	33,018	4,324	12	1,915	6
UnitedHealthcare Community & State (a)	16,422	14,954	13,123	1,468	10	1,831	14
UnitedHealthcare International	1,144	45	39	1,099	nm	6	15
Total UnitedHealthcare revenue	$103,419	$95,336	$88,730	$8,083	8%	$6,606	7%

nm = not meaningful

(a) In the fourth quarter of 2012, UnitedHealthcare reclassified 75,000 dually eligible enrollees to UnitedHealthcare Community & State from UnitedHealthcare Medicare & Retirement to better reflect how these members are served. Earlier periods presented have been conformed to reflect this change.

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2012	2011	2010	Increase/ (Decrease) 2012 vs. 2011		Increase/ (Decrease) 2011 vs. 2010	
Commercial risk-based	9,340	9,550	9,405	(210)	(2)%	145	2%
Commercial fee-based	17,585	16,320	15,405	1,265	8	915	6
Total commercial	26,925	25,870	24,810	1,055	4	1,060	4
Medicare Advantage (a)	2,565	2,165	2,005	400	18	160	8
Medicaid (a)	3,830	3,600	3,385	230	6	215	6
Medicare Supplement (Standardized)	3,180	2,935	2,770	245	8	165	6
Total public and senior	9,575	8,700	8,160	875	10	540	7
International	4,425	—	—	4,425	nm	—	—
Total UnitedHealthcare — medical	40,925	34,570	32,970	6,355	18%	1,600	5%
Supplemental Data:							
Medicare Part D stand-alone	4,225	4,855	4,530	(630)	(13)%	325	7%

nm = not meaningful

(a) Earlier periods presented above have been recast such that all periods presented reflect the dually eligible enrollment change from Medicare Advantage to Medicaid discussed above.

Commercial risk-based membership decreased in 2012 due to a competitive market environment, conversions to fee-based products by large public sector clients that we retained and other decreases in the public sector. In fee-based commercial products, the increase was due to a number of new business awards and strong customer retention. Medicare Advantage increased due to strengthened execution in product design, marketing and local engagement, which drove sales growth, combined with the addition of 185,000 Medicare Advantage members from 2012 acquisitions. Medicaid growth was due to a combination of winning new state accounts and growth within existing state customers, partially offset by a fourth quarter market withdrawal from one product in a specific region, affecting 175,000 beneficiaries. Medicare Supplement growth was due to strong retention and new sales. In our Medicare Part D stand-alone business, membership decreased primarily as a result of the first quarter 2012 loss of approximately 470,000 auto-assigned low-income subsidy Medicare Part D beneficiaries, due to pricing benchmarks for the government-subsidized low income Medicare Part D market coming in below our bids in a number of regions. International represents commercial membership in Brazil added as a result of the Amil acquisition in 2012.

UnitedHealthcare's revenue growth in 2012 was primarily due to growth in the number of individuals served, commercial premium rate increases related to expected increases in underlying medical cost trends and the impact of lower premium rebates.

UnitedHealthcare's earnings from operations for 2012 increased compared to the prior year primarily due to the factors that increased revenues combined with an improvement in the medical care ratio driven by effective management of medical costs and increased favorable medical reserve development. The favorable development for 2012 was driven by lower than expected health system utilization levels and increased efficiency in claims handling and processing.

In March 2012, UnitedHealthcare Military & Veterans was awarded the TRICARE West Region Managed Care Support Contract. The contract, for health care operations, includes a transition period and five one-year renewals at the government's option. The first year of operations is anticipated to begin April 1, 2013. The base administrative services contract is expected to generate a total of $1.4 billion in revenues over the five years.

Optum. Total revenues increased in 2012 due to business growth and 2011 acquisitions at OptumHealth, partially offset by a reduction in pharmacy service revenues related to reduced levels of UnitedHealthcare Part D prescription drug membership and related prescription volumes.

Optum's earnings from operations and operating margin for 2012 increased compared to 2011 due to improvements in operating cost structure stemming from advances in business simplification, integration and overall efficiency and revenue growth in higher margin products.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth for 2012 were primarily due to market expansion, including growth related to 2011 acquisitions in integrated care delivery, and strong overall business growth.

Earnings from operations for 2012 and operating margins increased compared to 2011 primarily due to gains in operating efficiency and cost management as well as increases in earnings from integrated care operations.

OptumInsight

Revenues at OptumInsight for 2012 increased primarily due to the impact of growth in compliance services for care providers and payment integrity offerings for commercial payers, which was partially offset by the June 2011 divestiture of the clinical trials services business.

The increases in earnings from operations and operating margins for 2012 reflect an improved mix of services and advances in operating efficiency and cost management.

OptumRx

The decreases in OptumRx revenues in 2012 were due to the reduction in UnitedHealthcare Medicare Part D plan participants. Intersegment revenues eliminated in consolidation were $15.6 billion for 2012 and $16.7 billion for 2011.

OptumRx earnings from operations and operating margins for 2012 decreased primarily due to decreased prescription volume in the Medicare Part D business and investments to support growth initiatives, which were partially offset by earnings contributions from specialty pharmacy growth and greater use of generic medications.

Over the course of 2013, we will consolidate and manage our commercial pharmacy benefit programs from Express Scripts' subsidiary, Medco Health Solutions, Inc. As a result of this transition, OptumRx expects to add approximately12 million members throughout 2013.

2011 RESULTS OF OPERATIONS COMPARED TO 2010 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues for 2011 were driven by strong organic growth in the number of individuals served in our UnitedHealthcare businesses, commercial premium rate increases reflecting underlying medical cost trends and revenue growth across all Optum businesses.

Medical Costs

Medical costs for 2011 increased due to risk-based membership growth in our commercial and public and senior markets businesses and continued increases in the cost per service paid for health system use, and a modest increase in health system utilization, mainly in outpatient and physician office settings.

For each period, our operating results include the effects of revisions in medical cost estimates related to prior periods. Changes in medical cost estimates related to prior periods, resulting from more complete claim information identified in the current period, are included in total medical costs reported for the current period. For 2011 and 2010 there was $720 million and $800 million, respectively, of net favorable medical cost development related to prior fiscal years. The favorable development in both periods was primarily driven by continued improvements in claims submission timeliness, which resulted in higher completion factors and lower than expected health system utilization levels. The favorable development in 2010 also benefited from a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

Operating Costs

The increase in our operating costs for 2011 was due to business growth, including an increased mix of Optum and UnitedHealthcare fee-based and service revenues, which have higher operating costs, and increased spending related to reform readiness and compliance. These factors were partially offset by overall operating cost management and the increase in 2010 operating costs due to the goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses.

Income Tax Rate

The effective income tax rate for 2011 decreased compared to the prior year due to favorable resolution of various historical tax matters in the current year as well as a higher effective income tax rate in 2010, due to the cumulative implementation of certain changes under the Health Reform Legislation.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth for 2011 was due to growth in the number of individuals served across our businesses and commercial premium rate increases reflecting expected underlying medical cost trends.

UnitedHealthcare's earnings from operations for 2011 increased compared to the prior year as revenue growth and improvements in the operating cost ratio more than offset increased compliance costs and an increase to the medical care ratio, which was primarily due to the initiation of premium rebate obligations in 2011, and lower favorable reserve development levels.

Optum. Total revenue for these businesses increased in 2011 due to business growth and acquisitions at OptumHealth and OptumInsight and growth in customers served through pharmaceutical benefit management programs at OptumRx.

Optum's operating margin for 2011 was down compared to 2010. The decrease was due to changes in business mix within Optum's businesses and realignment of certain internal business arrangements.

The results by segment were as follows:

OptumHealth

Increased revenues at OptumHealth for 2011 were primarily due to expansions in service offerings through acquisitions in clinical services, as well as growth in consumer and population health management offerings.

Earnings from operations for 2011 and operating margin decreased compared to 2010. The decreases reflect the impact from internal business and service arrangement realignments and the mix effect of growth and expansion in newer businesses such as clinical services.

OptumInsight

Increased revenues at OptumInsight for 2011 were due to the impact of organic growth and the full-year impact of 2010 acquisitions, which were partially offset by the divestiture of the clinical trials services business in June 2011.

The increases in earnings from operations and operating margins for 2011 reflect an increased mix of higher margin services in 2011 as well as the effect on 2010 earnings from operations and operating margin of the goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses.

OptumRx

The increase in OptumRx revenues for 2011 was due to increased prescription volumes, primarily due to growth in customers served through Medicare Part D prescription drug plans by our UnitedHealthcare Medicare & Retirement business, and a favorable mix of higher revenue specialty drug prescriptions. Intersegment revenues eliminated in consolidation were $16.7 billion and $14.4 billion for 2011 and 2010, respectively.

OptumRx earnings from operations and operating margins for 2011 decreased as the mix of lower margin specialty pharmaceuticals and Medicaid business and investments to support growth initiatives including the in-sourcing of our commercial pharmacy benefit programs more than offset the earnings contribution from higher revenues and greater use of generic medications.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short- and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before non-cash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the NAIC. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an "extraordinary dividend" and must receive prior regulatory approval. In 2012, based on the 2011 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends which could be paid by our U.S. regulated subsidiaries to their parent companies was $4.6 billion.

In 2012, our regulated subsidiaries paid their parent companies dividends of $4.9 billion, including $1.2 billion of extraordinary dividends. In 2011, our regulated subsidiaries paid their parent companies dividends of $4.5 billion, including $1.1 billion of extraordinary dividends.

Our non-regulated businesses also generate cash flows from operations for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long term debt as well as issuance of commercial paper or drawings under our committed credit facility, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash

(in millions)	For the Years Ended December 31, 2012	2011	2010	Increase/ (Decrease) 2012 vs. 2011	Increase/ (Decrease) 2011 vs. 2010
Sources of cash:					
Cash provided by operating activities	$ 7,155	$ 6,968	$ 6,273	$ 187	$ 695
Proceeds from issuances of long-term debt and commercial paper, net of repayments	4,567	346	94	4,221	252
Proceeds from common stock issuances	1,078	381	272	697	109
Net proceeds from customer funds administered	—	37	974	(37)	(937)
Other	—	391	20	(391)	371
Total sources of cash	12,800	8,123	7,633		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed and dispositions	(6,280)	(1,459)	(2,304)	(4,821)	845
Common stock repurchases	(3,084)	(2,994)	(2,517)	(90)	(477)
Purchases of investments, net of sales and maturities	(1,299)	(1,695)	(2,157)	396	462
Purchases of property, equipment and capitalized software, net of dispositions	(1,070)	(1,018)	(878)	(52)	(140)
Cash dividends paid	(820)	(651)	(449)	(169)	(202)
Net cash paid for customer funds administered	(324)	—	—	(324)	—
Acquisition of noncontrolling interest shares	(319)	—	—	(319)	—
Other	(627)	—	(5)	(627)	5
Total uses of cash	(13,823)	(7,817)	(8,310)		
Net (decrease) increase in cash	$ (1,023)	$ 306	$ (677)	$(1,329)	$ 983

2012 Cash Flows Compared to 2011 Cash Flows

Cash flows from operating activities for 2012 increased $187 million, or 3% from 2011 due to increased net income and related tax accruals, which were partially offset by the payment in 2012 of 2011 premium rebate obligations as 2012 was the first year rebate payments were made under the Health Reform Legislation.

Cash flows used for investing activities increased $4.5 billion, or 107%, primarily due to increased investments in acquisitions in 2012. See Note 6 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” for further information on 2012 acquisitions.

Cash flows from financing activities increased $3.0 billion primarily due to increases in long-term debt, commercial paper and common stock issuances, partially offset by increases in cash paid for customer funds related to Part D and increased shareholder dividend payments. The increases in long-term debt, commercial paper and common stock issuances were primarily related to the Amil acquisition.

2011 Cash Flows Compared to 2010 Cash Flows

Cash flows from operating activities increased $695 million, or 11%, from 2010. The increase was primarily driven by growth in net earnings and changes in various working capital accounts, which were partially offset by a reduction in unearned revenues due to the early receipt of certain 2011 state Medicaid premium payments in 2010, which increased 2010 cash from operating activities.

Cash flows used for investing activities decreased $1.2 billion, or 22%, primarily due to relatively lower investments in acquisitions in 2011 and a decrease in net purchases of investments.

Cash flows used for financing activities increased $879 million, or 55%, primarily due to increased share repurchases and cash dividends in 2011, partially offset by an increase in net borrowings.

Financial Condition

As of December 31, 2012, our cash, cash equivalent and available-for-sale investment balances of $28.3 billion included $8.4 billion of cash and cash equivalents (of which $1.1 billion was held by non-regulated entities), $19.2 billion of debt securities and $677 million of investments in equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. The use of different market assumptions or valuation methodologies, especially those used in valuing our $241 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” for further detail of our fair value measurements.

Our cash equivalent and investment portfolio had a weighted-average duration of 2.1 years and a weighted-average credit rating of “AA” as of December 31, 2012. Included in the debt securities balance was $1.9 billion of state and municipal obligations that are guaranteed by a number of third parties. Due to the high underlying credit ratings of the issuers, the weighted-average credit rating of these securities with and without the guarantee was “AA” as of December 31, 2012. We do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers. The commercial paper program is supported by the bank credit facilities described below. As of December 31, 2012, we had $1.6 billion of commercial paper outstanding at a weighted-average annual interest rate of 0.3%.

Bank Credit Facilities**.** We have $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 21 banks, which mature in November 2017 and November 2013, respectively. These facilities provide liquidity support for our $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2012. The interest rates on borrowings are variable depending on term and are calculated based on the LIBOR plus a credit spread based on our senior unsecured credit ratings. As of December 31, 2012, the annual interest rates on these facilities, had they been drawn, would have ranged from 1.0% to 1.3%.

Our bank credit facilities contain various covenants, including requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, which reasonably approximates the actual covenant ratio, was 35.0% as of December 31, 2012. We were in compliance with our debt covenants as of December 31, 2012.

Long-term debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

In connection with the Amil acquisition, we assumed variable rate debt denominated in Brazilian Reais, Amil's functional currency. The total Brazilian Real denominated long-term debt outstanding at December 31, 2012 was $611 million, and had an aggregate weighted average interest rate of approximately 9%. For more detail on the Amil debt see Note 8 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

In October 2012, we issued $2.5 billion in senior unsecured notes, which included: $625 million of 0.850% fixed-rate notes due October 2015, $625 million of 1.400% fixed-rate notes due October 2017, $625 million of 2.750% fixed-rate notes due February 2023 and $625 million of 3.950% fixed-rate notes due October 2042.

In August 2012, we completed an exchange of $1.1 billion of our zero coupon senior unsecured notes due November 2022 for $0.5 billion additional issuance of our 2.875% notes due in March 2022, $0.1 billion additional issuance of our 4.375% notes due March 2042 and $0.1 billion in cash. The transaction was undertaken to increase financial flexibility and reduce interest expense.

In March 2012, we issued $1.0 billion in senior unsecured notes. The issuance included $600 million of 2.875% fixed-rate notes due March 2022 and $400 million of 4.375% fixed-rate notes due March 2042.

Credit Ratings. Our credit ratings at December 31, 2012 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Negative	A	Stable	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Share Repurchase Program. Under our Board of Directors' authorization, we maintain a share repurchase program. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2012, our Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock. As of December 31, 2012, we had Board authorization to purchase up to an additional 85 million shares of our common stock. For details of our 2012 share repurchases, see Note 10 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

Dividends. In June 2012, our Board of Directors increased our cash dividend to shareholders to an annual dividend rate of $0.85 per share, paid quarterly. Since May 2011, we had paid an annual dividend of $0.65 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change. For details of our dividend payments, see Note 10 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

Amil Tender Offer. During the fourth quarter of 2012, we purchased approximately 65% of the outstanding shares of Amil for $3.5 billion. We expect to acquire an additional 25% ownership interest during the first half of 2013 through a tender offer for Amil's publicly traded shares. The tender offer price will be at the same price

paid to Amil's controlling shareholders, adjusted for statutory interest under Brazilian law from the date of payment to the controlling shareholders to the date of payment to the tendering minority shareholders.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2012, under our various contractual obligations and commitments:

(in millions)	2013	2014 to 2015	2016 to 2017	Thereafter	Total
Debt (a)	$3,413	$3,271	$3,384	$16,769	$26,837
Operating leases	380	676	510	556	2,122
Purchase obligations (b)	137	184	7	—	328
Future policy benefits (c)	135	256	265	1,923	2,579
Unrecognized tax benefits (d)	11	—	—	60	71
Other liabilities recorded on the Consolidated Balance Sheet (e)	89	18	6	1,511	1,624
Other obligations (f)	50	144	60	43	297
Redeemable noncontrolling interests (g)	1,393	182	546	—	2,121
Total contractual obligations	$5,608	$4,731	$4,778	$20,862	$35,979

(a) Includes interest coupon payments and maturities at par or put values. For variable rate debt, the rates in effect at December 31, 2012 were used to calculate the interest coupon payments. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2012.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter."

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, charitable contributions related to the PacifiCare acquisition and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."

(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

(g) Includes commitments to purchase the remaining publicly traded Amil shares as well as the put/call for the shares owned by Amil's remaining non-public shareholders. See Note 6 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

We do not have other significant contractual obligations 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.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2012, we were not involved in any off-balance sheet arrangements (as that phrase is defined by SEC rules applicable to this report) which have or are reasonably likely to have a material adverse effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

We have determined that there have been no recently issued, but not yet adopted, accounting standards that will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

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 processing backlogs, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the 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. As of December 31, 2012, our days outstanding in medical payables was 49 days.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust 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). Medical costs in 2012, 2011, and 2010 included favorable medical cost development related to prior years of $860 million, $720 million and $800 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical

costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. This approach is consistently applied from period to period.

Completion Factors. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. The completion factor includes judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2012:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 261
(0.50)	173
(0.25)	87
0.25	(86)
0.50	(172)
0.75	(257)

Medical cost PMPM trend factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design, and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates including: our ability and practices to manage medical costs, changes in level and mix of services utilized, mix of benefits offered including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2012:

Medical Costs PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 505
2	337
1	168
(1)	(168)
(2)	(337)
(3)	(505)

The analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2012, developed using consistently applied actuarial methods. Management believes

the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2012; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2012 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2012 net earnings would have increased or decreased by $62 million.

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.

Effective in 2011, U.S. commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the Health Reform Legislation, that fall below certain targets are required to rebate ratable portions of their premiums to their customers annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because we are able to reasonably estimate the ultimate premiums of these contracts. Each period, we estimate premium rebates based on the expected financial performance of the applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience.

Our Medicare Advantage and Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the government, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for additional information regarding these audits.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategy. Key assumptions used in these forecasts include:

- *Revenue trends.* Key drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions around unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated.
- *Medical cost trends.* See further discussion of medical costs trends within Medical Costs above. Similar factors are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost productivity initiatives.
- *Capital levels.* The capital structure and requirements for each business is considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, “Business—Government Regulation”. For additional discussions regarding how the enactment or implementation of health care reforms and how other factors could affect our business and the related long-term forecasts, see Item 1A, “Risk Factors” in Part I and “Regulatory Trends and Uncertainties” above.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty in regards to the reporting units’ operations could cause these assumptions to change in the future.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2013. All of our reporting units had fair values substantially in excess of their carrying values, thus we concluded that there was no need for any impairment of our goodwill balances as of December 31, 2012.

Intangible assets. Separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). Our intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis. Both finite-lived and indefinite-lived intangible assets are

evaluated for impairment between annual periods if an event occurs or circumstances change that may indicate impairment. Our most significant intangible assets are customer-related intangibles, which represent 77% of our total intangible asset balance of $4.7 billion.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and earnings growth, retention rate, perpetuity growth rate and discount rate. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset (or asset group) using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that an impairment exists, the amount by which the carrying value exceeds its estimated fair value would be recorded as an impairment.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we assess qualitative factors to determine whether the existence of events and circumstances indicate that it is more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value. If, after assessing the totality of events and circumstances, we conclude that it is not more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value, no impairment exists and no further testing is performed. If we conclude otherwise, we would perform a quantitative analysis by comparing its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value.

Intangible assets were not impaired in 2012.

Investments

As of December 31, 2012, we had investments with a carrying value of $21 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from earnings and report net unrealized gains or losses, 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, 2012, our investments had gross unrealized gains of $825 million and gross unrealized losses of $9 million.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell the security before recovery of the entire amortized cost basis or maturity of the security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.

For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair

value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in our income statement.

The most significant judgments and estimates related to investments are related to determination of their fair values and the other-than-temporary impairment assessment.

Fair values. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- the prices received from the pricing service to prices reported by a secondary pricing service, its custodian, its investment consultant and/or third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-than-temporary impairment assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations, etc.) as opposed to credit related. We do not expect that trend to change in the near term. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. The unrealized losses of $9 million and $32 million at December 31, 2012 and 2011, respectively, were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments during 2012, 2011 and 2010 were $6 million, $12 million and $23 million, respectively. Our cash equivalent and investment portfolio had a weighted-average duration of 2.1 years and a weighted-average credit rating of “AA” as of December 31, 2012. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market

factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available including current facts and circumstances changing, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A "Quantitative and Qualitative Disclosures About Market Risk" a 1% increase in market interest rates has the effect of decreasing the fair value of our investment portfolio by $656 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements.

Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes. We have established a valuation allowance against certain deferred tax assets based on the weight of available evidence (both positive and negative) for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized.

An uncertain tax position is recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax positions due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2012 earnings before income taxes would have caused the provision for income taxes and net earnings to change by $86 million.

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 where appropriate. Our estimates are developed in consultation with legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of costs resulting from legal and regulatory matters involving us are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, in many cases, we are unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Similarly, the assessment of the likelihood of assertion of unasserted claims involves significant judgment.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures each reporting period. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

LEGAL MATTERS

A description of our legal proceedings is included in Note 12 of Notes to the Consolidated Financial Statements included in Item 8 “Financial Statements.”

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2012, we had an aggregate $1.9 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. As of December 31, 2012, the reinsurer was rated by A.M. Best as “A+.” As of December 31, 2012, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian Real and (c) changes in equity prices that impact the value of our equity investments.

As of December 31, 2012, we had $9.4 billion of cash, cash equivalents and investments on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also, $6.7 billion of our debt and deposit liabilities as of December 31, 2012 were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2012, $19.1 billion of our investments were fixed-rate debt securities and $13.6 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as endeavoring to match our floating-rate assets and liabilities over time, either directly or periodically through the use of interest rate swap contracts.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% or 2% as of December 31, 2012 and 2011 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2012			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2%	$189	$134	$(1,303)	$(2,200)
1	94	67	(656)	(1,194)
(1)	(18)	(14)	518	1,366
(2)	nm	nm	686	2,747

	December 31, 2011			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2%	$199	$ 28	$(1,239)	$(1,946)
1	99	14	(622)	(1,082)
(1)	(12)	(4)	586	1,086
(2)	nm	nm	885	2,343

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2012 and 2011, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2012, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

With the Amil acquisition, we have an exposure to changes in the value of the Brazilian Real to the U.S. Dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign currency financial statements into U.S. dollars are included in shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian Real reduces the carrying value of the net assets denominated in Brazilian Real. For example, as of December 31, 2012 a hypothetical 10% increase in the value of the U.S. Dollar against the Brazilian Real would cause a reduction in net assets of $510 million. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies. We funded certain cash needs of Amil through intercompany notes. At December 31, 2012, we had currency swaps with a total notional amount of $256 million hedging the U.S. dollar to the Brazilian Real to provide a cash flow hedge on the principal amount of the intercompany notes to Amil.

As of December 31, 2012, we had $677 million of investments in equity securities, including employee savings plan related investments of $348 million and venture capital funds, a portion of which were invested 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 impact the value of our equity investments.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2012 and 2011, and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2012. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2012 and 2011, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2012, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2012, based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 6, 2013, expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 6, 2013

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2012	December 31, 2011
Assets		
Current assets:		
Cash and cash equivalents	$ 8,406	$ 9,429
Short-term investments	3,031	2,577
Accounts receivable, net of allowances of $189 and $196	2,709	2,294
Other current receivables, net of allowances of $206 and $72	2,889	2,255
Assets under management	2,773	2,708
Deferred income taxes	463	472
Prepaid expenses and other current assets	781	615
Total current assets	21,052	20,350
Long-term investments	17,711	16,166
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,564 and $2,440	3,939	2,515
Goodwill	31,286	23,975
Other intangible assets, net of accumulated amortization of $1,824 and $1,451	4,682	2,795
Other assets	2,215	2,088
Total assets	$80,885	$67,889
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$11,004	$ 9,799
Accounts payable and accrued liabilities	6,984	6,853
Other policy liabilities	4,910	5,063
Commercial paper and current maturities of long-term debt	2,713	982
Unearned revenues	1,505	1,225
Total current liabilities	27,116	23,922
Long-term debt, less current maturities	14,041	10,656
Future policy benefits	2,444	2,445
Deferred income taxes	2,450	1,351
Other liabilities	1,535	1,223
Total liabilities	47,586	39,597
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interest	2,121	—
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 1,019 and 1,039 issued and outstanding	10	10
Additional paid-in capital	66	—
Retained earnings	30,664	27,821
Accumulated other comprehensive income	438	461
Total shareholders' equity	31,178	28,292
Total liabilities and shareholders' equity	$80,885	$67,889

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2012	2011	2010
Revenues:			
Premiums	$ 99,728	$ 91,983	$85,405
Services	7,437	6,613	5,819
Products	2,773	2,612	2,322
Investment and other income	680	654	609
Total revenues	110,618	101,862	94,155
Operating costs:			
Medical costs	80,226	74,332	68,841
Operating costs	17,306	15,557	14,270
Cost of products sold	2,523	2,385	2,116
Depreciation and amortization	1,309	1,124	1,064
Total operating costs	101,364	93,398	86,291
Earnings from operations	9,254	8,464	7,864
Interest expense	(632)	(505)	(481)
Earnings before income taxes	8,622	7,959	7,383
Provision for income taxes	(3,096)	(2,817)	(2,749)
Net earnings	$ 5,526	$ 5,142	$ 4,634
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 5.38	$ 4.81	$ 4.14
Diluted	$ 5.28	$ 4.73	$ 4.10
Basic weighted-average number of common shares outstanding	1,027	1,070	1,120
Dilutive effect of common stock equivalents	19	17	11
Diluted weighted-average number of common shares outstanding	1,046	1,087	1,131
Anti-dilutive shares excluded from the calculation of dilutive effect of common stock equivalents	17	47	94
Cash dividends declared per common share	$ 0.8000	$ 0.6125	$0.4050

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2012	2011	2010
Net earnings	$5,526	$5,142	$4,634
Other comprehensive (loss) income:			
Gross unrealized holding gains on investment securities during the period	217	422	74
Income tax expense	(78)	(154)	(26)
Total unrealized gains, net of tax	139	268	48
Gross reclassification adjustment for net realized gains included in net earnings	(156)	(113)	(71)
Income tax effect	57	41	26
Total reclassification adjustment, net of tax	(99)	(72)	(45)
Foreign currency translation adjustments	(63)	13	(4)
Other comprehensive (loss) income	(23)	209	(1)
Comprehensive income	$5,503	$5,351	$4,633

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Total Equity
Balance at January 1, 2010	1,147	$11	$ —	$23,342	$277	$(24)	$23,606
Net earnings				4,634			4,634
Other comprehensive income					3	(4)	(1)
Issuances of common stock, and related tax effects	15	—	207				207
Share-based compensation, and related tax benefits			345				345
Common stock repurchases	(76)	—	(552)	(1,965)			(2,517)
Cash dividends paid on common stock				(449)			(449)
Balance at December 31, 2010	1,086	11	—	25,562	280	(28)	25,825
Net earnings				5,142			5,142
Other comprehensive income					196	13	209
Issuances of common stock, and related tax effects	18	—	308				308
Share-based compensation, and related tax benefits			453				453
Common stock repurchases	(65)	(1)	(761)	(2,232)			(2,994)
Cash dividends paid on common stock				(651)			(651)
Balance at December 31, 2011	1,039	10	—	27,821	476	(15)	28,292
Net earnings				5,526			5,526
Other comprehensive income					40	(63)	(23)
Issuances of common stock, and related tax effects	37	—	704				704
Share-based compensation, and related tax benefits			594				594
Common stock repurchases	(57)	—	(1,221)	(1,863)			(3,084)
Acquisition of noncontrolling interest			(11)				(11)
Cash dividends paid on common stock				(820)			(820)
Balance at December 31, 2012	1,019	$10	$ 66	$30,664	$516	$(78)	$31,178

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2012	2011	2010
Operating activities			
Net earnings	$ 5,526	$ 5,142	$ 4,634
Non-cash items:			
Depreciation and amortization	1,309	1,124	1,064
Deferred income taxes	308	59	45
Share-based compensation	421	401	326
Other, net	(231)	(67)	203
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(130)	(267)	(16)
Other assets	(295)	(121)	84
Medical costs payable	101	377	(88)
Accounts payable and other liabilities	199	146	(341)
Other policy liabilities	(81)	482	10
Unearned revenues	28	(308)	352
Cash flows from operating activities	7,155	6,968	6,273
Investing activities			
Purchases of investments	(9,903)	(9,895)	(7,855)
Sales of investments	3,794	3,949	2,593
Maturities of investments	4,810	4,251	3,105
Cash paid for acquisitions, net of cash assumed	(6,280)	(1,844)	(2,323)
Cash received from dispositions	—	385	19
Purchases of property, equipment and capitalized software	(1,070)	(1,067)	(878)
Proceeds from disposal of property, equipment and capitalized software	—	49	—
Cash flows used for investing activities	(8,649)	(4,172)	(5,339)
Financing activities			
Common stock repurchases	(3,084)	(2,994)	(2,517)
Proceeds from common stock issuances	1,078	381	272
Cash dividends paid	(820)	(651)	(449)
Proceeds from (repayments of) commercial paper, net	1,587	(933)	930
Proceeds from issuance of long-term debt	3,966	2,234	747
Repayments of long-term debt	(986)	(955)	(1,583)
Interest rate swap termination	—	132	—
Customer funds administered	(324)	37	974
Checks outstanding	(202)	206	(5)
Acquisition of noncontrolling interest shares	(319)	—	—
Other, net	(425)	53	20
Cash flows from (used for) financing activities	471	(2,490)	(1,611)
(Decrease) increase in cash and cash equivalents	(1,023)	306	(677)
Cash and cash equivalents, beginning of period	9,429	9,123	9,800
Cash and cash equivalents, end of period	$ 8,406	$ 9,429	$ 9,123
Supplemental cash flow disclosures			
Cash paid for interest	$ 600	$ 472	$ 509
Cash paid for income taxes	2,666	2,739	2,725

See Notes to the Consolidated Financial Statements

UnitedHealth Group

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (also referred to as "UnitedHealth Group" and "the Company") is a diversified health and well-being company whose mission is to help people live healthier lives and make health care work better.

The Company helps individuals access quality care at an affordable cost; simplifying health care administration and delivery; strengthening the physician/patient relationship; promoting evidence-based care; and empowering physicians, health care professionals, consumers, employers and other participants in the health system with actionable data to make better, more informed decisions.

Through the Company's diversified family of businesses, it leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. See Note 13 for a description of the Company's reportable segments and how the segments generate their revenues.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to United States of America (U.S.) Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The Company has eliminated intercompany balances and transactions.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs payable, premium rebates and risk-adjusted and risk-sharing provisions related to revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of investments, and estimates and judgments related to income taxes and contingent liabilities. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from its customers in advance of the service period are recorded as unearned revenues. Effective in 2011, U.S. commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because the Company is able to reasonably estimate the ultimate premiums of these contracts. Each period, the Company estimates premium rebates based on the expected financial performance of the

applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Part D premium revenues are subject to periodic adjustment under the Centers for Medicare and Medicaid Services' (CMS) risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans is subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependants. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependants, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

For the Company's OptumRx pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies or mail services, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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 processing backlogs, care provider contract rate changes, medical care utilization and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Medical costs also include the direct cost of patient care rendered through OptumHealth.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

The Company had checks outstanding of $1.3 billion and $1.5 billion as of December 31, 2012 and 2011, respectively, which were classified as Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets and the change in this balance has been reflected as Checks Outstanding within financing activities in the Consolidated Statements of Cash Flows. The outstanding checks are all related to zero balance accounts; the Company does not net checks outstanding with deposits in other accounts.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of shareholders' equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends to either sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in Investment and Other Income. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.
- For equity securities, the Company recognizes impairments in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the impairment in Investment and Other Income.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program), and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2017 for the AARP Program and give the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings until December 31, 2014, subject to certain limited exclusions.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the RSF and were $109 million, $99 million and $107 million in 2012, 2011 and 2010, respectively.

The effects of changes in balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of whom provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of Product Revenue. The Company generally receives rebates from two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivable" below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to Premium Revenues in the Consolidated Statements of Operations and Other Policy Liabilities or Other Current Receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Beginning in 2011, Health Reform Legislation mandated a consumer discount of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and, therefore, are recorded as Premium Revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records

premium payments received in advance of the applicable service period in Unearned Revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in Medical Costs and Operating Costs, respectively, in the Consolidated Statements of Operations.

The final 2012 risk-share amount is expected to be settled during the second half of 2013, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2012			December 31, 2011		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$461	$314	$ —	$ —	$509	$ —
Other policy liabilities	—	319	438	70	649	170

As of January 1, 2013, certain changes were made to the Medicare Part D coverage by CMS, including:

The initial coverage limit increased to $2,970 from $2,930 in 2012.

The catastrophic coverage begins at $6,734 as compared to $6,658 in 2012.

The annual out-of-pocket maximum increased to $4,750 from $4,700 in 2012.

The discounts on prescription drugs within the coverage gap increased to 52.5% from 50% in 2012 for brand name drugs and to 21% from 14% in 2012 for generic drugs.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development. The Company reviews property, equipment and capitalized software for events or changes in circumstances that would indicate that it might not recover their carrying value. If the Company determines that an asset may not be recoverable, an impairment charge is recorded.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, the Company performs a multi-step impairment test. First, the Company can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if the Company elects to proceed directly with quantitative testing, it will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

The Company estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test.

The Company elected to bypass the optional qualitative reporting-unit fair value assessment and completed its annual quantitative test for goodwill impairment as of January 1, 2013. As of December 31, 2012, no reporting unit had a fair value less than its carrying value and the Company concluded that there was no need for any impairment of its goodwill balances.

Intangible assets

Separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). The Company's intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives.

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset's (or asset group's) may be impaired. The Company's indefinite lived intangible assets are also tested for impairment annually. There were no material impairments of intangible assets during the year ended December 31, 2012.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program (described below), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits" above), accruals for premium rebate payments under the Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Underwriting gains or losses related to the AARP Program are directly 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. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF, losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. Changes in the RSF are reported in Medical Costs in the Consolidated Statement of Operations. As of December 31, 2012 and 2011, the balance in the RSF was $1.3 billion.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2012, the Company had an aggregate $1.9 billion reinsurance receivable, of which $135 million was recorded in Other Current Receivables and $1.8 billion was recorded in Other Assets in the Consolidated Balance Sheets. As of December 31, 2011, the Company had an aggregate $1.9 billion reinsurance receivable, of which $125 million was recorded in Other Current Receivables and $1.8 billion was recorded in Other Assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. As of December 31, 2012, the reinsurer was rated by A.M. Best as "A+."

Foreign currency translation

Assets and liabilities of the Company's foreign operations denominated in non-U.S. dollar functional currencies are translated into U.S. dollars at current exchange rates as of the end of each accounting period. Related revenue and expenses are translated at average exchange rates during the accounting period. The gains or losses resulting from translating foreign currency financial statements into U.S. dollars are included in shareholders' equity and comprehensive income.

Noncontrolling interests

Noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The redeemable noncontrolling interests are primarily related to holders of Amil Participações S.A. (Amil) shares. Amil was acquired in 2012, see Note 6 for more information. During 2012, the Company purchased noncontrolling interest shares for $319 million, of which $11 million was recorded as a reduction of Additional Paid-In Capital. For the year ended December 31, 2012, the Company's net earnings attributable to redeemable noncontrolling interests was nil and other noncontrolling interest activity was not material.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on

a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over three to four years and compensation expense related to restricted shares is based on the share price on date of grant. Stock options and SARs vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP) eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in Operating Costs in the Company's Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP, using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise, any unrecognized compensation cost and any related excess tax benefit. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Standards

In May 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-04, "Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs" (ASU 2011-04). This update provides guidance on how fair value measurement should be applied where existing GAAP already requires or permits fair value measurements. In addition, ASU 2011-04 requires expanded disclosures regarding fair value measurements. ASU 2011-04 became effective for the Company's fiscal year 2012. The adoption of the measurement guidance of ASU 2011-04 did not have a material impact on the Consolidated Financial Statements. The new disclosures have been included with the Company's fair value disclosures in Note 4.

In June 2011, the FASB issued ASU No. 2011-05, "Comprehensive Income (Topic 220) — Presentation of Comprehensive Income" (ASU 2011-05). ASU 2011-05 requires entities to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements and eliminates the option to present the components of other comprehensive income as a part of the statement of equity. ASU 2011-05 became effective for the Company's fiscal year 2012. The Company presented separate Consolidated Statements of Comprehensive Income, which appear consecutive to the Consolidated Statements of Operations.

The Company has determined that there have been no other recently adopted or issued accounting standards that had or will have a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2012				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,501	$ 38	$ (1)	$ 2,538
State and municipal obligations	6,282	388	(3)	6,667
Corporate obligations	6,930	283	(4)	7,209
U.S. agency mortgage-backed securities	2,168	70	—	2,238
Non-U.S. agency mortgage-backed securities	538	36	—	574
Total debt securities — available-for-sale	18,419	815	(8)	19,226
Equity securities — available-for-sale	668	10	(1)	677
Debt securities — held-to-maturity:				
U.S. government and agency obligations	168	6	—	174
State and municipal obligations	30	—	—	30
Corporate obligations	641	2	—	643
Total debt securities — held-to-maturity	839	8	—	847
Total investments	$19,926	$833	$ (9)	$20,750
December 31, 2011				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,319	$ 54	$ —	$ 2,373
State and municipal obligations	6,363	403	(1)	6,765
Corporate obligations	5,825	205	(23)	6,007
U.S. agency mortgage-backed securities	2,279	74	—	2,353
Non-U.S. agency mortgage-backed securities	476	28	—	504
Total debt securities — available-for-sale	17,262	764	(24)	18,002
Equity securities — available-for-sale	529	23	(8)	544
Debt securities — held-to-maturity:				
U.S. government and agency obligations	166	7	—	173
State and municipal obligations	13	—	—	13
Corporate obligations	18	—	—	18
Total debt securities — held-to-maturity	197	7	—	204
Total investments	$17,988	$794	$(32)	$18,750

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination as of December 31, 2012 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2012	$ 123	$ —	$ —	$ —	$ 123
2011	27	—	—	—	27
2010	—	3	—	—	3
2007	88	—	—	2	90
2006	137	—	11	8	156
Pre-2006	167	5	—	3	175
U.S. agency mortgage-backed securities	2,238	—	—	—	2,238
Total	$2,780	$ 8	$ 11	$ 13	$2,812

The Company includes in the non-investment grade column in the table above any securities backed by Alt-A or sub-prime mortgages and any commercial mortgage loans in default.

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2012, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 3,107	$ 3,120
Due after one year through five years	6,249	6,471
Due after five years through ten years	4,695	5,039
Due after ten years	1,662	1,784
U.S. agency mortgage-backed securities	2,168	2,238
Non-U.S. agency mortgage-backed securities	538	574
Total debt securities — available-for-sale	$18,419	$19,226

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2012, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$435	$436
Due after one year through five years	126	129
Due after five years through ten years	177	180
Due after ten years	101	102
Total debt securities — held-to-maturity	$839	$847

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2012						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 183	$ (1)	$ —	$ —	$ 183	$ (1)
State and municipal obligations	362	(3)	—	—	362	(3)
Corporate obligations	695	(4)	—	—	695	(4)
Total debt securities — available-for-sale	$1,240	$ (8)	$ —	$ —	$1,240	$ (8)
Equity securities — available-for-sale	$ 13	$ (1)	$ —	$ —	$ 13	$ (1)
December 31, 2011						
Debt securities — available-for-sale:						
State and municipal obligations	$ 85	$ (1)	$ 21	$ —	$ 106	$ (1)
Corporate obligations	1,496	(22)	28	(1)	1,524	(23)
Total debt securities — available-for-sale	$1,581	$(23)	$ 49	$ (1)	$1,630	$(24)
Equity securities — available-for-sale	$ 24	$ (7)	$ 3	$ (1)	$ 27	$ (8)

The unrealized losses from all securities as of December 31, 2012 were generated from approximately 1,300 positions out of a total of 18,000 positions. The Company believes that it will collect the principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of December 31, 2012, the Company did not have the intent to sell any of the securities in an unrealized loss position.

A portion of the Company's investments in equity securities and venture capital funds consists of investments held in various public and nonpublic companies concentrated in the areas of health care services and related information technologies. Market conditions that affect the value of health care and related technology stocks will likewise impact the value of the Company's equity portfolio. The equity securities and venture capital funds were evaluated for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains included in Investment and Other Income on the Consolidated Statements of Operations were from the following sources:

	For the Year Ended December 31,		
(in millions)	2012	2011	2010
Total OTTI	$ (6)	$ (12)	$ (23)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(6)	(12)	(23)
Gross realized losses from sales	(13)	(11)	(6)
Gross realized gains from sales	175	136	100
Net realized gains	$156	$113	$ 71

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2012 or 2011.

Non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2012, 2011, and 2010.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares

changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The Company's Level 3 equity securities are primarily investments in venture capital securities. The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; and similar preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair value of certain of the Company's venture capital securities are based off of recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

AARP Program-related Investments. AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's debt and equity securities.

Interest Rate and Currency Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-term debt. The fair value of the Company's long-term debt is estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets excluding AARP related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2012				
Cash and cash equivalents	$ 7,615	$ 791	$ —	$ 8,406
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,752	786	—	2,538
State and municipal obligations	—	6,667	—	6,667
Corporate obligations	13	7,185	11	7,209
U.S. agency mortgage-backed securities	—	2,238	—	2,238
Non-U.S. agency mortgage-backed securities	—	568	6	574
Total debt securities — available-for-sale	1,765	17,444	17	19,226
Equity securities — available-for-sale	450	3	224	677
Interest rate swap assets	—	14	—	14
Total assets at fair value	$ 9,830	$18,252	$241	$28,323
Percentage of total assets at fair value	35%	64%	1%	100%
Interest rate and currency swap liabilities	$ —	$ 14	$ —	$ 14
December 31, 2011				
Cash and cash equivalents	$ 8,569	$ 860	$ —	$ 9,429
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,551	822	—	2,373
State and municipal obligations	—	6,750	15	6,765
Corporate obligations	16	5,805	186	6,007
U.S. agency mortgage-backed securities	—	2,353	—	2,353
Non-U.S. agency mortgage-backed securities	—	497	7	504
Total debt securities — available-for-sale	1,567	16,227	208	18,002
Equity securities — available-for-sale	333	2	209	544
Total assets at fair value	$10,469	$17,089	$417	$27,975
Percentage of total assets at fair value	37%	61%	2%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2012					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$174	$ —	$ —	$ 174	$ 168
State and municipal obligations	—	1	29	30	30
Corporate obligations	10	346	287	643	641
Total debt securities — held-to-maturity	$184	$ 347	$316	$ 847	$ 839
Long-term debt	$ —	$17,034	$ —	$17,034	$15,167
December 31, 2011					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$173	$ —	$ —	$ 173	$ 166
State and municipal obligations	—	1	12	13	13
Corporate obligations	9	9	—	18	18
Total debt securities — held-to-maturity	$182	$ 10	$ 12	$ 204	$ 197
Long-term debt	$ —	$13,149	$ —	$13,149	$11,638

The carrying amounts reported in the Consolidated Balance Sheets for accounts and other current receivables, unearned revenues, commercial paper, accounts payable and accrued liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above. A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2012			December 31, 2011			December 31, 2010		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 208	$209	$ 417	$141	$208	$349	$120	$ 312	$ 432
Purchases	11	71	82	92	35	127	43	45	88
Sales	—	(34)	(34)	—	(17)	(17)	(4)	(167)	(171)
Settlements	(1)	—	(1)	(25)	(7)	(32)	(20)	—	(20)
Net unrealized (losses) gains in accumulated other comprehensive income	—	(14)	(14)	—	(4)	(4)	—	9	9
Net realized gains (losses) in investment and other income	—	13	13	—	(6)	(6)	2	9	11
Transfers to held-to-maturity	(201)	(21)	(222)	—	—	—	—	—	—
Balance at end of period	$ 17	$224	$ 241	$208	$209	$417	$141	$ 208	$ 349

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Low	High
December 31, 2012					
Equity securities — available-for-sale					
Venture capital portfolios	$193	Market approach - comparable companies	Revenue multiple	1.0	10.0
			EBITDA multiple	8.0	10.0
	31	Market approach - recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$224				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $17 million of available-for-sale debt securities at December 31, 2012, which were not significant.

The Company elected to measure the entirety of the AARP Assets Under Management at fair value pursuant to the fair value option. See Note 2 for further detail on AARP. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
December 31, 2012			
Cash and cash equivalents	$230	$ —	$ 230
Debt securities:			
U.S. government and agency obligations	545	244	789
State and municipal obligations	—	51	51
Corporate obligations	—	1,118	1,118
U.S. agency mortgage-backed securities	—	427	427
Non-U.S. agency mortgage-backed securities	—	155	155
Total debt securities	545	1,995	2,540
Equity securities — available-for-sale	—	3	3
Total assets at fair value	$775	$1,998	$2,773
Other liabilities	$ 23	$ 58	$ 81
December 31, 2011			
Cash and cash equivalents	$257	$ 10	$ 267
Debt securities:			
U.S. government and agency obligations	566	214	780
State and municipal obligations	—	25	25
Corporate obligations	—	1,048	1,048
U.S. agency mortgage-backed securities	—	436	436
Non-U.S. agency mortgage-backed securities	—	150	150
Total debt securities	566	1,873	2,439
Equity securities — available-for-sale	—	2	2
Total assets at fair value	$823	$1,885	$2,708
Other liabilities	$ 27	$ 49	$ 76

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2012	December 31, 2011
Land and improvements	$ 358	$ 45
Buildings and improvements	1,910	1,052
Computer equipment	1,447	1,345
Furniture and fixtures	488	274
Less accumulated depreciation	(1,542)	(1,424)
Property and equipment, net	2,661	1,292
Capitalized software	2,300	2,239
Less accumulated amortization	(1,022)	(1,016)
Capitalized software, net	1,278	1,223
Total property, equipment and capitalized software, net	$ 3,939	$ 2,515

Depreciation expense for property and equipment for 2012, 2011 and 2010 was $449 million, $386 million and $398 million, respectively. Amortization expense for capitalized software for 2012, 2011 and 2010 was $412 million, $377 million and $349 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2011	$17,837	$ 760	$3,308	$840	$22,745
Acquisitions	101	1,353	—	—	1,454
Dispositions	(2)	—	(214)	—	(216)
Adjustments, net	(4)	—	(4)	—	(8)
Balance at December 31, 2011	17,932	2,113	3,090	840	23,975
Acquisitions	6,557	705	98	—	7,360
Adjustments and foreign currency effects, net	(30)	—	(19)	—	(49)
Balance at December 31, 2012	$24,459	$2,818	$3,169	$840	$31,286

In October 2012, the Company purchased approximately 60% of the outstanding shares of Amil for approximately $3.2 billion in a private transaction. Later in the fourth quarter of 2012, the Company purchased an additional 17.8 million shares of Amil for $0.3 billion, bringing the stake in Amil attributable to the Company to approximately 65% of Amil's outstanding shares. Amil is a health care company located in Brazil, providing health and dental benefits, hospital and clinical services, and advanced care management resources to more than 5 million people. The total consideration paid and fair value of the noncontrolling interest exceeded the estimated fair value of the net tangible assets acquired by $5.9 billion, of which $1.0 billion has been allocated to finite-lived intangible assets, $0.6 billion to indefinite-lived intangible assets and $4.3 billion to goodwill. To estimate the acquisition date fair value of the noncontrolling interest of $2.2 billion, the Company utilized the public share price as of the date of acquisition. Contingent liabilities were measured based on the probable amount that could be reasonably estimated. The results of operations and financial condition of Amil have been included in the Company's consolidated results and the results of the UnitedHealthcare reportable segment since the acquisition date. The pro-forma effects of this acquisition on the Company's results of operations were not material. In conjunction with the 2012 purchases, the Company generated Brazilian tax deductible goodwill of approximately $2.7 billion.

Because of the acquisition of a controlling interest in Amil, the Company is required by Brazilian law to commence a mandatory tender offer for the remaining publicly traded shares. The Company expects to acquire an additional 25% ownership interest during the first half of 2013 through this tender offer. The tender offer price will be at the same price paid to Amil's controlling shareholders, adjusted for statutory interest under Brazilian law from the date of payment to the controlling shareholders to the date of payment to the tendering minority shareholders. The remaining 10% stake in Amil is held by shareholders, including Amil's CEO, who has been a member of the Company's Board of Directors since October 2012, who have committed to retain the shares for at least five years. They have the right to put the shares to the Company and the Company has the right to call these shares upon expiration of the five year term, unless accelerated upon certain events, at fair market value. Related to this acquisition, Amil's CEO invested approximately $470 million in unregistered UnitedHealth Group common shares in the fourth quarter of 2012 and has committed to hold those shares for the same five year term, subject to certain exceptions.

Acquired net tangible assets and liabilities for Amil at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 240
Investments	341
Accounts receivable and other current assets	207
Property, equipment and other long-term assets	1,266
Medical costs payable	586
Other current liabilities	638
Contingent liabilities	270
Long-term debt and other long-term liabilities	569

Since the Amil acquisition occurred in the fourth quarter, the purchase price allocation is subject to adjustment as valuation analyses, primarily related to intangible and fixed assets and contingent and tax liabilities, are finalized.

For the years ended December 31, 2012, 2011 and 2010, aggregate consideration paid, net of cash assumed, for acquisitions excluding Amil was $3.3 billion, $1.8 billion and $2.3 billion, respectively. These acquisitions were not material to the Company's Consolidated Financial Statements.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2012			December 31, 2011		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$5,229	$(1,629)	$3,600	$3,766	$(1,310)	$2,456
Trademarks and technology	445	(146)	299	368	(98)	270
Trademarks — indefinite-lived	611	—	611	—	—	—
Other	221	(49)	172	112	(43)	69
Total	$6,506	$(1,824)	$4,682	$4,246	$(1,451)	$2,795

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2012		2011	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$1,530	8 years	$187	9 years
Trademarks and technology	79	4 years	49	5 years
Other	111	15 years	5	15 years
Total acquired finite-lived intangible assets	$1,720	9 years	$241	9 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2013	$545
2014	527
2015	506
2016	480
2017	456

Amortization expense relating to intangible assets for 2012, 2011 and 2010 was $448 million, $361 million and $317 million, respectively.

7. Medical Costs and Medical Costs Payable

The following table provides details of the Company's favorable medical reserve development:

	For the Years Ended December 31,		
(in millions)	2012	2011	2010
Related to Prior Years	$860	$720	$800

The favorable development for 2012, 2011 and 2010 was driven by lower than expected health system utilization levels and increased efficiency in claims handling and processing. The favorable development for 2010 was also impacted by a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2012	2011	2010
Medical costs payable, beginning of period	$ 9,799	$ 9,220	$ 9,362
Acquisitions	1,029	155	—
Reported medical costs:			
Current year	81,086	75,052	69,641
Prior years	(860)	(720)	(800)
Total reported medical costs	80,226	74,332	68,841
Claim payments:			
Payments for current year	(71,832)	(65,763)	(60,949)
Payments for prior year	(8,218)	(8,145)	(8,034)
Total claim payments	(80,050)	(73,908)	(68,983)
Medical costs payable, end of period	$ 11,004	$ 9,799	$ 9,220

8. Commercial Paper and Long-Term Debt

Commercial paper and long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2012			December 31, 2011		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial Paper	$ 1,587	$ 1,587	$ 1,587	$ —	$ —	$ —
5.500% senior unsecured notes due November 2012	—	—	—	352	363	366
4.875% senior unsecured notes due February 2013	534	534	536	534	540	556
4.875% senior unsecured notes due April 2013	409	411	413	409	421	427
4.750% senior unsecured notes due February 2014	172	178	180	172	184	185
5.000% senior unsecured notes due August 2014	389	411	414	389	423	424
4.875% senior unsecured notes due March 2015 (a)	416	444	453	416	458	460
0.850% senior unsecured notes due October 2015 (a)	625	623	627	—	—	—
5.375% senior unsecured notes due March 2016	601	660	682	601	678	689
1.875% senior unsecured notes due November 2016	400	397	412	400	397	400
5.360% senior unsecured notes due November 2016	95	95	110	95	95	110
6.000% senior unsecured notes due June 2017	441	489	528	441	499	518
1.400% senior unsecured notes due October 2017 (a)	625	622	626	—	—	—
6.000% senior unsecured notes due November 2017	156	170	191	156	173	183
6.000% senior unsecured notes due February 2018	1,100	1,120	1,339	1,100	1,123	1,308
3.875% senior unsecured notes due October 2020	450	442	499	450	442	478
4.700% senior unsecured notes due February 2021	400	417	466	400	419	450
3.375% senior unsecured notes due November 2021 (a)	500	512	533	500	497	517
2.875% senior unsecured notes due March 2022	1,100	998	1,128	—	—	—
0.000% senior unsecured notes due November 2022	15	9	11	1,095	619	696
2.750% senior unsecured notes due February 2023 (a)	625	619	631	—	—	—
5.800% senior unsecured notes due March 2036	850	845	1,025	850	844	1,017
6.500% senior unsecured notes due June 2037	500	495	659	500	495	636
6.625% senior unsecured notes due November 2037	650	645	860	650	645	834
6.875% senior unsecured notes due February 2038	1,100	1,084	1,510	1,100	1,084	1,475
5.700% senior unsecured notes due October 2040	300	298	364	300	298	359
5.950% senior unsecured notes due February 2041	350	348	440	350	348	430
4.625% senior unsecured notes due November 2041	600	593	641	600	593	631
4.375% senior unsecured notes due March 2042	502	486	521	—	—	—
3.950% senior unsecured notes due October 2042	625	611	622	—	—	—
Total U.S. Dollar denominated debt	16,117	16,143	18,008	11,860	11,638	13,149
Cetip Interbank Deposit Rate (CDI) + 1.3% Subsidiary floating debt due October 2013	147	148	150	—	—	—
CDI + 1.45 % Subsidiary floating debt due October 2014	147	149	150	—	—	—
110% CDI Subsidiary floating debt due December 2014	147	151	147	—	—	—
CDI + 1.6% Subsidiary floating debt due October 2015	74	76	76	—	—	—
Brazilian Extended National Consumer Price Index (IPCA) + 7.61% Subsidiary floating debt due October 2015	73	87	90	—	—	—
Total Brazilian Real denominated debt (in U.S. Dollars)	588	611	613	—	—	—
Total commercial paper and long-term debt	$16,705	$16,754	$18,621	$11,860	$11,638	$13,149

(a) In 2012, the Company entered into interest rate swap contracts with a notional amount of $2.8 billion hedging these fixed-rate debt instruments. See below for more information on the Company's interest rate swaps.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2013 (a)	$2,713
2014	920
2015	1,175
2016	1,152
2017	1,281
Thereafter	9,513

(a) Includes $33 million of debt subject to acceleration clauses.

Long-Term Debt

In August 2012, the Company completed an exchange of $1.1 billion of its zero coupon senior unsecured notes due November of 2022 for $0.5 billion additional issuance of its 2.875% notes due in March 2022, $0.1 billion additional issuance of its 4.375% notes due March 2042 and $0.1 billion in cash.

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2012, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.3%.

The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facility with 21 banks, which mature in November 2017 and November 2013, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2012. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of December 31, 2012, the annual interest rates on both of the credit facilities, had they been drawn, would have ranged from 1.0% to 1.3%.

Debt Covenants

The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio not more than 50%. The Company was in compliance with its debt covenants as of December 31, 2012.

Interest Rate and Currency Swap Contracts

In 2012, the Company entered into interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are assumed to be highly effective hedges and all changes in fair value of the swaps are recorded as an adjustment to the carrying value of the related debt with no net impact recorded in the Consolidated Statements of Operations. Both the hedge fair value changes and the offsetting debt adjustments are recorded in Interest Expense on the Consolidated Statements of Operations. The net fair value of these swaps was $3 million at December 31, 2012 and is recorded in Other Long-Term Assets for $14 million and Other Long-Term Liabilities for $11 million in the Consolidated Balance Sheets.

In December 2012, the Company entered into currency swap contracts to hedge the foreign currency exposure on the principal amount of intercompany borrowings denominated in Brazilian Real. The currency swaps have a

notional amount of $256 million and mature on December 31, 2013. As of December 31, 2012, the fair value of the currency swap liability was $3 million, which was recorded in Other Current Liabilities in the Company's Consolidated Balance Sheets.

9. Income Taxes

The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2012	2011	2010
Current Provision:			
Federal	$2,638	$2,608	$2,524
State and local	150	150	180
Total current provision	2,788	2,758	2,704
Deferred provision	308	59	45
Total provision for income taxes	$3,096	$2,817	$2,749

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows:

(in millions, except percentages)	2012		2011		2010	
Tax provision at the U.S. federal statutory rate	$3,018	35.0%	$2,785	35.0%	$2,584	35.0%
State income taxes, net of federal benefit	143	1.7	136	1.7	129	1.7
Settlement of state exams, net of federal benefit	2	—	(29)	(0.4)	(3)	—
Tax-exempt investment income	(59)	(0.7)	(63)	(0.8)	(65)	(0.9)
Non-deductible compensation	22	0.2	10	0.1	64	0.9
Other, net	(30)	(0.3)	(22)	(0.2)	40	0.5
Provision for income taxes	$3,096	35.9%	$2,817	35.4%	$2,749	37.2%

The higher effective income tax rate for 2012 as compared to 2011 resulted from the favorable resolution of various tax matters in 2011. The 2010 effective income tax rates were at higher levels due to the cumulative implementation of changes under the Health Reform Legislation.

The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2012	2011
Deferred income tax assets:		
Accrued expenses and allowances	$ 306	$ 259
U.S. Federal and State net operating loss carryforwards	276	247
Share-based compensation	238	417
Long term liabilities	160	155
Medical costs payable and other policy liabilities	149	166
Non-U.S. tax loss carryforwards	126	—
Unearned revenues	64	56
Unrecognized tax benefits	25	44
Domestic other	93	192
Foreign other	142	—
Subtotal	1,579	1,536
Less: valuation allowances	(271)	(184)
Total deferred income tax assets	1,308	1,352
Deferred income tax liabilities:		
U.S. Federal and State intangible assets	(1,335)	(1,148)
Non-U.S. goodwill and intangible assets	(640)	—
Capitalized software development	(482)	(465)
Net unrealized gains on investments	(296)	(275)
Depreciation and amortization	(249)	(256)
Prepaid expenses	(113)	(86)
Foreign other	(179)	—
Total deferred income tax liabilities	(3,294)	(2,230)
Net deferred income tax liabilities	$(1,986)	$ (878)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $105 million expire beginning in 2019 through 2032, state net operating loss carryforwards expire beginning in 2013 through 2032. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2012 the Company had $94 million of undistributed earnings from non-U.S. subsidiaries that are intended to be reinvested in non-U.S. operations. Because these earnings are considered permanently reinvested, no U.S. tax provision has been accrued related to the repatriation of these earnings. It is not practicable to estimate the amount of U.S. tax that might be payable on the eventual remittance of such earnings.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2012	2011	2010
Gross unrecognized tax benefits, beginning of period	$129	$220	$220
Gross increases:			
Current year tax positions	6	11	13
Prior year tax positions	18	10	30
Gross decreases:			
Prior year tax positions	(48)	(34)	—
Settlements	(10)	(25)	—
Statute of limitations lapses	(14)	(53)	(43)
Gross unrecognized tax benefits, end of period	$ 81	$129	$220

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. The Company recognized tax benefits from the net reduction of interest and penalties accrued of $20 million and $12 million during the years ended December 31, 2012 and 2011, respectively. During the year ended December 31, 2010, the Company recognized $15 million of interest expense and penalties. The Company had $23 million and $41 million of accrued interest and penalties for uncertain tax positions as of December 31, 2012 and 2011, respectively. These amounts are not included in the reconciliation above. As of December 31, 2012, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $77 million.

The Company currently files income tax returns in the U.S., various states and foreign jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2011 and prior. The Company's 2012 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to 2007. The Brazilian federal revenue service — Secretaria da Receita Federal (SRF) may audit the Company's Brazilian subsidiaries for a period of five years from the date on which corporate income taxes should have been paid and/or the date when the tax return was filed. Estimated taxes are paid monthly or quarterly with an annual return due on June 30 following the end of the taxable year.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $37 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval. In

2012, based on the 2011 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could have been paid by the Company's U.S. regulated subsidiaries to their parent companies was $4.6 billion.

For the year ended December 31, 2012, the Company's regulated subsidiaries paid their parent companies dividends of $4.9 billion, including $1.2 billion of extraordinary dividends. For the year ended December 31, 2011, the Company's regulated subsidiaries paid their parent companies dividends of $4.5 billion, including $1.1 billion of extraordinary dividends. As of December 31, 2012, $1.1 billion of the Company's $8.4 billion of cash and cash equivalents was held by non-regulated entities.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $13 billion as of December 31, 2012; regulated entity statutory capital exceeded aggregate minimum capital requirements.

Optum Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2012, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2012, the Board renewed and expanded the Company's share repurchase program with an authorization to repurchase up to 110 million shares of its common stock. During the year ended December 31, 2012, the Company repurchased 57 million shares at an average price of $54.45 per share and an aggregate cost of $3.1 billion. As of December 31, 2012, the Company had Board authorization to purchase up to an additional 85 million shares of its common stock.

Dividends

In June 2012, the Company's Board of Directors increased the Company's cash dividend to shareholders to an annual dividend rate of $0.85 per share, paid quarterly. Since May 2011, the Company had paid an annual dividend of $0.65 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2010	$0.4050	$449
2011	0.6125	651
2012	0.8000	820

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2012, the Company had 43 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and up to 16 million of awards in restricted shares. As of December 31, 2012, there were also 20 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2012 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	91	$42		
Granted	2	55		
Exercised	(29)	36		
Forfeited	(1)	43		
Outstanding at end of period	63	45	4.0	$625
Exercisable at end of period	53	46	3.5	460
Vested and expected to vest, end of period	62	45	4.0	622

Restricted Shares

Restricted share activity for the year ended December 31, 2012 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	17	$36
Granted	7	52
Vested	(14)	37
Forfeited	(1)	44
Nonvested at end of period	9	46

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2012	2011	2010
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 18	$ 15	$ 13
Total intrinsic value of stock options and SARs exercised	559	327	164
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	52	42	32
Total fair value of restricted shares vested	716	113	99
Employee Stock Purchase Plan			
Number of shares purchased	3	3	4
Share-Based Compensation Items			
Share-based compensation expense, before tax	$421	$401	$326
Share-based compensation expense, net of tax effects	299	260	278
Income tax benefit realized from share-based award exercises	461	170	78

(in millions, except years)	December 31, 2012
Unrecognized compensation expense related to share awards	$307
Weighted-average years to recognize compensation expense	1.1

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	2012	2011	2010
Risk free interest rate	0.7% - 0.9%	0.9% - 2.3%	1.0% - 2.1%
Expected volatility	43.2% - 44.0%	44.3% - 45.1%	45.4% - 46.2%
Expected dividend yield	1.2% - 1.7%	1.0% -1.4%	0.1% -1.7%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.3 - 5.6	4.9 -5.0	4.6 -5.1

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company's Board of Directors. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for all employees. Compensation expense related to this plan was not material for the years 2012, 2011 and 2010.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within Long-Term Investments with an approximately equal amount in Other Liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $348 million and $281 million as of December 31, 2012 and 2011, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates through 2028. Rent expense under all operating leases for 2012, 2011 and 2010 was $334 million, $295 million and $297 million, respectively.

As of December 31, 2012, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2013	$380
2014	357
2015	319
2016	277
2017	233
Thereafter	556

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar

amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of or for the years ended December 31, 2012, 2011 and 2010.

As of December 31, 2012, the Company had outstanding, undrawn letters of credit with financial institutions of $45 million and surety bonds outstanding with insurance companies of $432 million, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

Out-of-Network Reimbursement Litigation. The Company is involved in a number of lawsuits challenging reimbursement amounts for non-network health care services based on the Company's use of a database previously maintained by Ingenix, Inc. (now known as OptumInsight), including putative class actions and multidistrict litigation brought on behalf of members of Aetna and WellPoint. These suits allege, among other things, that the database licensed to these companies by Ingenix was flawed and that Ingenix conspired with these companies to underpay their members' claims and seek unspecified damages and treble damages, injunctive and declaratory relief, interest, costs and attorneys' fees. The Company is vigorously defending these suits. In 2012, the Company was dismissed as a party from a similar lawsuit involving Cigna and its members. The Company cannot reasonably estimate the range of loss, if any, that may result from these matters due to the procedural status of the cases, dispositive motions that remain pending, the absence of class certification in any of the cases, the lack of a formal demand on the Company by the plaintiffs, and the involvement of other insurance companies as defendants.

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. The matter has been the subject of an administrative hearing before a California administrative law judge since December 2009. Although the Company believes that CDI has never issued a penalty in excess of $8 million, CDI is seeking a penalty of approximately $325 million in this matter. The Company is vigorously defending against the claims in this matter and believes that the penalty requested by CDI is excessive and without merit. After the administrative law judge issues a ruling at the conclusion of the administrative proceeding, expected in early 2013, the California Insurance Commissioner may accept, reject or modify the administrative law judge's ruling, issue his own decision, and impose a fine or penalty. The Commissioner's decision is subject to challenge in court. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given

the procedural status of the dispute, the novel legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting regulatory fines and penalties, and the various remedies and levels of judicial review available to the Company in the event a fine or penalty is assessed.

Government Investigations, Audits and Reviews

The Company has been and is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, the Federal Trade Commission (FTC), U.S. Congressional committees, the U.S. Department of Justice (DOJ), U.S. Attorneys, the Securities and Exchange Commission (SEC), the Brazilian securities regulator — Comissão de Valores Mobiliários (CVM), IRS, SRF, the U.S. Department of Labor (DOL), the FDIC and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final RADV audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs and could have a material effect on the Company's results of operations, financial position and cash flows.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International because they have similar economic characteristics, products and services, customers, distribution methods and operational processes and operate in a similar regulatory environment. The U.S. businesses also share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide and will serve TRICARE West Region members beginning April 1, 2013. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State provides health plans and care programs to beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans, Medicare-Medicaid Eligible beneficiaries eligible for both Medicare and Medicaid and other federal, state and community health care programs. UnitedHealthcare International is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits.

- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling consumer health management and integrated care delivery through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, integrated care delivery services, consumer relationship management and sales distribution platform services and financial services.
- *OptumInsight* is a health care information, technology, operational services and consulting company providing software and information products, advisory consulting services, and business process outsourcing services and support to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system work with OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers a multitude of pharmacy benefit management services and programs including claims processing, retail network contracting, rebate contracting and management, clinical programs, such as step therapy, formulary management and disease/drug therapy management programs to achieve a low-cost, high-quality pharmacy benefit. OptumRx also provides patient support programs and dispensing of prescribed medications, including specialty medications, through its mail order pharmacies for its clients' members.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and integrated care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 29% for the year ended December 31, 2012, 28% for year ended December 31, 2011, and 27% for the year ended December 31, 2010, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 99% of consolidated total revenues during 2012. Long-lived fixed assets located in the U.S. represented approximately 70% of the total long-lived fixed assets as of December 31, 2012.

Corporate and intersegment elimination amounts are presented to reconcile the reportable segment results to the consolidated results. The following table presents the reportable segment financial information:

		Optum					
(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Total Optum	Corporate and Intersegment Eliminations	Consolidated
2012							
Revenues — external customers:							
Premiums	$ 97,985	$ 1,743	$ —	$ —	$ 1,743	$ —	$ 99,728
Services	4,867	767	1,720	83	2,570	—	7,437
Products	—	21	87	2,665	2,773	—	2,773
Total revenues — external customers	102,852	2,531	1,807	2,748	7,086	—	109,938
Total revenues — intersegment	—	5,503	1,075	15,611	22,189	(22,189)	—
Investment and other income	567	113	—	—	113	—	680
Total revenues	$103,419	$ 8,147	$ 2,882	$18,359	$ 29,388	$(22,189)	$110,618
Earnings from operations	$ 7,815	$ 561	$ 485	$ 393	$ 1,439	$ —	$ 9,254
Interest expense	—	—	—	—	—	(632)	(632)
Earnings before income taxes	$ 7,815	$ 561	$ 485	$ 393	$ 1,439	$ (632)	$ 8,622
Total Assets	$ 63,591	$ 8,274	$ 5,463	$ 3,466	$ 17,203	$ 91	$ 80,885
Purchases of property, equipment and capitalized software	$ 585	$ 184	$ 165	$ 136	$ 485	$ —	$ 1,070
Depreciation and amortization	$ 794	$ 193	$ 210	$ 112	$ 515	$ —	$ 1,309
2011							
Revenues — external customers:							
Premiums	$ 90,487	$ 1,496	$ —	$ —	$ 1,496	$ —	$ 91,983
Services	4,291	628	1,616	78	2,322	—	6,613
Products	—	24	96	2,492	2,612	—	2,612
Total revenues — external customers	94,778	2,148	1,712	2,570	6,430	—	101,208
Total revenues — intersegment	—	4,461	958	16,708	22,127	(22,127)	—
Investment and other income	558	95	1	—	96	—	654
Total revenues	$ 95,336	$ 6,704	$ 2,671	$19,278	$ 28,653	$(22,127)	$101,862
Earnings from operations	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ —	$ 8,464
Interest expense	—	—	—	—	—	(505)	(505)
Earnings before income taxes	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ (505)	$ 7,959
Total Assets	$ 52,618	$ 6,756	$ 5,308	$ 3,503	$ 15,567	$ (296)	$ 67,889
Purchases of property, equipment and capitalized software	$ 635	$ 168	$ 175	$ 89	$ 432	$ —	$ 1,067
Depreciation and amortization	$ 680	$ 154	$ 195	$ 95	$ 444	$ —	$ 1,124
2010							
Revenues — external customers:							
Premiums	$ 84,158	$ 1,247	$ —	$ —	$ 1,247	$ —	$ 85,405
Services	4,021	331	1,403	64	1,798	—	5,819
Products	—	19	93	2,210	2,322	—	2,322
Total revenues — external customers	88,179	1,597	1,496	2,274	5,367	—	93,546
Total revenues — intersegment	—	2,912	845	14,449	18,206	(18,206)	—
Investment and other income	551	56	1	1	58	—	609
Total revenues	$ 88,730	$ 4,565	$ 2,342	$16,724	$ 23,631	$(18,206)	$ 94,155
Earnings from operations	$ 6,740	$ 511	$ 84	$ 529	$ 1,124	$ —	$ 7,864
Interest expense	—	—	—	—	—	(481)	(481)
Earnings before income taxes	$ 6,740	$ 511	$ 84	$ 529	$ 1,124	$ (481)	$ 7,383
Total Assets	$ 50,913	$ 3,897	$ 5,435	$ 3,087	$ 12,419	$ (269)	$ 63,063
Purchases of property, equipment and capitalized software	$ 525	$ 117	$ 156	$ 80	$ 353	$ —	$ 878
Depreciation and amortization	$ 725	$ 100	$ 159	$ 80	$ 339	$ —	$ 1,064
Goodwill impairment	$ —	$ —	$ 172	$ —	$ 172	$ —	$ 172

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2012 and 2011 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	**March 31**	**June 30**	**September 30**	**December 31**
2012				
Revenues	$27,282	$27,265	$27,302	$28,769
Operating costs	24,965	25,039	24,692	26,668
Earnings from operations	2,317	2,226	2,610	2,101
Net earnings	1,388	1,337	1,557	1,244
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	1.34	1.30	1.52	1.22
Diluted	1.31	1.27	1.50	1.20
2011				
Revenues	$25,432	$25,234	$25,280	$25,916
Operating costs	23,211	23,135	23,210	23,842
Earnings from operations	2,221	2,099	2,070	2,074
Net earnings	1,346	1,267	1,271	1,258
Basic net earnings per common share	1.24	1.18	1.19	1.19
Diluted net earnings per common share	1.22	1.16	1.17	1.17

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2012. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2012.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2012 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control over Financial Reporting as of December 31, 2012

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2012. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated F*ramework. Management's assessment of the effectiveness of our internal control over financial reporting excluded an assessment of the effectiveness of our internal control over financial reporting of Amil Participações S.A and its subsidiaries (Amil). Such exclusion was in accordance with Securities and Exchange Commission guidance that an assessment of a recently acquired business may be omitted in management's report on internal control over financial reporting in the year of acquisition. We acquired a controlling interest in Amil during October 2012. Amil represented 10% of our consolidated total assets and 1% of our consolidated total revenues as of and for the year ended December 31, 2012. Based on our assessment and the COSO criteria, we believe that, as of December 31, 2012, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2012, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal controls over financial reporting as of December 31, 2012.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Report of Management on Internal Control over Financial Reporting as of December 31, 2012, management excluded from its assessment the internal control over financial reporting at Amil Participações S.A and its subsidiaries (Amil), which was acquired during October 2012 and whose financial statements collectively constitute approximately 10% of total assets and 1% of total revenues of the consolidated financial statement amounts as of and for the year ended December 31, 2012. Accordingly, our audit did not include the internal control over financial reporting at Amil. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2012. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2012 of the Company and our reports dated February 6, 2013 expressed as an unqualified opinion on those consolidated financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 6, 2013

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2012, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights [3] (in millions)	(b) Weighted-average exercise price of outstanding options, warrants and rights [3]	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (in millions)
Equity compensation plans approved by shareholders[1]	51	$43	63[4]
Equity compensation plans not approved by shareholders[2]	—	—	—
Total[2]	51	$43	63

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended, and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 0.1 million shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average exercise price of $41 and an average remaining term of approximately 2.1 years. The options are administered pursuant to the terms of the plan under which the option originally was granted. No future awards will be granted under these acquired plans.

(3) Excludes stock appreciation rights (SARs) to acquire 12 million shares of common stock of the Company with exercise prices above $54.24, the closing price of a share of our common stock as reported on the NYSE on December 31, 2012.
(4) Includes 20 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2012, and 43 million shares available under the 2011 Stock Incentive Plan as of December 31, 2012. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 16 million of these shares are available for future grants of awards other than stock options or SARs.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2012 and 2011.
- Consolidated Statement of Operations for the years ended December 31, 2012, 2011, and 2010.
- Consolidated Statement of Comprehensive Income for the years ended December 31, 2012, 2011, and 2010.
- Consolidated Statement of Changes in Shareholders' Equity for the years ended December 31, 2012, 2011, and 2010.
- Consolidated Statement of Cash Flows for the years ended December 31, 2012, 2011, and 2010.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

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

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.3	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.4	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.5	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.6	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.7	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.8	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.9	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.10	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.11	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan
*10.12	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)

*10.13	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 31, 2006)
*10.14	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.15	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.16	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.17	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2012 and 2011, and for each of the three years in the period ended December 31, 2012, and the Company's internal control over financial reporting as of December 31, 2012, and have issued our reports thereon dated February 6, 2013; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 6, 2013

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2012	December 31, 2011
Assets		
Current assets:		
Cash and cash equivalents	$ 1,025	$ 1,506
Notes receivable from subsidiaries	2,889	—
Deferred income taxes, prepaid expenses and other current assets	225	179
Total current assets	4,139	1,685
Equity in net assets of subsidiaries	43,724	38,688
Other assets	106	77
Total assets	$47,969	$40,450
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 356	$ 351
Note payable to subsidiary	175	145
Commercial paper and current maturities of long-term debt	2,541	982
Total current liabilities	3,072	1,478
Long-term debt, less current maturities	13,602	10,656
Deferred income taxes and other liabilities	117	24
Total liabilities	16,791	12,158
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value —10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 1,019 and 1,039 issued and outstanding	10	10
Additional paid-in capital	66	—
Retained earnings	30,664	27,821
Accumulated other comprehensive income	438	461
Total UnitedHealth Group shareholders' equity	31,178	28,292
Total liabilities and shareholders' equity	$47,969	$40,450

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2012	2011	2010
Revenues:			
Investment and other income	$ 28	$ 3	$ 2
Total revenues	28	3	2
Operating costs:			
Operating costs	(2)	25	54
Interest expense	566	451	433
Total operating costs	564	476	487
Loss before income taxes	(536)	(473)	(485)
Benefit for income taxes	192	167	180
Loss of parent company	(344)	(306)	(305)
Equity in undistributed income of subsidiaries	5,870	5,448	4,939
Net earnings	5,526	5,142	4,634
Other comprehensive (loss) income	(23)	209	(1)
Comprehensive income	$5,503	$5,351	$4,633

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2012	2011	2010
Operating activities			
Cash flows from operating activities	$ 6,116	$ 5,560	$ 3,731
Investing activities			
Cash paid for acquisitions	(3,737)	(2,081)	(2,470)
Capital contributions to subsidiaries	(99)	(171)	(104)
Cash flows used for investing activities	(3,836)	(2,252)	(2,574)
Financing activities			
Common stock repurchases	(3,084)	(2,994)	(2,517)
Issuance of notes to subsidiaries	(4,149)	—	—
Proceeds from common stock issuance	1,078	381	272
Cash dividends paid	(820)	(651)	(449)
Proceeds from commercial paper, net	1,587	(933)	930
Proceeds from issuance of long term debt	3,966	2,234	747
Repayments of long-term debt	(986)	(955)	(1,583)
Interest rate swap termination	—	132	—
Proceeds of note from subsidiary	30	15	30
Other	(383)	53	20
Cash flows used for financing activities	(2,761)	(2,718)	(2,550)
(Decrease) increase in cash and cash equivalents	(481)	590	(1,393)
Cash and cash equivalents, beginning of period	1,506	916	2,309
Cash and cash equivalents, end of period	$ 1,025	$ 1,506	$ 916
Supplemental cash flow disclosures			
Cash paid for interest	$ 547	$ 418	$ 459
Cash paid for income taxes	2,666	2,739	2,725

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in the Summary of Significant Accounting Policies in Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Notes Receivable from Subsidiaries. Notes issued to subsidiaries were used primarily to fund acquisitions. During 2012, the parent company completed a non-cash exchange of a $3.9 billion intercompany note to a subsidiary for a new term note of $2.6 billion and an equity interest of $1.3 billion.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $7.8 billion, $5.6 billion and $4.3 billion in 2012, 2011 and 2010, respectively.

3. Commercial Paper and Long-Term Debt

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2013 (a)	$2,541
2014	589
2015	1,067
2016	1,152
2017	1,281
Thereafter	9,513

(a) Includes $9 million of debt subject to acceleration clauses.

Long-term debt obligations of the parent company do not include Brazilian real denominated debt of a subsidiary with a total par value of $588 million. Further information on commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 6, 2013

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director, President and Chief Executive Officer (principal executive officer)	February 6, 2013
/s/ DAVID S. WICHMANN **David S. Wichmann**	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations (principal financial officer)	February 6, 2013
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 6, 2013
* **William C. Ballard, Jr.**	Director	February 6, 2013
* **Richard T. Burke**	Director	February 6, 2013
* **Edson Bueno**	Director	February 6, 2013
* **Robert J. Darretta**	Director	February 6, 2013
* **Michele J. Hooper**	Director	February 6, 2013
* **Rodger A. Lawson**	Director	February 6, 2013
* **Douglas W. Leatherdale**	Director	February 6, 2013
* **Glenn M. Renwick**	Director	February 6, 2013
* **Kenneth I. Shine**	Director	February 6, 2013
* **Gail R. Wilensky**	Director	February 6, 2013

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.3	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.4	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.5	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.6	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.7	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)

*10.8	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 23, 2011)
*10.9	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.10	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.11	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2011**

or

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

Commission file number: 1-10864

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Minnesota	**KRS 61.878(1)(a)**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒
The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2011 was $54,799,296,021 (based on the last reported sale price of $51.58 per share on June 30, 2011, on the New York Stock Exchange).*
As of January 31, 2012, there were 1,044,964,149 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.
Note that in Part III of this report on Form 10-K, we incorporate by reference certain information from our Definitive Proxy Statement for the 2012 Annual Meeting of Shareholders. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.
* Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the Company have been excluded in determining this number.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company whose mission is to help people live healthier lives and help make health care work better (the terms "we," "our," "us," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries). Our business model has evolved and is informed by over three decades of serving the needs of the markets, and people, of health care.

Today, we are helping individuals access quality care at an affordable cost; simplifying health care administration and delivery; strengthening the physician/patient relationship; promoting evidence-based care; and empowering physicians, health care professionals, consumers, employers and other participants in the health system with actionable data to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare serves the health benefits needs of individuals across life's stages through three businesses. UnitedHealthcare Employer & Individual serves individual consumers and employers. The unique health needs of seniors are served by UnitedHealthcare Medicare & Retirement. UnitedHealthcare Community & State serves the public health marketplace, offering states innovative Medicaid solutions.

Optum serves health system participants including consumers, physicians, hospitals, governments, insurers, distributors and pharmaceutical companies, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that drive improved access, affordability, quality and simplicity across eight markets: integrated care delivery, care management, consumer engagement and support, distribution of benefits and services, health financial services, operational services and support, health care information technology and pharmacy.

Through UnitedHealthcare and Optum, in 2011, we managed approximately $135 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, see Note 13 of Notes to the Consolidated Financial Statements.

UnitedHealthcare

UnitedHealthcare is advancing strategies to improve the way health care is delivered and financed, offering consumers a simpler, more affordable health care experience. Our market position is built on:

- a national scale;
- the breadth of our product offerings, which are responsive to many distinct market segments in health care;
- strong local market relationships;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;

- extensive expertise in distinct market segments; and
- a commitment to innovation.

The financial results of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & State have been aggregated in the UnitedHealthcare reportable segment due to their similar economic characteristics, products and services, customers, distribution methods, operational processes and regulatory environment. These businesses also share significant common assets, including our contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx prescription drug services, OptumHealth care solutions and behavioral health services and OptumInsight fraud and abuse prevention and detection. UnitedHealthcare arranges for discounted access to care through networks that include a total of nearly 754,000 physicians and other health care professionals and nearly 5,400 hospitals across the United States (UnitedHealthcare Network).

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual works closely with employers and individuals to provide health benefit plans that provide personalized solutions to help members live healthier lives and achieve meaningful cost savings. UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide, providing nearly 26 million Americans access to health care as of December 31, 2011.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependants, UnitedHealthcare Employer & Individual receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependants, while UnitedHealthcare Employer & Individual provides customized services such as coordination and facilitation of medical services and related services to customers, consumers and health care professionals, transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision. Large employer groups, such as those serviced by UnitedHealthcare Employer & Individual National Accounts, typically use self-funded arrangements. As of December 31, 2011, UnitedHealthcare Employer & Individual National Accounts served approximately 400 large employer groups under these arrangements, including 147 of the *Fortune 500* companies. Smaller employer groups are more likely to purchase risk-based products because they are less willing or able to bear a greater potential liability for health care expenditures. UnitedHealthcare Employer & Individual also offers a variety of non-employer based insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families.

As the commercial market becomes more consumer-oriented, individuals are assuming more personal and financial responsibility for their care, and they are demanding more affordable products, greater transparency and choice and personalized help navigating the complex system. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals. Individuals served by UnitedHealthcare Employer & Individual have access to 90% of the physicians and other health care professionals and 97% of the hospitals in the UnitedHealthcare Network; certain care providers are available only to those consumers served through Medicare and/or Medicaid products.

UnitedHealthcare Employer & Individual is engaging physicians and consumers and using information to promote well-informed health decisions, improved medical outcomes and greater efficiency. It offers consumers engaging and informative tools and resources that provide greater transparency around quality and cost, such as our Premium Designation program and Treatment Cost Estimator tool, affording our members more control over their health care.

UnitedHealthcare Employer & Individual's innovative clinical programs, built around an extensive clinical data set and principles of evidence-based medicine, are enabling a more integrated, proactive and personalized health system. The programs promote consumer engagement, health education, admission counseling before hospital stays, care advocacy to help avoid prolonged patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. Disease and condition management programs help individuals address significant, complex disease states, including disease-specific benefit offerings such as the Diabetes Health Plan.

UnitedHealthcare Employer & Individual offers high-deductible consumer-driven benefit plans, which include health savings accounts (HSA) and health reimbursement accounts (HRA), enabling consumers to achieve even greater value and choice. During 2011, nearly 36,000 employer-sponsored benefit plans, including approximately 200 employers in the large group self-funded market, purchased one of these consumer-oriented products.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower

costs by using formulary programs to drive better unit costs, encouraging consumers to use drugs that offer better value and outcomes, and through physician and consumer programs that support the appropriate use of drugs based on clinical evidence. In addition, UnitedHealthcare Employer & Individual also offers a comprehensive range of dental, vision, life, and disability product offerings delivered through an integrated approach that enhances efficiency and effectiveness and includes a network of nearly 35,000 vision professionals in private and retail settings, and more than 180,000 dental providers.

UnitedHealthcare Employer & Individual's distribution system consists primarily of producers (i.e., brokers and agents) and direct and internet sales in the individual market, producers in the small employer group market, and producers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare Employer & Individual's direct distribution efforts are generally limited to the individual market, portions of the large employer group and public sector markets, and cross-selling of specialty products to existing customers. UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs).

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia, and most U.S. territories.

UnitedHealthcare Medicare & Retirement offers a wide spectrum of Medicare products, including Medicare Advantage plans, Medicare Part D prescription drug coverage, and Medigap products that supplement traditional fee-for-service coverage, which may be sold to individuals or on a group basis. Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 28% of our total consolidated revenues for the year ended December 31, 2011, most of which were generated by UnitedHealthcare Medicare & Retirement under a number of contracts.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over; state and U.S. government agencies; and employer groups. UnitedHealthcare Medicare & Retirement also has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to risk-based health products and services in the senior and geriatric markets.

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Special Needs Plans, Point-of-Service (POS) plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS. Premium amounts vary based on the geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement also provides complete, individualized care planning and care benefits for retirees, aging, disabled and chronically ill individuals, serving individuals enrolled in Medicare Advantage products in 30 states and in the District of Columbia in long-term care settings including nursing homes, community-based settings and private homes. In addition, UnitedHealthcare Medicare & Retirement offers innovative care management and clinical programs, integrating federal, state and personal funding through a continuum of products from Medicare Advantage and Special Needs Plans to hospice care. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. UnitedHealthcare Medicare & Retirement had approximately 2.2 million members enrolled in its Medicare Advantage products as of December 31, 2011. Proprietary predictive modeling tools help identify members at high risk and allow care managers to proactively outreach to members to create individualized care plans and help members obtain the right care, in the right place, at the right time.

Prescription Drug Benefit (Part D). UnitedHealthcare Medicare & Retirement provides the Medicare prescription drug benefit (Part D) to beneficiaries throughout the United States and its territories. UnitedHealthcare Medicare & Retirement provides Part D drug coverage through its Medicare Advantage program and stand-alone Part D plans. As of December 31, 2011, UnitedHealthcare Medicare & Retirement had enrolled 7.1 million members in the Part D program, including 4.9 million members in the stand-alone Part D plans and 2.2 million members in its Medicare Advantage plans incorporating Part D coverage.

Medicare Supplement. In association with AARP, UnitedHealthcare Medicare & Retirement provides a range of Medicare supplement and hospital indemnity insurance offerings through insurance company affiliates to 3.8 million AARP members.

Additional UnitedHealthcare Medicare & Retirement services include a nurse health line service, a lower cost Medicare supplement offering that provides consumers with a national hospital network, 24-hour access to health care information, and

access to discounted health services from a network of physicians.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to providing innovative Medicaid managed care solutions to states that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage in exchange for a monthly premium per member from the applicable state. States using managed care services for Medicaid beneficiaries select health plans using either a formal bid process, or award individual contracts. As of December 31, 2011, UnitedHealthcare Community & State participates in programs in 23 states and the District of Columbia, serving approximately 3.5 million beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs.

UnitedHealthcare Community & State's health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with higher risk medical, behavioral and social conditions. UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group, delivering them at the local market level to support effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care. For example, the Personal Care Model establishes an ongoing relationship between health care professionals and individuals who have serious and chronic health conditions to help them maintain the best possible health and functional status, whether care is delivered in an acute care setting, long-term care facility or at home. Programs for families and children focus on high-prevalence and debilitating chronic illnesses such as hypertension and cardiovascular disease, asthma, sickle cell disease, diabetes, HIV/AIDS and high-risk pregnancies. Programs for the long-term care population focus on dementia, depression, coronary disease and functional-use deficiencies that impede daily living.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including payers, care providers, employers, government, life sciences companies and consumers. By helping connect and align health system participants and providing them actionable information at the points of decision-making, Optum helps improve overall health system performance: optimizing care quality, reducing costs and improving the consumer experience and care provider performance. Optum is organized in three segments:

- OptumHealth focuses on health management and wellness, clinical services and financial services;
- OptumInsight delivers technology, health intelligence, consulting and business outsourcing solutions; and
- OptumRx specializes in pharmacy services.

The breadth of this portfolio allows Optum to impact key activities that help enable better integrated, more sustainable health care.

OptumHealth

OptumHealth serves the physical, emotional and financial needs of 60 million unique individuals, enabling consumer health management and collaborative care delivery through programs offered by employers, payers, government entities and, increasingly, directly through the care delivery system. OptumHealth's products and services can be deployed individually or integrated to provide comprehensive solutions, addressing a broad base of needs within the health care system. OptumHealth's solutions reduce costs for customers, improve workforce productivity and consumer satisfaction and optimize the overall health and well-being of populations.

OptumHealth's simple, modular service designs can be easily integrated to meet varying employer, payer, government entity, care provider and consumer needs at a wide range of price points. OptumHealth offers its products, primarily, on an administrative fee basis whereby it manages or administers delivery of the product or services in exchange for a fixed fee per individual served, and on a risk basis, where OptumHealth assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes States, CMS, Department of Defense, Veterans Administration and other federal procurement). As provider reimbursement models evolve, care providers are emerging as a fourth market segment for our health management, financial services and collaborative care services.

OptumHealth is organized into five major operating groups: Care Solutions, Behavioral Solutions, Financial Services, Collaborative Care, and Logistics Health, Inc.

Care Solutions. Care Solutions serves more than 41 million individuals through personalized health management (e.g., wellness, chronic and complex conditions), decision support (e.g., insurance choices, treatment and health care provider options) and access to networks of care provider specialists linked to medical conditions with high variation of quality and cost (e.g., physical health, cancer and transplants). This comprehensive solution set empowers consumers and enables their collaboration with specialty care providers that is critical to decisions that drive hospitalization and surgery.

Behavioral Solutions. Behavioral Solutions serves more than 52 million individuals through global well-being solutions (e.g., employee assistance programs) and behavioral health management solutions (e.g., mental health, substance abuse) that address the emotional health needs of consumers, spanning the stress and anxiety of daily living, to depression associated with chronic illness, to clinically diagnosed mental illness. Programs combine predictive modeling, evidence-based clinical outcomes management, consumer support and peer support, with access to a leading network of behavioral health care providers. Behavioral Solutions customers have access to a national network of more than 112,000 clinicians and counselors and 3,300 facilities in approximately 6,600 locations nationwide.

Financial Services. Dedicated solely to the health care market, OptumHealth Financial Services helps organizations and individuals optimize their health care finances. As a leading provider of consumer health care accounts (e.g., health savings accounts, flexible spending accounts), OptumHealth Financial Services enables people to use those tax-favored accounts to save money today and build health savings for the future. Organizations rely upon OptumHealth Financial Services to manage and improve their cash flows through turnkey electronic payment solutions (e.g., remittance advices, funds transfers) health care-related lending and credit (e.g., financing of care provider medical equipment) and financial risk protection for third party payers and self-funded employers (e.g., comprehensive stop-loss insurance coverage).

Financial Services is comprised of OptumHealth Bank, which is a member of the Federal Deposit Insurance Corporation (FDIC), a TPA and a transaction processing service for the health care industry. As of December 31, 2011, Financial Services had $1.5 billion in customer assets under management and during 2011 processed $54 billion in medical payments to physicians and other health care providers.

Collaborative Care. Working closely with various health care providers in local markets and communities, Collaborative Care believes that the market is moving to a collaborative network model aligned around total population health management and outcomes-based reimbursement. In close coordination with local integrated care delivery systems, it deploys a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. OptumHealth's coordinated post-acute care services augment primary care physicians to deliver services outside of hospitals to vulnerable, chronically ill populations. In affiliation with a broad variety of payers, Collaborative Care also delivers care to approximately 700,000 people through a spectrum of models ranging from medical clinics to contracts with individual practice association networks.

Logistics Health, Inc. Acquired in 2011, Logistics Health, Inc. (LHI) focuses on mobile care delivery, logistically arranging for convenient access to care at the time and place most needed. LHI designs and implements occupational health, medical and dental readiness services, treatments and immunization programs and disability exams for the U.S. Military, Veterans Administration and Department of Health and Human Services, as well as numerous commercial companies. Services are delivered in provider clinics or through temporary on-site resources.

OptumInsight

OptumInsight is a health information, technology, services and consulting company providing software and information products, advisory consulting services, and business process outsourcing to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system work with OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape. As of December 31, 2011, OptumInsight's customer base included more than 6,000 hospital facilities, nearly 250,000 health care professionals or groups, nearly 300 commercial insurance companies and health plans, approximately 400 global life sciences companies, over 300 federal and state government agencies, including all 50 states, and approximately 150 United Kingdom government payers, as well as other UnitedHealth Group businesses.

OptumInsight’s products and services are sold primarily through a direct sales force. OptumInsight’s products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

OptumInsight's technology products and services solutions are offered through four integrated market groups. These market groups are Provider (e.g., physician practices and hospitals), Payer, Government and Life Sciences.

Provider. The Provider market group combines a comprehensive range of technology and information products, advisory

consulting, and outsourcing services focused on hospitals, integrated delivery networks, and physician practices. These solutions help providers establish efficient administrative and clinical workflows, improve patient care, and meet compliance mandates and are organized around hospital and physician practice needs for:

- Financial Performance Improvement: Provides comprehensive revenue cycle management technology, coding solutions, and full business process outsourcing for hospitals and physicians practices that drive higher net patient revenue and lower operational costs;
- Compliance: Delivers real-time medical necessity reviews and retrospective appeals management services to nearly 2,000 hospitals in all 50 states;
- Clinical Workflow and Connectivity: Provides high-acuity and ambulatory clinical workflow and electronic medical records software that makes hospital departments and physician practices more efficient, improves patient experience, and enables sharing of clinical data in integrated care settings. OptumInsight Health Information Exchange (HIE) solutions power 11 statewide HIEs and 36 regional and hospital integrated delivery network HIEs, and are used by more than 370 hospitals, more than 50,000 physicians and 165,000 health care professionals; and
- Accountable Care Solutions: Working with early adopters of Accountable Care Organization models to build the administrative, analytics, compliance, and care management infrastructure to succeed in outcomes-based payment models.

Payer. OptumInsight's Payer business serves clients that offer commercial health insurance or privately administer health insurance programs on behalf of federal or state governments (e.g., Medicare Advantage or Managed Medicaid). The business offers technology, services and consulting capabilities that supplement OptumInsight's clients' existing operations, as well as fully outsourced solutions. The business addresses diverse needs for payer clients, serving four primary areas:

- Network Performance: Comprehensive offerings to enhance performance of provider networks and improve population health, including network design, management and operation services, as well as analytical tools that support care management;
- Clinical Quality: Services that align clinical quality and performance with financial outcomes for payers, such as Medicare risk adjustment services and quality improvement consulting;
- Operational Efficiency and Payment Integrity: A spectrum of offerings focused on improving the efficiency and cost-effectiveness of payer operations. Solutions assist in addressing a wide variety of operational improvement opportunities such as process improvement and automation, fraud and abuse, claims payment accuracy and coordination of benefits; and
- Risk Optimization: Solutions help payers to grow and improve financial performance through predictive analytics and risk management services. Offerings include actuarial services, rating and underwriting products, and membership population modeling, as well as analytics and consulting.

Government Solutions. OptumInsight Government Solutions helps state and federal governments improve the efficiency and quality of health and human services programs by offering a broad range of solutions including:

- Program Integrity: Improves the accuracy and efficiency of provider payments through prospective and retrospective analysis of claims transactions, driving detection of fraud and abuse and checking payment accuracy;
- Health Management and Population Analytics: Measures and identifies opportunities for improvement in cost, network performance, and care management for populations of covered members. Also includes health policy advisory services; and
- Data Warehousing and Business Intelligence: Builds and manages health care specific data model and warehouse solutions for Federal and State based programs. Applies business intelligence to analyze and drive decision making to improve cost, clinical outcomes, and member satisfaction.

Life Sciences. The Life Sciences business addresses the changing global economic and regulatory competitive landscape by assisting life sciences clients in identifying, analyzing and measuring the value of their products. The Life Sciences business consults with clients by working across both research and development and brand/marketing so they can improve market access and product positioning. OptumInsight utilizes extensive real world data assets, scientifically-based research design and analytics to support the global life sciences industry and its markets through:

- Market Access and Optimization: Utilizes real-world evidence to drive increased drug revenues and decreased commercialization costs through health economics and outcomes research, pricing and reimbursements strategies, data and informatics, and late phase/Phase IV research studies;
- Strategic Regulatory Services: Focuses on design and execution of multi-national regulatory strategies to help clients speed regulatory approval and maintain compliance with dynamic regulations across geographies;

- Risk Management: Designs and executes epidemiology studies to understand detailed drug safety profiles and build integrated plans to address safety issues with regulators, providers, and patients; and
- Patient Insights: Drives collection and understanding of patient reported outcomes to inform comparative effectiveness research, patient engagement and adherence, and population health management.

Many of OptumInsight's software and information products, advisory consulting arrangements, and outsourcing contracts are performed over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. In 2011, OptumInsight standardized backlog reporting across recent acquisitions and as a result increased the backlog by $0.4 billion. OptumInsight's aggregate backlog at December 31, 2011 was $4.0 billion, of which $2.4 billion is expected to be realized within the next 12 months. This includes $0.9 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services, the potential for cancellation, non-renewal, or early termination of service arrangements.

OptumRx

OptumRx provides a multitude of pharmacy benefit management (PBM) services. It serves more than 14 million people nationwide through its network of approximately 66,000 retail pharmacies and two mail service facilities, processing nearly 370 million adjusted retail, mail and specialty drug prescriptions annually. OptumRx is dedicated to helping its customers achieve optimal health while maximizing cost savings. It does this by working closely with customers to create customized solutions to improve quality and safety, increase compliance and adherence and reduce fraud and waste.

OptumRx provides PBM services and manages specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses, as well as for external employer groups, union trusts, managed care organizations, Medicare-contracted plans, Medicaid plans and TPAs, including for pharmacy benefit services, mail service only, rebate services only and network services. Services include providing prescribed medications, patient support and clinical programs that ensure quality and value for consumers. OptumRx also provides claims processing, retail network contracting, rebate contracting and management and clinical programs, such as step therapy, formulary management and disease/drug therapy management programs to achieve a low-cost, high-quality pharmacy benefit. The mail order and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component in serving employers, commercial health plans, Medicaid plans and Medicare-contracted businesses, including Part D prescription drug plans. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated by federal and state regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. In the first quarter of 2010, the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Reform Legislation, were signed into law. The Health Reform Legislation, portions of which are summarized below, alters the regulatory environment in which we operate, in some cases to a significant degree. Federal and state governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, as well as a result of changes in the political climate, could adversely affect our business.

In the event we fail to comply with, or we fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, “Risk Factors” for a discussion of the risks related to compliance with federal and state laws and regulations.

Health Care Reforms

The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system. Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. The U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Treasury Department have issued or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance on other key aspects of the legislation remain pending.

Certain aspects of the Health Reform Legislation are also being challenged in federal court, with the proponents of such

challenges seeking to limit the scope of or have all or portions of the Health Reform Legislation declared unconstitutional. The United States Supreme Court is scheduled to hear oral arguments on certain aspects of these cases in March 2012, including the constitutionality of the individual mandate. Congress may also withhold the funding necessary to implement the Health Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether.

The following outlines certain provisions of the Health Reform Legislation that have recently taken effect or are expected to take effect in the coming years, assuming the legislation is implemented in its current form.

Effective 2010: The Health Reform Legislation mandated: the expansion of dependent coverage to include adult children until age 26; eliminated certain annual and lifetime caps on the dollar value of certain essential health benefits; eliminated pre-existing condition limits for enrollees under age 19; prohibited certain policy rescissions; prohibited plans and issuers from charging higher cost sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network; and included a requirement to provide coverage for preventive services without cost to members (for non-grandfathered plans).

The Health Reform Legislation also mandated certain changes to coverage determination and appeals processes, including: expanding the definition of "adverse benefit determination" to include rescissions; extending external review rights of adverse benefit determinations to insured and self-funded plans; and improving the clarity of and expanding the types of information in adverse benefit determination notices.

Effective 2011: Commercial fully insured health plans in the large employer group, small employer group and individual markets with medical loss ratios below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals, as calculated under the definitions in the Health Reform Legislation and regulations, subject to state specific exceptions) are required to rebate ratable portions of their premiums to their customers annually. Rebate payments for 2011 will be made in mid 2012. A state can request a waiver of the individual market medical loss ratio for up to three years if the state petitions and provides to HHS certain supporting data, and HHS determines that the requirement is disruptive to the market in that state. By the end of 2011, 17 states petitioned HHS for waivers of the mandated individual market medical loss ratio, of which six were wholly or partially granted. The Health Reform Legislation also mandated consumer discounts of 50% on brand name prescription drugs and 7% on generic prescription drugs for Part D plan participants in the coverage gap. These consumer discounts will gradually increase over the next several years, which will decrease consumer out-of-pocket drug spending within the coverage gap, shifting a portion of these costs to the plan sponsor.

In addition, as required under the Health Reform Legislation, HHS established a federal premium rate review process, which became effective in September 2011 and generally applies to proposed rate increases equal to or exceeding 10% (with state-specific thresholds to be applicable commencing September 2012). The regulations further require commercial health plans to provide to the states and HHS extensive information supporting any rate increases subject to the new federal rate review process. The regulations clarify that HHS review will not supersede existing state review and approval processes, but plans deemed to have a history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that become active under the Health Reform Legislation in 2014. Under the regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

Effective 2011/2012: CMS reduced or froze benchmarks which affect our Medicare Advantage reimbursements from CMS between 2009 and 2011, and beginning in 2012, additional cuts to Medicare Advantage benchmarks will take effect (benchmarks will ultimately range from 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), with changes being phased-in over two to six years, depending on the level of benchmark reduction in a county. In addition to other measures, quality bonuses may partially offset these anticipated benchmark reductions as CMS quality rating bonuses are phased in over three years beginning in 2012.

Effective 2013: Effective beginning in 2013 with respect to services performed after 2009, the Health Reform Legislation limits the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code for insurance providers if at least 25% of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements.

Effective 2013/2014: The Health Reform Legislation provides for an increase in Medicaid fee-for-service and managed care program reimbursements for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014, and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009.

Effective 2014: A number of the provisions of the Health Reform Legislation are scheduled to take effect in 2014, including: an annual insurance industry assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter), which is not deductible for income tax purposes; expansion of Medicaid eligibility for all individuals and families with incomes up to 133% of the federal poverty level (states can early adopt the expansion without increased federal funding prior to 2014) with states receiving full federal matching in 2014 through 2016; all

individual and group health plans must offer coverage on a guaranteed issue and guaranteed renewal basis during annual open enrollment and special enrollment periods and cannot apply pre-existing condition exclusions or health status rating adjustments; elimination of annual limits on essential benefits coverage on certain plans; establishment of state-based exchanges for individuals and small employers (generally, with up to 100 employees) as well as certain CHIP eligibles; introduction of plan designs based on set actuarial values to increase comparability of competing products on the exchanges; and establishment of minimum medical loss ratio of 85% for Medicare Advantage plans, as calculated under rules that have not yet been issued.

The Health Reform Legislation and the related federal and state regulations will impact how we do business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase our medical and administrative costs, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business. In addition, our results of operations, financial position, including our ability to maintain the value of our goodwill, and cash flows could be materially and adversely affected by such changes. The Health Reform Legislation may also create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known. See also Item 1A, “Risk Factors” for a discussion of the risks related to the Health Reform Legislation and related matters.

Other Federal Laws and Regulation

We are subject to various levels of federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State Medicare and Medicaid businesses, as well as certain aspects of our Optum businesses. Our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS (or state agencies) for purposes of determining the amount of certain payments to us. CMS also has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care given to Medicare beneficiaries. See Note 12 of Notes to the Consolidated Financial Statements and risk factors in this Form 10-K for a discussion of audits by CMS.

Our UnitedHealthcare reporting segment, through UnitedHealthcare Community & State, also has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance, and the regulatory environment with respect to these programs has become and will continue to become increasingly complex as a result of the Health Reform Legislation. In addition, certain of Optum's businesses hold contracts with federal agencies, including the U.S. Department of Defense, and we are subject to federal law and regulations relating to the administration of these contracts.

Certain of UnitedHealthcare's and Optum's businesses, such as UnitedHealthcare's eyeglass manufacturing activities and Optum's high clinical acuity workflow software, hearing aid products, and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration, and the clinical research activities are also subject to laws and regulations outside of the United States that regulate clinical trials. Laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust also affect us.

HIPAA, GLBA and Other Privacy and Security Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. HIPAA requires guaranteed health care coverage for small employers and certain eligible individuals. It also requires guaranteed renewability for employers and individuals and limits exclusions based on pre-existing conditions. Federal regulations related to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may also apply to us.

Federal privacy and security requirements change frequently because of legislation, regulations and judicial or administrative interpretation. For example, the U.S. Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), which significantly amends, and adds new privacy and security provisions to HIPAA and imposes additional requirements on uses and disclosures of health information. ARRA includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. We are awaiting final

regulations on many key aspects of the ARRA amendments to HIPAA. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personal identifiable information. The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with HIPAA, GLBA and other privacy-related regulations.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the DOL as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL provide additional rules for claims payment and member appeals under health care plans governed by ERISA. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

FDIC. The FDIC has federal regulatory authority over OptumHealth Bank and performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements. In addition to such annual examinations, the FDIC performs periodic examinations of the bank's compliance with applicable federal banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subject to increased operational expenses and capital requirements, governmental oversight and monetary penalties.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners (NAIC) to adopt elements substantially similar to the Sarbanes-Oxley Act of 2002, we expect that these states will continue to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Certain states have also adopted their own regulations for minimum medical loss ratios with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the Health Reform Legislation. We expect the states to continue to introduce and pass similar laws in 2012, and this will affect our operations and our financial results.

Health plans and insurance companies are also regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

In addition, some of our business and related activities may be subject to other health care-related regulations and requirements, including PPO, managed care organization (MCO), utilization review (UR) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, adequacy of health care professional networks, fraud prevention, the protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker, and sales distributions laws and regulations. Our UnitedHealthcare Community & State and UnitedHealthcare Medicare & Retirement businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually-eligible Medicaid beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies (and HMOs in some states), including those issuing health, long-term care, life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies

that write the same line or lines of business. Assessments generally are based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets. See Note 12 of Notes to the Consolidated Financial Statements for a discussion of a matter involving Penn Treaty Network American Insurance Company and its subsidiary (Penn Treaty), which have been placed in rehabilitation.

Pharmacy Regulation. OptumRx's mail order pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, “Risk Factors” for a discussion of the risks related to our PBM businesses.

Privacy and Security Laws. States have adopted regulations to implement provisions of the GLBA. Like HIPAA, GLBA allows states to adopt more stringent requirements governing privacy protection. A number of states have also adopted other laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure and protection of social security numbers and sensitive health information or that are designed to protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security-related regulations.

UDFI. The Utah State Department of Financial Institutions (UDFI) has state regulatory and supervisory authority over OptumHealth Bank and in conjunction with federal regulators performs annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements. In addition to such annual examinations, the UDFI in conjunction with federal regulators performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subjected to increased operational expenses and capital requirements, governmental oversight and monetary penalties.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct service providers to care delivery systems and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit certain entities from practicing medicine or employing physicians to practice medicine. Additionally, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be a matter of judicial or regulatory interpretation. These laws, regulations and interpretations have, in certain states, been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Audits and Investigations

We have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the FTC, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the Internal Revenue Service (IRS), the DOL, the FDIC and other governmental authorities. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. See Note 12 of Notes to the Consolidated Financial Statements for details. In addition, disclosure of any adverse investigation, audit results or sanctions could adversely affect our reputation in various markets and make it more difficult for us to sell our products and services and retain our current business.

International Regulation

Most of our business is conducted in the United States. However, some of our businesses and operations are international in nature and are consequently subject to regulation in the jurisdictions in which they are organized or conduct business. These

regulatory regimes encompass tax, licensing, tariffs, intellectual property, investment, management control, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary from jurisdiction to jurisdiction, among other matters. These international operations are also subject to United States laws that regulate activities of U.S.-based businesses abroad.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to directly contract with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our UnitedHealthcare businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas. For our OptumRx businesses, competitors include Medco Health Solutions, Inc., CVS Caremark Corporation and Express Scripts, Inc. Our OptumHealth and OptumInsight reportable segments also compete with a broad and diverse set of businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales, marketing and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

EMPLOYEES

As of December 31, 2011, we employed approximately 99,000 individuals. We believe our employee relations are generally positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 8, 2012, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	59	President and Chief Executive Officer
David S. Wichmann	49	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations
Richard N. Baer	54	Executive Vice President and Chief Legal Officer
Gail K. Boudreaux	51	Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare
William A. Munsell	59	Executive Vice President
Eric S. Rangen	55	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	58	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum
Lori Sweere	53	Executive Vice President of Human Capital
Reed V. Tuckson, M.D.	60	Executive Vice President and Chief of Medical Affairs
Anthony Welters	56	Executive Vice President

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since January 2007, and has been a member of the Board of Directors since February 2000.

Mr. Wichmann is Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since January 2011. Mr. Wichmann has served as Executive Vice President and President of UnitedHealth Group Operations since April 2008. From January 2007 to April 2008, Mr. Wichmann served as

Executive Vice President of UnitedHealth Group and President of the Commercial Markets Group (now UnitedHealthcare Employer & Individual).

Mr. Baer is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since May 2011. Prior to joining UnitedHealth Group, Mr. Baer served as Executive Vice President and General Counsel of Qwest Communications International Inc. from 2007 to April 2011 and Chief Administrative Officer from August 2008 to April 2011.

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since January 2011. Ms. Boudreaux has overall responsibility for all UnitedHealthcare health benefits businesses. Ms. Boudreaux served as Executive Vice President of UnitedHealth Group and President of UnitedHealthcare from May 2008 to January 2011. Prior to joining UnitedHealth Group, Ms. Boudreaux served as Executive Vice President of Health Care Services Corporation (HCSC) from January 2007 to April 2008.

Mr. Munsell is Executive Vice President of UnitedHealth Group and has served in that capacity since January 2011. Mr. Munsell focuses on enterprise-wide initiatives, including emerging growth and expansion opportunities; public, regulatory and governmental affairs and representation; reputation and market image efforts, and external relationships and alliances for the enterprise. Mr. Munsell served as Executive Vice President of UnitedHealth Group and President of the Enterprise Services Group from September 2007 to January 2011. From January 2007 to August 2007, Mr. Munsell served as Executive Vice President of UnitedHealth Group.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since January 2007.

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations (now UnitedHealthcare Medicare & Retirement). Prior to joining UnitedHealth Group, Mr. Renfro served as President of Fidelity Developing Businesses at Fidelity Investments and as a member of the Fidelity Executive Committee from June 2008 to January 2009. From January 2007 to May 2008, Mr. Renfro held several senior positions at AARP Services Inc., including President and Chief Executive Officer of AARP Services Inc., Chief Operating Officer of AARP Services Inc., President and Chief Executive Officer of AARP Financial and President of the AARP Funds.

Ms. Sweere is Executive Vice President of Human Capital of UnitedHealth Group and has served in that capacity since June 2007. Prior to joining UnitedHealth Group, Ms. Sweere served as Executive Vice President of Human Resources of CNA Financial Corporation from January 2007 to May 2007.

Dr. Tuckson is Executive Vice President and Chief of Medical Affairs of UnitedHealth Group and has served in that capacity since January 2007.

Mr. Welters is Executive Vice President of UnitedHealth Group and has served in that capacity since January 2007. Mr. Welters focuses on enterprise-wide initiatives, including emerging growth and expansion opportunities; public, regulatory and governmental affairs and representation; reputation and market image efforts, and external relationships and alliances for the enterprise. Mr. Welters served as Executive Vice President of UnitedHealth Group and President of the Public and Senior Market Group from September 2007 to January 2011.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to

our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "plan," project," "should" or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. 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. We do not undertake to address or update forward-looking statements in future filings or communications regarding our business or results of operations, 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 past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or 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. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in this report or any of our prior communications.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Under our risk-based benefit product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of these products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, the Health Reform Legislation established minimum medical loss ratios for certain health plans, and authorized HHS to maintain an annual review process of "unreasonable" increases in premiums for commercial health plans. In addition, a number of states have enhanced (or are proposing to enhance) their premium review and approval processes. See the risk factor below relating to health care reform for further discussion of these provisions.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue on commercial policies is typically at a fixed rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. We base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period; however, medical cost inflation, regulation and other factors may cause actual costs to exceed what was estimated and reflected in premiums or bids. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical costs on our financial results, relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for commercial insured products our annual net earnings for 2011 would have been reduced by approximately $215 million, excluding any offsetting impact from premium rebates.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, our results of operations could be materially and adversely affected.

Our business activities are highly regulated; new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our results of operations, financial position and cash flows.

Our business is regulated at the federal, state, local and international levels. Our insurance and HMO subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, utilization review and TPA-related regulations and licensure requirements. Some of our businesses hold or provide services related to government contracts and are subject to federal and state anti-kickback and other laws and regulations governing government contractors. See Item 1, "Business - Government Regulation" for further information.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. For example, in the first quarter of 2010, the Health Reform Legislation was signed into law, legislating broad-based changes to the U.S. health care system. See Item 1, "Business - Government Regulation" for a discussion of the Health Reform Legislation. The broad latitude that is given to the agencies administering regulations governing our business, as well as future laws and rules, and interpretation and enforcement of those laws and rules by governmental enforcement authorities, 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 also obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions, including integration of certain acquisitions. For example, premium rates for our health insurance and/or managed care products are subject to regulatory review or approval in many states, and a number of states have enhanced (or are proposing to enhance) their rate review processes. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our revenues, results of operations, financial position and cash flows.

Under state guaranty fund laws, certain insurance companies (and HMOs in some states), including those issuing health (which includes long-term care), life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Changes in these laws or the interpretation thereof, or insolvency by another insurer, could have a material adverse effect on our results of operations, financial position and cash flows. See Note 12 of Notes to the Consolidated Financial Statements in this Form 10-K for a discussion of a matter involving an unaffiliated entity, Penn Treaty, which has been placed in rehabilitation.

Certain Optum businesses are also subject to regulatory and other risks and uncertainties in addition to the risks of our businesses of providing managed care and health insurance products. For example, state corporate practice of medicine doctrines and fee-splitting rules can impact our relationships with physicians, hospitals and customers. OptumHealth is subject to state telemedicine laws and regulations that apply to its telemedicine initiatives. Additionally, OptumHealth participates in the emerging private exchange markets and it is not yet known to what extent the states will issue new regulations that apply to private exchanges. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or increase the regulatory burdens under which we operate.

We are also involved in various governmental investigations, audits and reviews. See Note 12 of Notes to the Consolidated Financial Statements in this Form 10-K for a discussion of certain of these matters. See also the risk factor below relating to our activities as a payer in various government health care programs for a discussion of audits by CMS. Reviews and investigations of this sort can lead to government actions, which can result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, and could have a material adverse effect on our results of operations, financial position and cash flows.

The health care industry is also regularly subject to negative publicity, including as a result of routine governmental investigations, the political debate surrounding the Health Reform Legislation and the political environment in general. Negative publicity may adversely affect our stock price, damage our reputation in various markets, foster an increasingly active regulatory environment or result in increased regulation and legislative review of industry practices. This may further increase our costs of doing business and the regulatory burdens under which we operate.

Some of our businesses and operations are international in nature and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, management control, fraud and anti-corruption present additional challenges for us beyond those faced by U.S.-based businesses. Such requirements and uncertainties may adversely affect our ability to market our products and services, or

to do so at targeted margins, or increase the regulatory burdens under which we operate.

For a discussion of various laws and regulations that impact our businesses, see Item 1, “Business - Government Regulation.”

The enactment or implementation of health care reforms could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

In the first quarter of 2010, the Health Reform Legislation was signed into law. The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs and CHIP and other aspects of the health care system. Among other things, the Health Reform Legislation includes guaranteed coverage and expanded benefit requirements, eliminates pre-existing condition exclusions and annual and lifetime maximum limits, restricts the extent to which policies can be rescinded, establishes minimum medical loss ratios, creates a federal premium review process, imposes new requirements on the format and content of communications (such as explanations of benefits, or EOBs) between health insurers and their members, grants to members new and additional appeal rights, imposes new and significant taxes on health insurers and health care benefits, reduces the Medicare Part D coverage gap and reduces payments to private plans offering Medicare Advantage.

Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. HHS, the DOL and the Treasury Department have issued or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance on other key aspects of the legislation remain pending. Due to the complexity of the Health Reform Legislation, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

For example, effective in 2011, the Health Reform Legislation established minimum medical loss ratios for all commercial health plans in the large employer group, small employer group and individual markets (85% for large employer groups, 80% for small employer groups and 80% for individuals, calculated under the definitions in the Health Reform Legislation and regulations). Companies with medical loss ratios below these targets are required to rebate ratable portions of their premiums to their customers annually. The potential for and size of the rebates will be measured by state, by group size and by licensed subsidiary. This disaggregation of insurance pools into much smaller pools will likely decrease the predictability of results for any given pool and could lead to variation over time in the estimates of rebates owed in total. Effective in 2014, Medicare Advantage plans will be required to maintain a minimum medical loss ratio of 85%. Depending on the results of these calculations and the manner in which we adjust our business model in light of these requirements, there could be meaningful disruptions in local health care markets, and our market share, revenues, results of operations, financial position and cash flows could be materially and adversely affected.

In addition, the Health Reform Legislation requires the establishment of state-based health insurance exchanges for individuals and small employers by 2014. The types of exchange participation requirements ultimately enacted by each state, the availability of federal premium subsidies within exchanges, the potential for differential imposition of state benefit mandates inside and outside the exchanges, the operation of reinsurance, risk corridors and risk adjustment mechanisms inside and outside the exchanges and the possibility that certain states may restrict the ability of health plans to continue to offer coverage to individuals and small employers outside of the exchanges, could result in disruptions in local health care markets and our revenues, results of operations, financial position and cash flows could be materially and adversely affected.

The Health Reform Legislation includes a “maintenance of effort” (MOE) provision that requires states to maintain their eligibility rules for people covered by Medicaid, until the Secretary of HHS determines that an insurance exchange is operational in a given state. The MOE provision is intended to prevent states from reducing eligibility standards and determination procedures as a way to remove adults above 133% of the federal poverty level from Medicaid before implementation of expanded Medicaid coverage effective in January 2014. However, states with, or projecting, a budget deficit may apply for an exception to the MOE provision. If states are successful in obtaining MOE waivers and allow certain Medicaid programs to expire, we could experience reduced Medicaid enrollment, which could materially and adversely affect our revenues, results of operations, financial position and cash flows.

Several of the provisions in the Health Reform Legislation will likely increase our medical cost trends. Examples of these provisions are the excise tax on medical devices, annual fees on prescription drug manufacturers, enhanced coverage requirements (including discounted prescription drugs for Medicare Part D participants) and the prohibition of pre-existing condition exclusions. The annual insurance industry assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter), which is not deductible for income tax purposes, will increase our operating costs. Premium increases will be necessary to offset the impact these and other provisions will have on our medical and operating costs. These premium increases are oftentimes subject to state regulatory approval. In this regard, the Federal government is encouraging states to intensify their reviews of requests for rate increases by commercial health plans and providing funding to assist in those state-level reviews. We have begun to experience greater regulatory challenges to appropriate premium rate increases in several states, including California, New York and Rhode Island. In addition, as required under the Health Reform Legislation, HHS established a federal premium rate review process, which became effective in September 2011 and generally

applies to proposed rate increases equal to or exceeding 10% (with state-specific thresholds to be applicable commencing September 2012). The regulations further require commercial health plans in the individual and small group markets to provide to the states and HHS extensive information supporting any rate increases subject to the new federal rate review process. If we are not able to secure approval for adequate premium increases to offset increases in our cost structure, our revenues, results of operations, financial position and cash flows could be materially and adversely affected. In addition, plans deemed to have a history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that become active under the Health Reform Legislation in 2014. Under the regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

The Congressional Budget Office has estimated that up to 34 million new individuals may eventually gain insurance coverage if the Health Reform Legislation is implemented broadly in its current form. In addition, we expect that implementation of the Health Reform Legislation will increase the demand for products and capabilities offered by our Optum businesses. We have made and will continue to make strategic decisions and investments based, in part, on these assumptions, and our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under the Health Reform Legislation than estimated or we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for our Optum businesses does not increase.

Certain aspects of the Health Reform Legislation are also being challenged in federal court, with the proponents of such challenges seeking to limit the scope of or have all or portions of the Health Reform Legislation declared unconstitutional. The United States Supreme Court is scheduled to hear oral arguments on certain aspects of these cases in March 2012, including the constitutionality of the individual mandate. Congress may withhold the funding necessary to implement the Health Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether. Any partial or complete repeal or amendment or implementation difficulties, or uncertainty regarding such events, could materially and adversely impact our ability to capitalize on the opportunities presented by the Health Reform Legislation or may cause us to incur additional costs of compliance. For example, if the individual mandate is declared unconstitutional or repealed without corresponding changes to other provisions of the Health Reform Legislation to protect against the risk of adverse selection (such as revisions to the guaranteed issue and renewal requirements, prohibition on pre-existing condition exclusions, and rating restrictions), our results of operations, financial position and cash flows could be materially and adversely affected.

Congress is also considering additional health care reform measures, and a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the Health Reform Legislation. The effects of the Health Reform Legislation and recently adopted state laws, and the regulations that have been and will be promulgated thereunder, are difficult to predict, and we cannot predict whether any other federal or state proposals will ultimately become law. Such laws and rules could force us to materially change how we do business, restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, adversely change the nature of our contracted network relationships, increase our medical and administrative costs and capital requirements, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business. In addition, our market share, our results of operations, our financial position, including our ability to maintain the value of our goodwill, and our cash flows could be materially and adversely affected by such changes.

For additional information regarding the Health Reform Legislation, see Item 1, "Business - Government Regulation" and Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations - Executive Overview - Regulatory Trends and Uncertainties."

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments and audits that could materially and adversely affect our revenues, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. We also provide services to payers through our Optum businesses. These programs generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. For example, CMS reduced or froze Medicare Advantage benchmarks that drive reimbursements between 2009 and 2011, and beginning in 2012, additional cuts to Medicare Advantage benchmarks will take effect, with changes being phased-in over two to six years, depending on the level of benchmark reduction in a county. Although we have adjusted members' benefits and premiums on a selective basis, terminated benefit plans in certain counties, and intensified both our medical and operating cost management in response to these benchmark reductions, there can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage program.

As part of the Health Reform Legislation, CMS has developed a system whereby a plan that meets certain quality ratings will

be entitled to various quality bonus payments. There can be no assurance that any of our plans will meet these quality ratings. Our revenues, results of operations, financial position and cash flows could be materially and adversely affected by funding reductions, or if our plans do not meet the requirements to receive quality bonus payments. Similarly, any reduction in Medicare Advantage payments could result in downward pressure on payments made to our Collaborative Care business in exchange for services provided to Medicare Advantage plans.

Our participation in the Medicare Advantage, Medicare Part D, and various Medicaid and CHIP programs occurs through bids that are submitted periodically. Revenues for these programs are dependent upon periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs is dependent upon many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level, and general political issues and priorities. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies may materially and adversely affect our revenues, results of operations, financial position and cash flows. State Medicaid programs are also imposing other reforms, such as medical loss ratio requirements on Medicaid managed care organizations, which generally require such plans to rebate ratable portions of their premiums to their state customers if they cannot demonstrate they have met the ratio standards.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers as well as, for Medicare Part D plans only, based on comparing costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. In 2008, CMS announced that it will perform risk adjustment data validation (RADV) audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. These audits may result in retrospective adjustments to payments made to our health plans. In December 2010, CMS published for public comment a new proposed RADV audit and payment adjustment methodology. The proposed methodology contains provisions allowing retroactive contract level payment adjustments for the year audited using an extrapolation of the “error rate” identified in audit samples. In February 2011, CMS announced that it would be making changes to the proposed methodology based, in part, on comments submitted by industry participants. As of the date of this filing, CMS has not published the revised methodology. Depending on the methodology utilized, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

In addition, the Office of Inspector General for HHS has audited our risk adjustment data for two local plans and has initially communicated its findings, although we cannot predict the final outcome of the audit process. Any payment adjustments required as a result of the audits or otherwise could have a material adverse effect on our results of operations, financial position and cash flows. See Note 12 of Notes to the Consolidated Financial Statements in this Form 10-K for additional information regarding these audits.

CMS conducts a variety of routine, regular and special investigations, audits and reviews across the industry. For example, in the fourth quarter of 2011, CMS conducted an audit of our Medicare Advantage and Part D business. We are in the process of responding to preliminary findings. As with any CMS review, in the event we fail to comply with applicable CMS and state laws, regulations and rules, our results of operations, financial position and cash flows could be materially and adversely affected.

Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and we will not have additional members auto-assigned to us. For example, we lost approximately 470,000 of our auto-enrolled low-income subsidy members effective January 1, 2012, because certain of our bids exceeded thresholds set by the government. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Medicare program or other programs on which we bid, or our competitors submit bids at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, or if we fail to address emerging security threats or detect and prevent privacy and security incidents, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Further, many of our businesses are subject to the Payment Card Industry Data Security Standards (PCI DSS), which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. See Item 1, "Business - Government Regulation" for additional information. HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. Even though we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we still have limited oversight or control over their actions and practices.

Our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations.

Compliance with new laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. For example, our ability to collect, disclose and use sensitive personal information may be further restricted, and we are awaiting final HHS regulations for many key aspects of the ARRA amendments to HIPAA, such as with regard to marketing, electronic health records and access reports (which may necessitate system changes). In addition, HHS has announced a pilot audit program to assess HIPAA compliance efforts by covered entities through 2012. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation, results of operations, financial position and cash flows, including the following consequences: mandatory disclosure of a privacy or security breach to the media; significant increases in the cost of managing and remediating privacy or security incidents; enforcement actions; material fines and penalties; an impact on our ability to process credit card transactions as well as an increase in related expenses; litigation; compensatory, special, punitive, and statutory damages; consent orders regarding our privacy and security practices; adverse actions against our licenses to do business; and injunctive relief.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices. See Item 1, "Business - Government Regulation" for a discussion of various federal and state laws and regulations governing our PBM businesses.

OptumRx also conducts business as a mail order pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. The failure to adhere to these laws and regulations could expose OptumRx to civil and criminal penalties.

Our PBM businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to timely process and dispense prescriptions and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we

could be subject to claims for breaches of fiduciary obligations or entering into certain prohibited transactions.

UnitedHealthcare Employer & Individual is transitioning pharmacy benefit management for approximately 12 million of its commercial members, including pharmacy claims adjudication and customer service, from Medco Health Solutions, Inc. to OptumRx beginning in 2013. If we are unable to execute the transition effectively, UnitedHealthcare Employer & Individual could face loss of business, which could adversely impact our results of operations, financial position and cash flows.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States and face significant competition in all of the geographic markets in which we operate. We compete with other companies on the basis of many factors, including price of benefits offered and cost and risk of alternatives, location and choice of health care providers, quality of customer service, comprehensiveness of coverage offered, reputation for quality care, financial stability and diversity of product offerings. For our UnitedHealthcare reporting segment, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the BlueCross BlueShield Association and other enterprises that serve more limited geographic areas or market segments such as Medicare and Medicaid specialty services. For our OptumRx business, competitors include Medco Health Solutions, Inc., CVS/Caremark Corporation and Express Scripts, Inc. Our OptumHealth and OptumInsight reporting segments also compete with a broad and diverse set of businesses.

In particular markets, competitors may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; existing business relationships; or other factors that give such competitors a competitive advantage. In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers (including hospitals, physician groups and other care professionals) in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or increase profitability. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect, if membership or demand for other services declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products, our business, results of operations, financial position and cash flows could be materially and adversely affected.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be materially and adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for services. Our results of operations and prospects are substantially dependent on our continued ability to contract for these services at competitive prices. Failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of premiums to cover all or a defined portion of the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the

services available to our members. There can be no assurance that health care providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, it is either not defined or it is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example, we are involved in litigation with out-of-network providers, as described in more detail in “Litigation Matters” in Note 12 of Notes to the Consolidated Financial Statements.

Accountable care organizations (ACOs) and other organizational structures that physicians, hospitals, and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. These changes may affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our results of operations, financial position and cash flows could be adversely affected.

The success of certain Optum businesses depends on maintaining satisfactory physician relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. If we are unable to maintain satisfactory relationships with primary care physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. If our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, our results of operations, financial position and cash flows could be materially and adversely affected.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of independent producers and consultants.

Our products are sold in part through independent producers and consultants who assist in the production and servicing of business. We typically do not have long-term contracts with our producers and consultants, who generally are not exclusive to us and who typically also recommend and/or market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be materially and adversely affected if we are unable to attract or retain independent producers and consultants or if we do not adequately provide support, training and education to them regarding our product portfolio, or if our sales strategy is not appropriately aligned across distribution channels.

Because producer commissions are included as administrative expenses under the medical loss ratio requirements of the Health Reform Legislation, these expenses will be under the same cost reduction pressures as other administrative costs. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

In addition, there have been a number of investigations regarding the marketing practices of producers selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and producers marketing and selling these companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of producers who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Our relationship with AARP is important and the loss of such relationship could have an adverse effect on our business and results of operations.

Under our agreements with AARP, we provide AARP-branded Medicare Supplement insurance, hospital indemnity insurance and other products and services to AARP members under a Supplement Health Insurance Program (the AARP Program). We also provide AARP-branded Medicare Advantage and Medicare Part D prescription drug plans to both AARP members and non-members. Our agreements with AARP extend to December 31, 2017 for the AARP Program and December 31, 2014 for the Medicare Advantage and Medicare Part D offerings. Our agreements with AARP contain commitments regarding corporate governance, corporate social responsibility, diversity and measures intended to improve and simplify the health care experience for consumers. The AARP agreements may be terminated early under certain circumstances, including, depending on the

agreement, a material breach by either party, insolvency of either party, a material adverse change in our financial condition, material changes in the Medicare programs, material harm to AARP caused by us, and by mutual agreement. The success of our AARP arrangements depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, meet our corporate governance, corporate social responsibility, and diversity commitments, and respond effectively to federal and state regulatory changes. The loss of our AARP relationship could have an adverse effect on our business and results of operations.

Because of the nature of our business, we are routinely subject to various litigation actions, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties and/or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

Because of the nature of our business, we are routinely made party to a variety of legal actions related to, among other things, the design, management and delivery of our product and service offerings. These matters have included or could in the future include claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort (including claims related to the delivery of health care services), contract disputes and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters; however, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

A description of significant legal actions in which we are currently involved is included in Note 12 of Notes to the Consolidated Financial Statements. We cannot predict the outcome of these actions with certainty, and we are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in select markets and businesses.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may continue to impact demand for certain of our products and services. For example, decreases in employment have caused and could continue to cause lower enrollment in our employer group plans, lower enrollment in our non-employer individual plans and a higher number of employees opting out of our employer group plans. Unfavorable economic conditions have also caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could continue to adversely impact our employer group renewal prospects and our ability to increase premiums and could result in cancellation of products and services by our customers. All of these could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to payments already negotiated and/or received from the government and could materially and adversely affect our revenues, results of operations, financial position and cash flows. In addition, the state and federal budgetary pressures could cause the government to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and health maintenance organizations and surcharges or fees on select fee-for-service and capitated medical claims, and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, a prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2011. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and a prolonged low interest rate environment could further

adversely affect our investment income. In addition, a delay in payment of principal and/or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and we may be required to write down the value of our investments, which would materially and adversely affect our profitability and shareholders' equity.

We also allocate a small proportion of our portfolio to equity investments, which are subject to greater volatility than fixed income investments. General economic conditions, stock market conditions, and many other factors beyond our control can materially and adversely affect the value of our equity investments and may result in investment losses.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and debt ratings could be materially and adversely affected.

Goodwill and other intangible assets were $26.8 billion as of December 31, 2011, representing 39% of our total assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the manner in or the extent to which the Health Reform Legislation is implemented may impact our ability to maintain the value of our goodwill and other intangible assets in our business. Similarly, the value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, adversely impact our debt ratings or potentially impact our compliance with existing debt covenants.

Large-scale medical emergencies may result in significant medical costs and may have a material adverse effect on our results of operations, financial position and cash flows.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. Such emergencies could materially and adversely affect the U.S. economy in general and the health care industry specifically. For example, in the event of a natural disaster, bioterrorism attack, pandemic or other extreme events, we could face, among other things, significant medical costs and increased use of health care services. Any such disaster or similar event could have a material adverse effect on our results of operations, financial position and cash flows.

If we fail to properly maintain the integrity or availability of our data or to strategically implement new or upgrade or consolidate existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to adequately price our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to accurately report our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we have been consolidating and integrating the number of systems we operate and have upgraded and expanded our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, emerging cybersecurity risks and threats, and changing customer patterns. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, have regulatory sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, protecting our systems against cybersecurity risks and threats, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install hardware and software products, and these products may contain unexpected design

defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

In addition, an uncertain and rapidly evolving federal, state, international and industry legislative and regulatory framework related to the health information technology market may make it difficult to achieve and maintain compliance and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations and financial position could be materially and adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by states' departments of insurance. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated by the applicable subsidiary. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations and financial position could be materially and adversely affected.

Any failure by us to manage and complete acquisitions and other significant strategic transactions successfully could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations. We are required to integrate these businesses into our internal control environment, which may present challenges that are different than those presented by organic growth and that may be difficult to manage. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically and there can be no assurance that current credit ratings will be maintained in the future. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. Downgrades in our credit

ratings, should they occur, may adversely affect our results of operations, financial position and cash flows.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries, as of December 31, 2011, we owned and/or leased real properties totaling approximately 16 million square feet, owning approximately 1 million aggregate square feet of space and leasing the remainder, primarily in the United States. Our leases expire at various dates through September 2028. Our various reporting segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Note 12 of Notes to the Consolidated Financial Statements in this Form 10-K, which is incorporated by reference in this report.

ITEM 4. MINE SAFETY DISCLOSURES

N/A

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2012, there were 15,978 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE were as follows:

	High	Low	Cash Dividends Declared
2012			
First quarter (through February 8, 2012)	$ 54.18	$ 49.82	$ 0.1625
2011			
First quarter	$ 45.75	$ 36.37	$ 0.1250
Second quarter	$ 52.64	$ 43.30	$ 0.1625
Third quarter	$ 53.50	$ 41.27	$ 0.1625
Fourth quarter	$ 51.71	$ 41.32	$ 0.1625
2010			
First quarter	$ 36.07	$ 30.97	$ 0.0300
Second quarter	$ 34.00	$ 27.97	$ 0.1250
Third quarter	$ 35.94	$ 27.13	$ 0.1250
Fourth quarter	$ 38.06	$ 33.94	$ 0.1250

DIVIDEND POLICY

In May 2011, our Board of Directors increased our cash dividend to shareholders to an annual dividend rate of $0.65 per share, paid quarterly. Since June 2010, we had paid a quarterly dividend of $0.125 per share. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2011

For the Month Ended	Total Number of Shares Purchased		Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)			(in millions)	(in millions)
October 31, 2011	—		$ —	—	84
November 30, 2011	—		$ —	—	84
December 31, 2011	19	(b)	$ 47	19	65
Total	19		$ 47	19	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In May 2011, the Board renewed our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs). There is no established expiration date for the program. As of December 31, 2011, we had Board authorization to purchase up to an additional 65 million shares of our common stock.

(b) Shares repurchased in December were purchased under a prepaid share repurchase program based on volume weighted average share prices for the fourth quarter.

PERFORMANCE GRAPHS

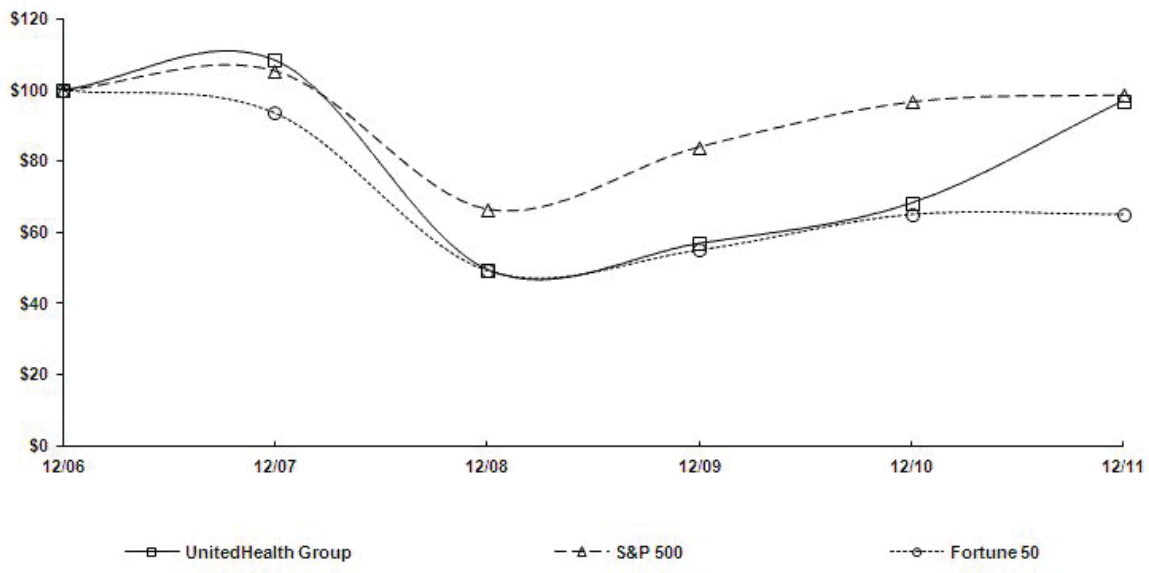
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group"), for the five-year period ended December 31, 2011. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2011. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2006 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index, and Fortune 50



	12/06	12/07	12/08	12/09	12/10	12/11
UnitedHealth Group	$ 100.00	$ 108.38	$ 49.58	$ 56.89	$ 68.21	$ 96.98
S&P 500	100.00	105.49	66.46	84.05	96.71	98.75
Fortune 50 Group	100.00	93.51	49.24	55.06	65.06	65.04

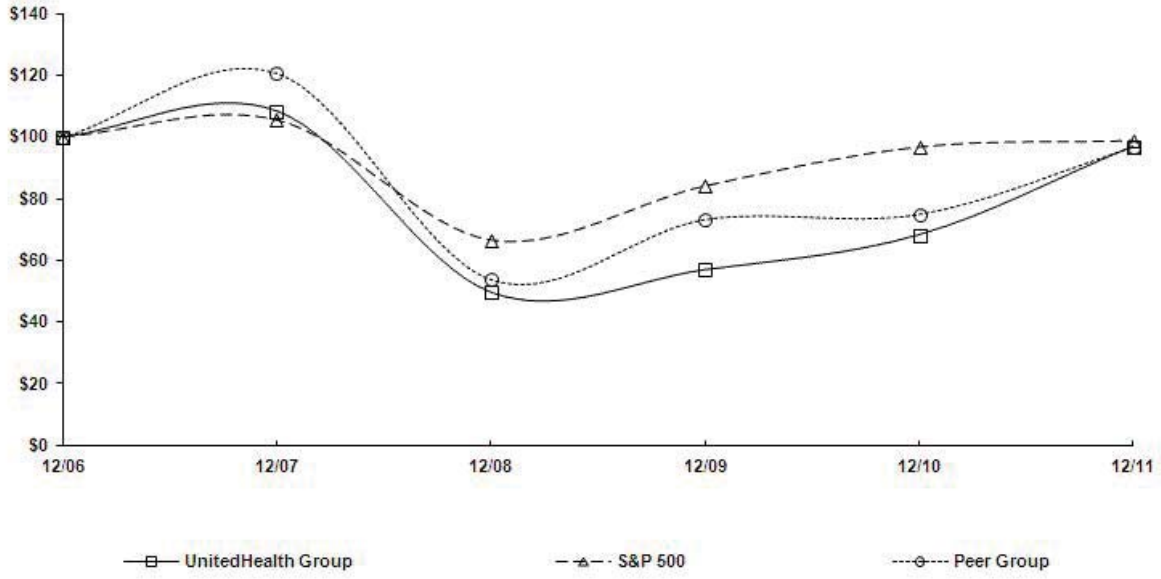
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc. and WellPoint, Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P 500 Index, and a Peer Group



	12/06	12/07	12/08	12/09	12/10	12/11
UnitedHealth Group	$ 100.00	$ 108.38	$ 49.58	$ 56.89	$ 68.21	$ 96.98
S&P 500	100.00	105.49	66.46	84.05	96.71	98.75
Peer Group	100.00	120.65	53.78	73.27	74.94	96.59

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(In millions, except percentages and per share data)	For the Year Ended December 31, 2011	2010	2009	2008	2007
Consolidated operating results					
Revenues	$101,862	$ 94,155	$ 87,138	$ 81,186	$ 75,431
Earnings from operations	8,464	7,864	6,359	5,263	7,849
Net earnings	5,142	4,634	3,822	2,977	4,654
Return on shareholders' equity (a)	18.9%	18.7%	17.3%	14.9%	22.4%
Basic net earnings per common share	$ 4.81	$ 4.14	$ 3.27	$ 2.45	$ 3.55
Diluted net earnings per common share	4.73	4.10	3.24	2.40	3.42
Common stock dividends per share	0.6125	0.4050	0.0300	0.0300	0.0300
Consolidated cash flows from (used for)					
Operating activities	$ 6,968	$ 6,273	$ 5,625	$ 4,238	$ 5,877
Investing activities	(4,172)	(5,339)	(976)	(5,072)	(4,147)
Financing activities	(2,490)	(1,611)	(2,275)	(605)	(3,185)
Consolidated financial condition					
(As of December 31)					
Cash and investments	$ 28,172	$ 25,902	$ 24,350	$ 21,575	$ 22,286
Total assets	67,889	63,063	59,045	55,815	50,899
Total commercial paper and long-term debt	11,638	11,142	11,173	12,794	11,009
Shareholder's equity	28,292	25,825	23,606	20,780	20,063
Debt to debt-plus-equity ratio	29.1%	30.1%	32.1%	38.1%	35.4%

(a) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

Financial Highlights should be read with the accompanying Management's Discussion and Analysis of Financial Condition and Results of Operations and Consolidated Financial Statements and Notes to the Consolidated Financial Statements.

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or PSLRA. 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. A description of some of the risks and uncertainties can be found in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company, whose mission is to help people live healthier lives and help make health care work better. Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare serves the health benefits needs of individuals across life's stages through three businesses. UnitedHealthcare Employer & Individual serves individual consumers and employers. The unique health needs of seniors are served by UnitedHealthcare Medicare & Retirement. UnitedHealthcare Community & State serves the public health marketplace, offering states innovative Medicaid solutions.

Optum serves health system participants including consumers, physicians, hospitals, governments, insurers, distributors and pharmaceutical companies, through its OptumHealth, OptumInsight and OptumRx businesses.

Revenues

Our revenues are primarily comprised of premiums derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and we assume the economic risk of funding our customers' health care benefits and related administrative costs. Effective in 2011, commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the Health Reform Legislation and implementing regulations, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals, subject to state-specific exceptions) are required to rebate ratable portions of their premiums annually. As a result, our quarterly premium revenue may be reduced by a pro rata estimate of our full-year premium rebate payable under the Health Reform Legislation. Any required rebate payments for the current year are made in the third quarter of the subsequent year. We also generate revenues from fee-based services performed for customers that self-insure the health care costs of their employees and employees' dependants. For both risk-based and fee-based health care benefit arrangements, we provide coordination and facilitation of medical services; transaction processing; health care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. We also generate service revenues from our Optum businesses. Product revenues are mainly comprised of products sold by our pharmacy benefit management business. We derive investment income primarily from interest earned on our investments in debt securities; investment income also includes gains or losses when investment securities are sold, or other-than-temporarily impaired.

Operating Costs

Medical Costs. Our operating results depend in large part on our ability to effectively estimate, price for and manage our medical costs through underwriting criteria, product design, negotiation of favorable care provider contracts and care coordination programs. Controlling medical costs requires a comprehensive and integrated approach to organize and advance the full range of interrelationships among patients/consumers, health professionals, hospitals, pharmaceutical/technology manufacturers and other key stakeholders.

Medical costs include estimates of our obligations for medical care services rendered on behalf of insured consumers for which we have not yet received or processed claims, and our estimates for physician, hospital and other medical cost disputes. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Our medical care ratio, calculated as medical costs as a percentage of premium revenues, reflects the combination of pricing, rebates, benefit designs, consumer health care utilization and comprehensive care facilitation efforts.

Operating Costs. Operating costs are primarily comprised of costs related to employee compensation and benefits, agent and broker commissions, premium taxes and assessments, professional fees, advertising and occupancy costs. We seek to improve our operating cost ratio, calculated as operating costs as a percentage of total revenues, for an equivalent mix of business. However, changes in business mix, such as increases in the size of our health services businesses may impact our operating costs and operating cost ratio.

Cash Flows

We generate cash primarily from premiums, service and product revenues and investment income, as well as proceeds from the sale or maturity of our investments. Our primary uses of cash are for payments of medical claims and operating costs, payments on debt, purchases of investments, acquisitions, dividends to shareholders and common stock repurchases. For more information on our cash flows, see "Liquidity" below.

Business Trends

Our businesses participate in the U.S. health economy, which comprises approximately 18% of U.S. gross domestic product and has grown consistently for many years. We expect overall spending on health care in the U.S. to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the U.S. population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms, which could also impact our results of

operations.

In 2012, we expect increasing unit costs to continue to be the primary cost driver of medical cost trends and we project steadily increasing medical system utilization over the course of the year. We also expect an increase in prescription drug costs. We will continue to work to manage medical cost trends through care management programs, affordable network relationships, pay-for-performance reimbursement programs for care providers, and targeted clinical management programs and initiatives focused on improving quality and affordability. Additionally, employers are continuing to select products with benefit designs that shift more of the costs to the employee. This cost shifting continues to mitigate increases in medical cost trends.

Our businesses focus on affordability, consumer empowerment, wellness and prevention, payment innovations, and enhanced distribution to better serve our customer and consumer needs and demands. These business objectives are consistent with the goals of health care reform. We expect that the portion of our costs that is tied to incentive contracts that reward providers for outcome-based results and improved cost efficiencies will continue to increase. Care providers are facing market pressures to change from fee-for-service models to new delivery models focused on the holistic health of the consumer, integrated care across care providers and pay-for-performance payment structures. This is creating the need for health management services that can coordinate care around the primary care physician and for investment in new clinical and administrative information and management systems. The impact of such changes on our results of operations is uncertain but, we expect them to moderate the rate at which medical costs increase. This trend also provides growth opportunities for our OptumHealth and OptumInsight businesses.

We attempt to price our products consistent with anticipated underlying medical trends, while balancing growth, margins, competitive dynamics and premium rebates at the local market level. We seek to sustain a stable medical care ratio for an equivalent mix of business. However, changes in business mix, such as expanding participation in comparatively higher medical care ratio government-sponsored public sector programs and Health Reform Legislation may impact our premiums, medical costs and medical care ratio. In 2012, we continue to expect reimbursements to be under pressure through government payment rates and continued market competition in commercial products.

Regulatory Trends and Uncertainties

In the first quarter of 2010, the Health Reform Legislation was signed into law. The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, the Medicaid and Medicare programs, CHIP and other aspects of the health care system. HHS, the DOL, the IRS and the Treasury Department have issued or proposed regulations on a number of aspects of Health Reform Legislation, but final rules and interim guidance on other key aspects of the legislation, all of which have a variety of effective dates, remain pending.

The Health Reform Legislation and the related federal and state regulations will impact how we do business and could restrict growth and restrict premium rate increases in certain products and market segments, increase our medical and administrative costs, or expose us to an increased risk of liability, any or all of which could have a material adverse effect on us.

We also anticipate that the Health Reform Legislation will further increase attention on the need for health care cost containment and improvements in quality, with a focus on prevention, wellness and disease management. We believe demand for many of our service offerings, such as consulting services, data management, information technology and related infrastructure construction, disease management, and population-based health and wellness programs will continue to grow.

Following is a listing of some of the key provisions of the Health Reform Legislation and other regulatory items along with management's view of the related trends and uncertainties that may cause reported financial information to not be indicative of future operating performance or of future financial condition.

Premium Rebates

Effective in 2011, commercial health plans with medical loss ratios on fully insured products that fall below certain targets are required to rebate ratable portions of their premiums annually. The potential for and size of the rebates are measured by state, by group size and by licensed subsidiary.

In the aggregate, the rebate regulations cap the level of margin that can be attained.

The disaggregation of insurance pools into smaller pools will likely decrease the predictability of results for any given pool and could lead to variation over time in the estimates of rebates owed.

Other market participants could implement changes to their business practices in response to the Health Reform Legislation, which could positively or negatively impact our growth and market share. Insurers could elect to change pricing, modify product features or benefits, adjust their mix of business or even exit segments of the market. They could also seek to adjust

their operating costs by making changes to their distribution arrangements or decreasing spending on non-medical product features and services. We have made changes to reduce our product distribution costs in the individual market in response to the Health Reform Legislation, including reducing producer commissions, and are implementing changes to distribution in the large group insured market segment. These changes could impact future growth in these products.

Commercial Rate Increase Review

The Health Reform Legislation also requires HHS to maintain an annual review of "unreasonable" increases in premium rates for commercial health plans. HHS established a review threshold of annual premium rate increases generally at or above 10% (with state-specific thresholds to be applicable commencing September 2012), and clarified that the HHS review will not supersede existing state review and approval processes. The regulations further require commercial health plans to provide to the states and HHS extensive information supporting any rate increase of 10% (or applicable state threshold) or more. Under the regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

The Federal government is also encouraging states to intensify their reviews of requests for rate increases by affected commercial health plans (including large group plans) and providing funding to assist in those state-level reviews. Since August 2010, HHS has allocated approximately $250 million for grants to states to enable the states to conduct more robust reviews of requests for premium increases. Many states have applied for and received grants, and state regulators have signaled their intent to more closely scrutinize premium rates.

Premium rate review legislation (ranging from new or enhanced rate filing requirements to prior approval requirements) has been introduced or passed in more than half of the states in 2011. As a result, we have begun to experience greater regulatory challenges to appropriate premium rate increases in several states, including California, New York and Rhode Island. Depending on the level of scrutiny by the states, there is a broad range of potential business impacts. For example, it may become more difficult to price our commercial risk business consistent with expected underlying cost trends, leading to the risk of operating margin compression.

Medicare Advantage Rates

As part of the Health Reform Legislation, Medicare Advantage risk adjusted benchmarks, which ultimately drive our CMS payments, were reduced by 1.6% in 2011 from 2010 levels. Beginning in 2012, additional cuts to Medicare Advantage benchmarks have taken effect (benchmarks will ultimately range from 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), with changes being phased-in over two to six years, depending on the level of benchmark reduction in a county. These changes could result in reduced enrollment or reimbursement or payment levels.

We expect the 2012 rates will be outpaced by underlying medical trends, placing continued importance on effective medical management and ongoing improvements in administrative costs. There are a number of annual adjustments we can make to our operations, which may partially offset any impact from these rate reductions. For example, we can seek to intensify our medical and operating cost management, adjust members' benefits and decide on a county-by-county basis in which geographies to participate.

Additionally, achieving high quality scores from CMS for improving upon certain clinical and operational performance standards will impact future quality bonuses that may offset these anticipated rate reductions. We also may be able to mitigate the effects of reduced funding on margins by increasing enrollment due to the increases in the number of people eligible for Medicare in coming years. Longer term, market wide decreases in the availability or relative quality of Medicare Advantage products may increase demand for other senior health benefits products such as our Medicare Part D and Medicare Supplement insurance offerings.

It is also anticipated that CMS will release the final Medicare Advantage Risk Adjustment Data Validation (RADV) audit methodology in 2012. RADV audits are intended to validate that the risk-adjusted payments Medicare Advantage plans receive are supported by medical record data. Depending upon the final RADV methodology released by CMS, recoveries from RADV audits may result in additional rate pressure.

Budget Control Act's Medicare Sequestration

Congress passed the Budget Control Act of 2011, which, following the failure of the Joint Select Committee on Deficit Reduction to cut the federal deficit by $1.2 trillion, triggers automatic across-the-board budget cuts (sequestration), including Medicare spending cuts averaging 2% of total program costs for nine years, starting in 2013. Medicare payments exempted from sequestration include:

- Part D low-income subsidies;
- Part D catastrophic subsidies; and

- Payments to states for coverage of Medicare cost-sharing for certain low-income Medicare beneficiaries.

The Office of Management and Budget is responsible for determining, calculating and implementing cuts. We are exploring strategies to mitigate any impact that may result from the cuts beginning in 2013.

Insurance Industry Fee

The Health Reform Legislation includes an annual insurance industry assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter). The annual fee will be allocated based on the ratio of an entity's net premiums written during the preceding calendar year to the total health insurance for any U.S. health risk that is written during the preceding calendar year, subject to certain exceptions and uncertainties.

Our effective income tax rate will increase significantly in 2014 due to the non-deductibility of these fees.

Premium increases will be necessary to offset the impact of these and other provisions. Premium increases are generally subject to state regulatory approval and potentially to federal review. Other market participants could increase premiums at different levels which could impact our market share positively or negatively.

State-based Exchanges and Coverage Expansion

Effective in 2014, exchanges are required to be established for individuals and small employers as well as certain CHIP eligibles. The exchanges will be state-based. If a state fails to establish an exchange by the required deadline, exchanges may be administered through a federal/state partnership or by the federal government.

Among other things, the Health Reform Legislation eliminates pre-existing condition exclusions and annual and lifetime maximum limits and restricts the extent to which policies can be rescinded. The Health Reform Legislation also provides for expanded Medicaid coverage effective in January 2014. The Health Reform Legislation includes an MOE provision that requires states to maintain their eligibility rules for people covered by Medicaid, until the Secretary of HHS determines that an insurance exchange is operational in a given state. The MOE provision is intended to prevent states from reducing eligibility standards and determination procedures as a way to remove adults above 133% of the federal poverty level from Medicaid before implementation of expanded Medicaid coverage effective in January 2014. However, states with, or projecting, a budget deficit may apply for an exception to the MOE provision. Additionally, individual states may accelerate their procurement of Medicaid managed care services in 2012 and 2013 for sizeable groups of Medicaid program beneficiaries in order to even their administrative workloads in advance of Medicaid market expansion taking place in 2014.

The Congressional Budget Office has estimated that up to 34 million additional individuals may eventually gain insurance coverage if the Health Reform Legislation is implemented broadly in its current form. This represents an opportunity for us to increase membership. However, serving these individuals may generate different profit margins than our existing business due to various factors, including the health status of the newly insured individuals.

We expect existing participants in Medicare and Medicaid and new enrollees in state-based exchanges to transition between products and programs, offering us opportunities to design products and services that enable us to compete for new business across business segments on an ongoing basis. An acceleration of Medicaid managed care services could increase near-term business growth opportunities for UnitedHealthcare Community & State. However, if states are successful in obtaining MOE waivers and allow certain Medicaid programs to expire, we could experience reduced Medicaid enrollment.

Court Proceedings

Court proceedings related to the Health Reform Legislation continue to evolve. These court proceedings, and the potential for Congressional action to impede implementation, create additional uncertainties with respect to the law. For additional information regarding the Health Reform Legislation, see Item 1, “Business - Government Regulation” and Item 1A, “Risk Factors.”

RESULTS SUMMARY

(in millions, except percentages and per share data)	2011	2010	2009	Change 2011 vs. 2010		Change 2010 vs. 2009	
Revenues:							
Premiums	$ 91,983	$85,405	$79,315	$ 6,578	8%	$ 6,090	8%
Services	6,613	5,819	5,306	794	14	513	10
Products	2,612	2,322	1,925	290	12	397	21
Investment and other income	654	609	592	45	7	17	3
Total revenues	101,862	94,155	87,138	7,707	8	7,017	8
Operating costs:							
Medical costs	74,332	68,841	65,289	5,491	8	3,552	5
Operating costs	15,557	14,270	12,734	1,287	9	1,536	12
Cost of products sold	2,385	2,116	1,765	269	13	351	20
Depreciation and amortization	1,124	1,064	991	60	6	73	7
Total operating costs	93,398	86,291	80,779	7,107	8	5,512	7
Earnings from operations	8,464	7,864	6,359	600	8	1,505	24
Interest expense	(505)	(481)	(551)	24	5	(70)	(13)
Earnings before income taxes	7,959	7,383	5,808	576	8	1,575	27
Provision for income taxes	(2,817)	(2,749)	(1,986)	68	2	763	38
Net earnings	$ 5,142	$ 4,634	$ 3,822	$ 508	11%	$ 812	21%
Diluted net earnings per common share	$ 4.73	$ 4.10	$ 3.24	$ 0.63	15%	$ 0.86	27%
Medical care ratio (a)	80.8%	80.6%	82.3%	0.2%		(1.7)%	
Operating cost ratio (b)	15.3	15.2	14.6	0.1		0.6	
Operating margin	8.3	8.4	7.3	(0.1)		1.1	
Tax rate	35.4	37.2	34.2	(1.8)		3.0	
Net margin	5.0	4.9	4.4	0.1		0.5	
Return on equity (c)	18.9%	18.7%	17.3%	0.2%		1.4%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.
(b) Operating cost ratio is calculated as operating costs divided by total revenues.
(c) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

SELECTED OPERATING PERFORMANCE AND FINANCIAL LIQUIDITY ITEMS

The following represents a summary of selected 2011 operating and liquidity items. These matters should not be considered by themselves; see below for further discussion and analysis.

- Consolidated total revenues of $102 billion increased 8% over 2010.
- UnitedHealthcare revenues of $95 billion rose 7% over 2010.
- Optum revenues of $29 billion increased 21% over 2010.
- UnitedHealthcare enrollment during 2011 grew by 1.6 million people in 2011.
- Consolidated medical care ratio of 80.8% increased 20 basis points over 2010.
- Net earnings of $5 billion and diluted earnings per share of $4.73 are up 11% and 15%, respectively over 2010.
- Return on Equity of 18.9% increased 20 basis points over 2010.
- Operating cash flows of $7 billion rose 11% over 2010.
- Liquidity:
  - Extended our credit agreement to December 2016 and increased capacity to $3 billion.
  - 2011 debt offerings raised new debt totaling $2.25 billion.
  - Debt to debt-plus-equity ratio decreased 100 basis points from 2010 to 29.1%.

2011 RESULTS OF OPERATIONS COMPARED TO 2010 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues for the year ended December 31, 2011 were driven by strong organic growth in the number of individuals served in our UnitedHealthcare businesses, commercial premium rate increases reflecting underlying medical cost trends and revenue growth across all Optum businesses.

Medical Costs

Medical costs for the year ended December 31, 2011 increased due to risk-based membership growth in our commercial and public and senior markets businesses and continued increases in the cost per service paid for health system use, and a modest increase in health system utilization, mainly in outpatient and physician office settings. Unit cost increases represented the majority of the increases in our medical cost trend, with the largest contributor being price increases to hospitals.

For each period, our operating results include the effects of revisions in medical cost estimates related to prior periods. Changes in medical cost estimates related to prior periods, resulting from more complete claim information identified in the current period, are included in total medical costs reported for the current period. For 2011 and 2010 there was $720 million and $800 million, respectively, of net favorable medical cost development related to prior fiscal years. The favorable development in both periods was primarily driven by continued improvements in claims submission timeliness, which resulted in higher completion factors and lower than expected health system utilization levels. The favorable development in 2010 also benefited from a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

Operating Costs

The increase in our operating costs for the year ended December 31, 2011 was due to business growth, including an increased mix of Optum and UnitedHealthcare fee-based and service revenues, which have higher operating costs, and increased spending related to reform readiness and compliance. These factors were partially offset by overall operating cost management and the increase in 2010 operating costs due to the goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses. See Note 6 of Notes to the Consolidated Financial Statements for further detail on the goodwill impairment.

Income Tax Rate

The effective income tax rate for the year ended December 31, 2011 decreased compared to the prior year due to favorable resolution of various historical tax matters in the current year as well as a higher effective income tax rate in 2010, due to the cumulative implementation of certain changes under the Health Reform Legislation.

Reportable Segments

Our two business platforms, UnitedHealthcare and Optum, are comprised of four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State;
- OptumHealth;
- OptumInsight; and
- OptumRx.

See Note 13 of Notes to the Consolidated Financial Statements for a description of the types and services from which each of our reportable segments derives its revenues.

Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and clinical services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management’s estimate of fair value. Intersegment transactions are eliminated in consolidation.

On January 1, 2011, we realigned certain of our businesses to respond to changes in the markets we serve. Prior period segment financial information has been recast to conform to the 2011 presentation. See Note 2 of Notes to Consolidated Financial Statements for more information on our business realignment. The following table presents reportable segment financial information:

(in millions, except percentages)	2011	2010	2009	Change 2011 vs. 2010		Change 2010 vs. 2009	
Revenues							
UnitedHealthcare	$ 95,336	$ 88,730	$ 82,730	$ 6,606	7%	$ 6,000	7%
OptumHealth	6,704	4,565	4,212	2,139	47	353	8
OptumInsight	2,671	2,342	1,823	329	14	519	28
OptumRx	19,278	16,724	14,401	2,554	15	2,323	16
Total Optum	28,653	23,631	20,436	5,022	21	3,195	16
Eliminations	(22,127)	(18,206)	(16,028)	(3,921)	nm	(2,178)	nm
Consolidated revenues	$ 101,862	$ 94,155	$ 87,138	$ 7,707	8%	$ 7,017	8%
Earnings from operations							
UnitedHealthcare	$ 7,203	$ 6,740	$ 4,833	$ 463	7%	$ 1,907	39%
OptumHealth	423	511	599	(88)	(17)	(88)	(15)
OptumInsight	381	84	246	297	354	(162)	(66)
OptumRx	457	529	681	(72)	(14)	(152)	(22)
Total Optum	1,261	1,124	1,526	137	12	(402)	(26)
Consolidated earnings from operations	$ 8,464	$ 7,864	$ 6,359	$ 600	8%	$ 1,505	24%
Operating margin							
UnitedHealthcare	7.6%	7.6%	5.8%	— %		1.8%	
OptumHealth	6.3	11.2	14.2	(4.9)		(3.0)	
OptumInsight	14.3	3.6	13.5	10.7		(9.9)	
OptumRx	2.4	3.2	4.7	(0.8)		(1.5)	
Total Optum	4.4	4.8	7.5	(0.4)		(2.7)	
Consolidated operating margin	8.3%	8.4%	7.3%	(0.1)%		1.1%	

nm = not meaningful

UnitedHealthcare

The following table summarizes UnitedHealthcare revenue by business:

(in billions, except percentages)	2011	2010	2009	Change 2011 vs. 2010		Change 2010 vs. 2009	
UnitedHealthcare Employer & Individual	$ 45.4	$ 42.6	$ 42.3	$ 2.8	7%	$ 0.3	1%
UnitedHealthcare Medicare & Retirement	36.1	34.0	30.6	2.1	6	3.4	11
UnitedHealthcare Community & State	13.8	12.1	9.8	1.7	14	2.3	23
Total UnitedHealthcare revenue	$ 95.3	$ 88.7	$ 82.7	$ 6.6	7%	$ 6.0	7%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	2011	2010	2009	Change 2011 vs. 2010		Change 2010 vs. 2009	
Commercial risk-based	9,550	9,405	9,415	145	2%	(10)	— %
Commercial fee-based	16,320	15,405	15,210	915	6	195	1
Total commercial	25,870	24,810	24,625	1,060	4	185	1
Medicare Advantage	2,240	2,070	1,790	170	8	280	16
Medicaid	3,525	3,320	2,900	205	6	420	14
Medicare Supplement	2,935	2,770	2,680	165	6	90	3
Total public and senior	8,700	8,160	7,370	540	7	790	11
Total UnitedHealthcare - medical	34,570	32,970	31,995	1,600	5%	975	3 %
Supplemental Data:							
Medicare Part D stand-alone	4,855	4,530	4,300	325	7%	230	5 %

UnitedHealthcare's revenue growth for the year ended December 31, 2011 was due to growth in the number of individuals served across our businesses and commercial premium rate increases reflecting expected underlying medical cost trends.

UnitedHealthcare's earnings from operations for the year ended December 31, 2011 increased compared to the prior year as revenue growth and improvements in the operating cost ratio more than offset increased compliance costs and an increase to the medical care ratio, which was primarily due to the initiation of premium rebate obligations in 2011, and lower favorable reserve development levels.

In our Medicare Part D stand-alone business, we estimate that we entered January 2012 down approximately 625,000 people, primarily as a result of the loss of approximately 470,000 of our auto-assigned low-income subsidy Medicare Part D beneficiaries in a number of regions being automatically reassigned to other plans as part of the annual bid process managed by CMS. We believe that we will grow from this level throughout the course of the year in the open retail market.

In February 2012, we added 117,000 Medicare Advantage members from the acquisition of XLHealth Corporation.

Optum. Total revenue for these businesses increased in 2011 due to business growth and acquisitions at OptumHealth and OptumInsight and growth in customers served through pharmaceutical benefit management programs at OptumRx.

Optum’s operating margin for the year ended December 31, 2011 was down compared to 2010. The decrease was due to changes in business mix within Optum’s businesses and realignment of certain internal business arrangements.

The results by segment were as follows:

OptumHealth

Increased revenues at OptumHealth for the year ended December 31, 2011 were primarily due to expansions in service offerings through acquisitions in clinical services, as well as growth in consumer and population health management offerings.

Earnings from operations for the year ended December 31, 2011 and operating margin decreased compared to 2010. The decreases reflect the impact from internal business and service arrangement realignments and the mix effect of growth and expansion in newer businesses such as clinical services.

OptumInsight

Increased revenues at OptumInsight for the year ended December 31, 2011 were due to the impact of organic growth and the full-year impact of 2010 acquisitions, which were partially offset by the divestiture of the clinical trials services business in June 2011.

The increases in earnings from operations and operating margins for the year ended December 31, 2011 reflect an increased mix of higher margin services in 2011 as well as the effect on 2010 earnings from operations and operating margin of the goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses. See Note 6 of Notes to the Consolidated Financial Statements for further detail on the goodwill impairment.

OptumRx

The increase in OptumRx revenues for the year ended December 31, 2011 was due to increased prescription volumes, primarily due to growth in customers served through Medicare Part D prescription drug plans by our UnitedHealthcare Medicare & Retirement business, and a favorable mix of higher revenue specialty drug prescriptions. Intersegment revenues eliminated in consolidation were $16.7 billion and $14.4 billion for the years ended December 31, 2011 and 2010, respectively.

OptumRx earnings from operations and operating margins for 2011 decreased as the mix of lower margin specialty pharmaceuticals and Medicaid business and investments to support growth initiatives including the in-sourcing of our commercial pharmacy benefit programs more than offset the earnings contribution from higher revenues and greater use of generic medications.

We will consolidate and manage the majority of our commercial pharmacy benefit programs internally when our contract with Medco Health Solutions, Inc. expires at the end of 2012. The investments in our infrastructure and to expand our capacity will likely cause a decrease in earnings from operations and operating margin as in 2012, OptumRx expects to absorb approximately $115 million of the $150 million consolidated in-sourcing related operating costs. As a result of this transition, OptumRx expects to add 12 million members on a staged basis in 2013. See Item 1A, “Risk Factors” for a discussion of certain risks associated with the transition of our commercial pharmacy benefit programs to OptumRx.

2010 RESULTS OF OPERATIONS COMPARED TO 2009 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues for 2010 were primarily due to strong organic growth in risk-based benefit offerings in our public and senior markets businesses and commercial premium rate increases reflecting underlying medical cost trends. Growth in customers served by our health services businesses, particularly through pharmaceutical benefit management programs, increased revenues from public sector behavioral health programs and increased sales of health care technology software and services also contributed to our revenue growth.

Medical Costs and Medical Care Ratio

Medical costs for 2010 increased primarily due to growth in our public and senior markets risk-based businesses and medical cost inflation, which were partially offset by net favorable development of prior period medical costs.

For 2010 and 2009, there was $800 million and $310 million, respectively, of net favorable medical cost development related to prior fiscal years.

The medical care ratio decreased due to a moderation in overall demand for medical services, successful clinical engagement and management and the increase in prior period favorable development discussed previously.

Operating Costs

Operating costs for 2010 increased due to acquired and organic growth in health services businesses, which are generally more operating cost intensive than our benefits businesses, goodwill impairment and charges for a business line disposition at OptumInsight, which is discussed in more detail below, an increase in staffing and selling expenses primarily due to the change in the Medicare Advantage annual enrollment period, costs related to increased employee headcount and compensation, increased advertising costs, and the absorption of new business development and start-up costs.

Income Tax Rate

The increase in our effective income tax rate for 2010 as compared to 2009 resulted from a benefit in the 2009 tax rate from the resolution of various historical state income tax matters and an increase in the 2010 rate related to limitations on the future deductibility of certain compensation due to the Health Reform Legislation.

Reportable Segments

UnitedHealthcare

The revenue growth in UnitedHealthcare for 2010 was primarily due to growth in the number of individuals served by our public and senior markets businesses and commercial premium rate increases reflecting underlying medical cost trends, partially offset by Medicare Advantage premium rate decreases.

UnitedHealthcare earnings from operations and operating margins for 2010 increased over the prior year due to factors that increased revenues described above, continued cost management disciplines on behalf of our commercial and governmental

customers, a general moderation in year-over-year growth in demand for medical services and the effect of increased net favorable development in prior period medical costs.

OptumHealth

Increased revenues in OptumHealth for 2010 were primarily driven by new business development in large scale public sector programs and increased sales of benefits and services to external employer markets.

The operating margin for 2010 decreased due to growth in lower margin public sector business, new market development and startup costs and costs related to the implementation of the federal Mental Health Parity & Addiction Equity Act of 2008.

OptumInsight

Increased revenues in OptumInsight for 2010 were primarily due to the impact of acquisitions and growth in health information technology offerings and services focused on cost and data management and regulatory compliance.

The decrease in operating margin for 2010 was primarily due to a goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses. In addition, increases in the mix of lower margin business, continued margin pressure in the pharmaceutical services business and continued investments in new growth areas also contributed to the decrease in operating margin in 2010. See Note 6 of Notes to the Consolidated Financial Statements for further detail on the goodwill impairment.

OptumRx

The increased OptumRx revenues for 2010 were primarily due to growth in customers served through Medicare Part D prescription drug plans by our UnitedHealthcare Medicare & Retirement business and higher prescription volumes. Intersegment revenues eliminated in consolidation were $14.4 billion and $12.5 billion for 2010 and 2009, respectively.

OptumRx operating margin for 2010 decreased due to changes in performance-based pricing contracts with Medicare Part D plan sponsors, which were partially offset by prescription volume growth, increased usage of mail service and generic drugs by consumers and effective operating cost management.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short- and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before non-cash expenses. The risk of decreased operating cash flow from a decline in earnings is partially mitigated by the diversity of our businesses, geographies and customers; our disciplined underwriting and pricing processes for our risk-based businesses; and continued productivity improvements that lower our operating costs.

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 exceeds our expected short-term obligations in longer term, liquid, investment-grade, debt securities to improve our overall investment return. We make these investments pursuant to our Board of Directors' approved investment policy, which focuses on preservation of capital through risk tolerances around liquidity, credit quality, issuer limits, asset class diversification, income and duration. The policy emphasizes investment grade bonds with durations that are short to intermediate term in nature. The policy also generally governs return objectives, regulatory limitations and tax implications.

Our regulated subsidiaries are subject to financial regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the 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. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary’s level of statutory net income and statutory capital and surplus. These dividends are referred to as “ordinary dividends” and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an “extraordinary dividend” and must receive prior regulatory approval.

In 2011, based on the 2010 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends which could be paid was $3.4 billion. For the year ended December 31, 2011, our regulated subsidiaries paid their parent companies dividends of $4.5 billion, including $1.1 billion of extraordinary dividends. For the year ended December 31, 2010, our regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $686 million of extraordinary dividends.

Our non-regulated businesses also generate cash flows from operations for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long term debt as well as issuance of commercial paper or drawings under our committed credit facility, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, or return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash

	For the Year Ended December 31,		
(in millions)	**2011**	**2010**	**2009**
Sources of cash:			
Cash provided by operating activities	$ 6,968	$ 6,273	$ 5,625
Issuance of long-term debt and commercial paper, net of repayments	346	94	—
Interest rate swap termination	132	—	513
Proceeds from customer funds administered	37	974	204
Sales and maturities of investments, net of purchases	—	—	249
Other	640	292	304
Total sources of cash	8,123	7,633	6,895
Uses of cash:			
Common stock repurchases	(2,994)	(2,517)	(1,801)
Purchases of investments, net of sales and maturities	(1,695)	(2,157)	—
Cash paid for acquisitions, net of cash assumed and dispositions	(1,459)	(2,304)	(486)
Purchases of property, equipment and capitalized software, net of dispositions	(1,018)	(878)	(739)
Dividends paid	(651)	(449)	(36)
Repayments of long-term debt and commercial paper	—	—	(1,449)
Other	—	(5)	(10)
Total uses of cash	(7,817)	(8,310)	(4,521)
Net increase (decrease) in cash	$ 306	$ (677)	$ 2,374

2011 Cash Flows Compared to 2010 Cash Flows

Cash flows from operating activities increased $695 million, or 11%, from 2010. The increase was primarily driven by growth in net earnings and changes in various working capital accounts, which were partially offset by a reduction in unearned revenues due to the early receipt of certain 2011 state Medicaid premium payments in 2010, which increased 2010 cash from operating activities. We anticipate lower year over year cash flows from operations in 2012, which will include payments in the third quarter for 2011 premium rebate obligations.

Cash flows used for investing activities decreased $1.2 billion, or 22%, primarily due to relatively lower investments in acquisitions in 2011 and a decrease in net purchases of investments. We anticipate an increase in cash paid for acquisitions in 2012 as compared to 2011.

Cash flows used for financing activities increased $879 million, or 55%, primarily due to increased share repurchases and cash dividends in 2011, partially offset by an increase in net borrowings.

2010 Cash Flows Compared to 2009 Cash Flows

Cash flows from operating activities increased $648 million, or 12%, for 2010. Factors that increased cash flows from operating activities were growth in net earnings, an acceleration of certain 2011 premium payments, and an increase in pharmacy rebate collections, which were partially offset by a mandated acceleration in the claim payment cycle associated with the Medicare Part D program and payment for the settlement of the American Medical Association class action litigation

related to reimbursement for out-of-network medical services.

Cash flows used for investing activities increased $4.4 billion, primarily due to acquisitions completed in 2010, decreases in sales of investments due to a more stable market environment and the use of operating cash to purchase investments.

Cash flows used for financing activities decreased $664 million, or 29%, primarily due to proceeds from the issuance of commercial paper and long-term debt, partially offset by increases in common stock repurchases and cash dividends paid on our common stock.

Financial Condition

As of December 31, 2011, our cash, cash equivalent and available-for-sale investment balances of $28.0 billion included $9.4 billion of cash and cash equivalents (of which $1.6 billion was held by non-regulated entities), $18.0 billion of debt securities and $544 million of investments in equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. The use of different market assumptions or valuation methodologies, primarily used in valuing our Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. We had $417 million of Level 3 securities as of December 31, 2011. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our $3.0 billion bank credit facility, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements for further detail of our fair value measurements.

Our cash equivalent and investment portfolio has a weighted-average duration of 2.1 years and a weighted-average credit rating of “AA” as of December 31, 2011. Included in the debt securities balance are $2.4 billion of state and municipal obligations that are guaranteed by a number of third parties. Due to the high underlying credit ratings of the issuers, the weighted-average credit rating of these securities both with and without the guarantee is “AA” as of December 31, 2011. We do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers. The commercial paper program is supported by the $3.0 billion bank credit facility described below. As of December 31, 2011, we had no commercial paper outstanding.

Bank Credit Facility. In December 2011, we amended and renewed our five-year revolving bank credit facility with 21 banks, which will mature in December 2016. The amendment included increasing the borrowing capacity to $3.0 billion. This facility supports our commercial paper program and is available for general corporate purposes. There were no amounts outstanding under this facility as of December 31, 2011. The interest rate on borrowings is variable based on term and amount and is calculated based on the LIBOR plus a credit spread based on our senior unsecured credit ratings. As of December 31, 2011, the annual interest rate on this facility, had it been drawn, would have ranged from 1.2% to 1.7%.

Our bank credit facility contains various covenants, including requiring us to maintain a debt to debt-plus-equity ratio below 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, was 29.1% and 30.1% as of December 31, 2011 and December 31, 2010, respectively. We were in compliance with our debt covenants as of December 31, 2011.

Long-term debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes and the funds may be used, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions, for share repurchases or for other general corporate purposes.

In November 2011, we issued $1.5 billion in senior unsecured notes. The issuance included $400 million of 1.9% fixed-rate notes due November 2016, $500 million of 3.4% fixed-rate notes due November 2021 and $600 million of 4.6% notes due November 2041.

In February 2011, we issued $750 million in senior unsecured notes. The issuance included $400 million of 4.7% fixed-rate

notes due February 2021 and $350 million of 6.0% fixed-rate notes due February 2041.

Credit Ratings. Our credit ratings at December 31, 2011 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A-	Positive	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-2	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Share Repurchases. Under our Board of Directors' authorization, we maintain a common share repurchase program. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured repurchase programs), subject to certain preset parameters established by our Board. In May 2011, our Board renewed our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock. During the year ended December 31, 2011, we repurchased 65 million shares at an average price of approximately $46 per share and an aggregate cost of $3.0 billion. As of December 31, 2011, we had Board authorization to purchase up to an additional 65 million shares of our common stock.

Dividends. In May 2011, our Board of Directors increased our cash dividend to shareholders to an annual dividend rate of $0.65 per share, paid quarterly. Since June 2010, we had paid a quarterly dividend of $0.125 per share. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change. On February 8, 2012, our Board of Directors approved a quarterly dividend of $0.1625 per share.

The following table provides details of our dividend payments and annual dividend rate:

Years ended December 31,	Amount Paid per Share	Total Amount Paid	Annual Dividend Rate per Share at December 31,
		(in millions)	
2009	$ 0.0300	$ 36	$ 0.03
2010	0.4050	449	0.50
2011	0.6125	651	0.65

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2011, under our various contractual obligations and commitments:

(in millions)	2012	2013 to 2014	2015 to 2016	Thereafter	Total
Debt (a)	$ 1,580	$ 2,551	$ 2,437	$ 13,529	$ 20,097
Operating leases	279	455	303	564	1,601
Purchase obligations (b)	180	105	34	1	320
Future policy benefits (c)	125	257	271	1,917	2,570
Unrecognized tax benefits (d)	9	—	—	108	117
Other liabilities recorded on the Consolidated Balance Sheet (e)	203	7	—	2,459	2,669
Other obligations (f)	101	66	122	32	321
Total contractual obligations	$ 2,477	$ 3,441	$ 3,167	$ 18,610	$ 27,695

(a) Includes interest coupon payments and maturities at par or put values. Coupon payments have been calculated using stated rates from the debt agreements and assuming amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2011.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements for more detail.

(d) As the timing of future settlements is uncertain, the long-term portion has been classified as “Thereafter.”

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, charitable contributions related to the PacifiCare acquisition and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as “Thereafter.”

(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

We do not have other significant contractual obligations 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.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2011, we were not involved in off-balance sheet arrangements which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-06, “Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers a consensus of the FASB Emerging Issues Task Force” (ASU 2011-06). This update addresses the recognition and classification of an entity's share of the annual health insurance industry assessment (the fee) mandated by Health Reform Legislation. The fee will be levied on health insurers for each calendar year beginning on or after January 1, 2014 and is not deductible for income tax purposes. The fee will be allocated to health insurers based on the ratio of an entity's net health premiums written during the preceding calendar year to the total health insurance for any U.S. health risk that is written during the preceding calendar year. In accordance with the amendments in ASU 2011-06, our liability for the fee will be estimated and recorded in full once we provide qualifying health insurance in the applicable calendar year in which the fee is payable (first applicable in 2014) with a corresponding deferred cost that will be amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable.

We have determined that there have been no other recently issued accounting standards that will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

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 processing backlogs, seasonal variances in medical care consumption, health care professional 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 professional and type of service, the typical billing lag for services can be up to 90 days from the 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 liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement actions.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust 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). Medical costs in 2011, 2010 and 2009, included net favorable medical cost development related to prior periods of $720 million, $800 million and $310 million, respectively. This development represented approximately 8%, 9% and 4% of the medical claims payable balance as of December 31, 2010, 2009 and 2008, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. This approach is consistently applied from period to period.

Completion Factors. Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. The completion factor includes judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2011:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 211
(0.50)	141
(0.25)	70
0.25	(70)
0.50	(139)
0.75	(208)

Medical cost PMPM trend factors. Medical cost PMPM trend factors are the most significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design, and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates including: our ability and practices to manage medical costs, changes in level and mix of services utilized, mix of benefits offered including the impact of co-pays and deductibles, changes in medical practices, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2011:

Medical Costs PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 415
2	277
1	138
(1)	(138)
(2)	(277)
(3)	(415)

The analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2011, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2011; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2011 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2011 net earnings would have increased or decreased by $56 million and diluted net earnings per common share would have increased or decreased by $0.05 per share.

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 coordinating care with physicians and other health care professionals and rate discounts from physicians and other health care professionals. Through contracts with physicians and other health care professionals, 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 professionals 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.

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. Effective in 2011, premium revenue subject to the premium rebates of the Health Reform Legislation are recognized based on the estimated premium earned net of the projected rebates over the period of the contract, when that amount can be reasonably estimated. The estimated premium is revised each period to reflect current experience. The most significant factors in estimating these rebates are financial performance within each aggregation set, including medical claim experience and effective tax rates, as well as changes in business mix and regulatory requirements. We revise estimates of revenue adjustments each period and record changes in the period they become known.

Our Medicare Advantage and Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and other health care plans collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Medicare Advantage risk adjustment data for certain of our plans is subject to audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements in this Form 10-K for additional information regarding these audits.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategy. Key assumptions used in these forecasts include:

- *Revenue trends.* Key drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions around unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated.
- *Medical cost trends.* See further discussion of medical costs trends within Medical Costs above. Similar factors are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost productivity initiatives.
- *Capital levels.* The capital structure and requirements for each business is considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the

long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, “Business - Government Regulation”. For additional discussions regarding how the enactment or implementation of health care reforms and how other factors could affect our business and the related long-term forecasts, see Item 1A, “Risk Factors” in Part I and "Regulatory Trends and Uncertainties" above.

Discount rates are determined for each reporting unit based on the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty in regards to the reporting units' operations could cause these assumptions to change in the future.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2012. All of our reporting units had fair values substantially in excess of their carrying values, thus we concluded that there was no need for any impairment of our goodwill balances as of December 31, 2011.

Intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). We do not have material holdings of indefinite-lived intangible assets. Our intangible assets are initially recorded at their fair values and are then amortized over their expected useful lives. Our most significant intangible assets are customer-related intangibles which represent 88% of our total intangible balance of $2.8 billion.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and earnings growth, retention rate, perpetuity growth rate and discount rate. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of an intangible asset, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If the carrying value exceeds its estimated fair value, an impairment would be recorded.

There were no material impairments of finite-lived intangible assets during 2011.

Investments

As of December 31, 2011, we had investments with a carrying value of $18.7 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from earnings and report net unrealized gains or losses, 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, 2011, our investments had gross unrealized gains of $787 million and gross unrealized losses of $32 million. We evaluate investments for impairment considering factors including:

- our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost;
- the length of time and extent to which market value has been less than cost; and
- the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.

For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in through our income statement.

Inherently, there is uncertainty included in the impairment assessment of investments. Our analysis includes significant judgments and estimates including: the fair value of the investment, the underlying credit quality of the issuers and the credit ratings of the issuer other forms of credit enhancements, the financial condition and near term prospects of the issuer, and general industry and sector economic conditions.

Fair values. We perform an analysis around the fair values of the securities held including obtaining an understanding of the pricing method and procedures over the valuation of securities. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- the prices received from the pricing service to prices reported by a secondary pricing service, its custodian, its investment consultant and/or third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-than-temporary impairment assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the factors above including: the length of time of impairment, credit standing, financial condition, near term-prospects and other factors specific to the issuer. Other factors included in the assessment include the type and nature of the securities and liquidity. Given the nature of our portfolio, primarily investment grade securities, the primary causes of historical impairments were market related (e.g., interest rate fluctuations, etc) as opposed to credit related. We do not expect that trend to change in the near term. Generally, we do not assume that we will be required to sell a security because our large cash holdings reduce this risk. However, our intent to sell a security may change from period to period if facts and circumstances change.

We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. The unrealized losses at December 31, 2011 and 2010 were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments during 2011, 2010 and 2009 were $12 million, $23 million and $64 million, respectively. Our cash equivalent and investment portfolio has a weighted-average duration of 2.1 years and a weighted-average credit rating of “AA” as of December 31, 2011. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial

condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available including current facts and circumstances changing, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A "Quantitative and Qualitative Disclosures About Market Risk" a 1% increase in market interest rates has the effect of decreasing the fair value of our investment portfolio by $622 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements. Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes.

We have established a valuation allowance against certain deferred tax assets based on the weight of available evidence (both positive and negative) for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized. After application of the valuation allowances, we anticipate that no limitations will apply with respect to utilization of any of the other net deferred income tax assets. We believe that our estimates for the valuation allowances against deferred tax assets and tax contingency reserves are appropriate based on current facts and circumstances.

According to U.S. Generally Accepted Accounting Principles (GAAP), a tax benefit from an uncertain tax position may be recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits.

We have established an estimated liability for federal, state and non-U.S. income tax exposures that arise and meet the criteria for accrual under U.S. GAAP. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax contingencies due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2011 earnings before income taxes would have caused the provision for income taxes to change by $80 million.

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 where appropriate. Our estimates are developed in consultation with outside legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of probable costs resulting from legal and regulatory matters involving us are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, in many cases, we are unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures each reporting period, see Note 12 of Notes to the Consolidated Financial Statements for discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

LEGAL MATTERS

A description of our legal proceedings is included in Note 12 of Notes to the Consolidated Financial Statements and is incorporated by reference in this report.

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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 and other customers that constitute our client base. As of December 31, 2011, we had an aggregate $1.9 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as "A+." As of December 31, 2011, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt and (b) changes in equity prices that impact the value of our equity investments.

As of December 31, 2011, $9.4 billion of our investments were classified as cash and cash equivalents on which interest rates received vary with market interest rates, which may materially impact our investment income. Also, OptumHealth Bank held $1.4 billion of deposit liabilities as of December 31, 2011 at interest rates that vary with market rates.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2011, $18.2 billion of our investments were fixed-rate debt securities and $11.6 billion of our debt was fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as endeavoring to match our floating-rate assets and liabilities over time, either directly or periodically through the use of interest rate swap contracts. In the second half of 2011, we terminated all of our interest rate swap fair value hedges with a $5.4 billion notional amount in order to lock-in the impact of low market floating interest rates and reduce the effective interest rate on hedged long-term debt. The gain of $132 million will be realized over the remaining life of the applicable hedged fixed-rate debt as a reduction to interest expense in the Consolidated Statements of Operations. Additional information on our interest rate swaps is included in Note 8 of Notes to the Consolidated Financial Statements. Since the interest rate swaps have been terminated, the fair value of our long-term debt is now more sensitive to hypothetical changes in interest rates as the change in the fair value of the debt is no longer offset by the swaps. Also as a result of the swaps' termination, our exposure to hypothetical changes in market rates on our interest expense is less volatile.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% or 2% as of December 31, 2011 and 2010 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions):

	December 31, 2011			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2 %	$ 199	$ 28	$ (1,239)	$ (1,946)
1	99	14	(622)	(1,082)
(1)	(12)	(4)	586	1,086
(2)	nm	nm	885	2,343

	December 31, 2010			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments	Fair Value of Debt
2 %	$ 182	$ 163	$ (1,177)	$ (860)
1	91	82	(602)	(471)
(1)	(10)	(21)	613	560
(2)	nm	nm	1,227	1,240

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2011 and 2010, the assumed hypothetical change in interest rates does not reflect the full 1% point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 2% point reduction is not meaningful.

(b) As of December 31, 2011, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 2% point reduction.

As of December 31, 2011, we had $544 million of investments in equity securities and venture capital funds, a portion of which were invested 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 impact the value of our equity investments.

ITEM 8. FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2011 and 2010, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2011, based on the criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 8, 2012 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 8, 2012

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2011	December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	$ 9,429	$ 9,123
Short-term investments	2,577	2,072
Accounts receivable, net of allowances of $196 and $241	2,294	2,061
Other current receivables, net of allowances of $72 and $66	2,255	1,643
Assets under management	2,708	2,550
Deferred income taxes	472	403
Prepaid expenses and other current assets	615	541
Total current assets	20,350	18,393
Long-term investments	16,166	14,707
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,440 and $2,779	2,515	2,200
Goodwill	23,975	22,745
Other intangible assets, net of accumulated amortization of $1,451 and $1,350	2,795	2,910
Other assets	2,088	2,108
Total assets	$ 67,889	$ 63,063
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$ 9,799	$ 9,220
Accounts payable and accrued liabilities	6,853	6,488
Other policy liabilities	5,063	3,979
Commercial paper and current maturities of long-term debt	982	2,480
Unearned revenues	1,225	1,533
Total current liabilities	23,922	23,700
Long-term debt, less current maturities	10,656	8,662
Future policy benefits	2,445	2,361
Deferred income taxes and other liabilities	2,574	2,515
Total liabilities	39,597	37,238
Commitments and contingencies (Note 12)		
Shareholders' equity:		
Preferred stock, $0.001 par value - 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value - 3,000 shares authorized; 1,039 and 1,086 issued and outstanding	10	11
Retained earnings	27,821	25,562
Accumulated other comprehensive income (loss):		
Net unrealized gains on investments, net of tax effects	476	280
Foreign currency translation losses	(15)	(28)
Total shareholders' equity	28,292	25,825
Total liabilities and shareholders' equity	$ 67,889	$ 63,063

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Year Ended December 31, 2011	2010	2009
Revenues:			
Premiums	$ 91,983	$ 85,405	$ 79,315
Services	6,613	5,819	5,306
Products	2,612	2,322	1,925
Investment and other income	654	609	592
Total revenues	101,862	94,155	87,138
Operating costs:			
Medical costs	74,332	68,841	65,289
Operating costs	15,557	14,270	12,734
Cost of products sold	2,385	2,116	1,765
Depreciation and amortization	1,124	1,064	991
Total operating costs	93,398	86,291	80,779
Earnings from operations	8,464	7,864	6,359
Interest expense	(505)	(481)	(551)
Earnings before income taxes	7,959	7,383	5,808
Provision for income taxes	(2,817)	(2,749)	(1,986)
Net earnings	$ 5,142	$ 4,634	$ 3,822
Basic net earnings per common share	$ 4.81	$ 4.14	$ 3.27
Diluted net earnings per common share	$ 4.73	$ 4.10	$ 3.24
Basic weighted-average number of common shares outstanding	1,070	1,120	1,168
Dilutive effect of common stock equivalents	17	11	11
Diluted weighted-average number of common shares outstanding	1,087	1,131	1,179
Anti-dilutive shares excluded from the calculation of dilutive effect of common stock equivalents	47	94	107
Cash dividends declared per common share	$ 0.6125	$ 0.4050	$ 0.0300

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
Balance at January 1, 2009	1,201	$ 12	$ 38	$ 20,782	$ (52)	$ 20,780
Net earnings				3,822		3,822
Net unrealized holding gains on investment securities during the period, net of tax expense of $187					314	314
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $4					(7)	(7)
Foreign currency translation loss					(2)	(2)
Comprehensive income						4,127
Issuances of common stock, and related tax benefits	20	—	221			221
Common stock repurchases	(74)	(1)	(574)	(1,226)		(1,801)
Share-based compensation, and related tax benefits			315			315
Common stock dividends				(36)		(36)
Balance at December 31, 2009	1,147	11	—	23,342	253	23,606
Net earnings				4,634		4,634
Net unrealized holding gains on investment securities during the period, net of tax expense of $26					48	48
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $26					(45)	(45)
Foreign currency translation loss					(4)	(4)
Comprehensive income						4,633
Issuances of common stock, and related tax benefits	15	—	207			207
Common stock repurchases	(76)	—	(552)	(1,965)		(2,517)
Share-based compensation, and related tax benefits			345			345
Common stock dividends				(449)		(449)
Balance at December 31, 2010	1,086	11	—	25,562	252	25,825
Net earnings				5,142		5,142
Net unrealized holding gains on investment securities during the period, net of tax expense of $154					268	268
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $41					(72)	(72)
Foreign currency translation gain					13	13
Comprehensive income						5,351
Issuances of common stock, and related tax benefits	18	—	308			308
Common stock repurchases	(65)	(1)	(761)	(2,232)		(2,994)
Share-based compensation, and related tax benefits			453			453
Common stock dividends				(651)		(651)
Balance at December 31, 2011	1,039	$ 10	$ —	$ 27,821	$ 461	$ 28,292

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2011	2010	2009
Operating activities			
Net earnings	$ 5,142	$ 4,634	$ 3,822
Noncash items:			
Depreciation and amortization	1,124	1,064	991
Deferred income taxes	59	45	(16)
Share-based compensation	401	326	334
Other, net	(67)	203	23
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(267)	(16)	100
Other assets	(121)	84	(250)
Medical costs payable	377	(88)	424
Accounts payable and other liabilities	146	(341)	99
Other policy liabilities	482	10	104
Unearned revenues	(308)	352	(6)
Cash flows from operating activities	6,968	6,273	5,625
Investing activities			
Purchases of investments	(9,895)	(7,855)	(6,466)
Sales of investments	3,949	2,593	4,040
Maturities of investments	4,251	3,105	2,675
Cash paid for acquisitions, net of cash assumed	(1,844)	(2,323)	(486)
Cash received from dispositions, net of cash transferred	385	19	—
Purchases of property, equipment and capitalized software	(1,067)	(878)	(739)
Proceeds from disposal of property, equipment and capitalized software	49	—	—
Cash flows used for investing activities	(4,172)	(5,339)	(976)
Financing activities			
Common stock repurchases	(2,994)	(2,517)	(1,801)
Proceeds from common stock issuances	381	272	282
Dividends paid	(651)	(449)	(36)
(Repayments of) proceeds from commercial paper, net	(933)	930	(99)
Proceeds from issuance of long-term debt	2,234	747	—
Repayments of long-term debt	(955)	(1,583)	(1,350)
Interest rate swap termination	132	—	513
Customer funds administered	37	974	204
Checks outstanding in excess of bank deposits	206	(5)	22
Other, net	53	20	(10)
Cash flows used for financing activities	(2,490)	(1,611)	(2,275)
Increase (decrease) in cash and cash equivalents	306	(677)	2,374
Cash and cash equivalents, beginning of period	9,123	9,800	7,426
Cash and cash equivalents, end of period	$ 9,429	$ 9,123	$ 9,800
Supplemental cash flow disclosures			
Cash paid for interest	$ 472	$ 509	$ 527
Cash paid for income taxes	$ 2,739	$ 2,725	$ 2,048

See Notes to the Consolidated Financial Statements

UNITEDHEALTH GROUP
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Description of Business

UnitedHealth Group Incorporated (also referred to as "UnitedHealth Group" and "the Company") is a diversified health and well-being company whose mission is to help people live healthier lives and make health care work better.

The Company helps individuals access quality care at an affordable cost; simplifying health care administration and delivery; strengthening the physician/patient relationship; promoting evidence-based care; and empowering physicians, health care professionals, consumers, employers and other participants in the health system with actionable data to make better, more informed decisions.

Through the Company's diversified family of businesses, it leverages core competencies in advanced, enabling technology; health care data, information and intelligence; and care management and coordination to help meet the demands of the health system.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The Company has eliminated intercompany balances and transactions.

During the first quarter of 2011, the Company renamed its reportable segments to conform to the naming conventions of its market facing businesses. Consequently, the Health Benefits reportable segment is now UnitedHealthcare, and the health services businesses, OptumHealth, Ingenix, and Prescriptions Solutions, are now aligned under Optum as OptumHealth, OptumInsight, and OptumRx, respectively. On January 1, 2011, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. For example, OptumHealth's results of operations now include the Company's clinical services assets, including Southwest Medical multi-specialty clinics in Nevada and Evercare nurse practitioners serving the frail and elderly, which had historically been reported in UnitedHealthcare Employer & Individual and UnitedHealthcare Medicare & Retirement, respectively. UnitedHealthcare Employer & Individual's results of operations now include OptumHealth Specialty Benefits, including dental, vision, life and disability. The Company's reportable segments remain the same and prior period segment financial information has been recast to conform to the 2011 presentation. See Note 13 of Notes to the Consolidated Financial Statements for segment financial information.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs payable and medical costs, premium rebates and risk-sharing provisions related to revenues, valuation and impairment analysis of goodwill and other intangible assets, other policy liabilities, other current receivables, valuation of investments, income taxes and contingent liabilities. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs. Effective in 2011, commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the Patient Protection and Affordable Care Act and its related reconciliation act (Health Reform Legislation) and implementing regulations, that fall below certain targets are required to rebate ratable portions of their premiums annually. The Company classifies its estimated rebates as an offset to Premium Revenues in the Consolidated Statement of Operations. Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from its customers in advance of the service period are recorded as unearned revenues. The Company also records premium revenues from capitation arrangements at its collaborative care businesses.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that apportions premiums paid to all

health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans is subject to audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependants. Under service fee contracts, the Company recognizes revenue in the period the related services are performed. The customers retain the risk of financing health care costs for their employees and employees' dependants, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

For the Company's OptumRx pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized always exclude the member's applicable co-payment. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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 processing backlogs, care provider contract rate changes, medical care consumption and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Medical costs also include the direct cost of patient care rendered through OptumHealth.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

The Company had checks outstanding in excess of bank deposits at the related accounts of $1.5 billion as of December 31, 2011 and $1.3 billion as of December 31, 2010, which were classified as Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets and the change in this balance has been reflected as Checks Outstanding in Excess of Bank Deposits within financing activities in the Consolidated Statements of Cash Flows. The Company does not net checks outstanding with deposits in other accounts.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings and reports them, net of income tax effects, as a separate component of shareholders' equity. To calculate realized gains and losses on the sale of investments, the Company uses the specific cost or amortized cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends to either sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in Investment and Other Income. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income.
- For equity securities, the Company recognizes impairments in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the impairment in Investment and Other Income.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program), and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

The Company's arrangements with AARP extend to December 31, 2017 for the AARP Program and give the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage and Medicare Part D offerings until December 31, 2014, subject to certain limited exclusions.

Pursuant to the Company's agreement, AARP Program assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the RSF and were $99 million, $107 million and $99 million in 2011, 2010 and 2009, respectively.

The effects of changes in balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows. For more detail on the RSF, see "Other Policy Liabilities" below.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of whom provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of Product Revenue. The Company generally receives rebates from two to five months after billing.

For details on the Company's Medicare Part D receivables see “Medicare Part D Pharmacy Benefits” below.

For details on the Company's reinsurance receivable see “Future Policy Benefits and Reinsurance Receivable” below.

Medicare Part D Pharmacy Benefits

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including member eligibility status differences with CMS. The Company records risk-share adjustments to Premium Revenues in the Consolidated Statements of Operations and Other Policy Liabilities or Other Current Receivables in the Consolidated Balance Sheets.
- *Drug Discount.* Beginning in 2011, Health Reform Legislation mandated a consumer discount of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds. Amounts received are not reflected as premium revenues, but rather are accounted for as deposits. The Company records a liability when amounts are received from CMS and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as Customer Funds Administered within financing activities in the Condensed Consolidated Statements of Cash Flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and therefore are recorded as Premium Revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in Unearned Revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy (Subsidies) represent cost reimbursements under the Medicare Part D program. Amounts received for these Subsidies are not reflected as premium revenues, but rather are accounted for as receivables and/or deposits. Related cash flows are presented as Customer Funds

Administered within financing activities in the Condensed Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in Medical Costs and Operating Costs, respectively, in the Consolidated Statements of Operations.

The final 2011 risk-share amount is expected to be settled during the second half of 2012, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2011			December 31, 2010	
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Risk-Share
Other current receivables	$ —	$ 509	$ —	$ —	$ —
Other policy liabilities	70	649	170	475	265

As of January 1, 2012, certain changes were made to the Medicare Part D coverage by CMS, including:

The initial coverage limit increased to $2,930 from $2,840 in 2011.

The catastrophic coverage begins at $6,658 as compared to $6,448 in 2011.

The annual out-of-pocket maximum increased to $4,700 from $4,550 in 2011.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. The Company reviews property, equipment and capitalized software for events or changes in circumstances that would indicate that it might not recover their carrying value. If the Company determines that an asset may not be recoverable, an impairment charge is recorded.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, the Company performs a multi-step impairment test. First, the Company can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if the Company elects to proceed directly with quantitative testing, it will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

The Company estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

The Company elected to bypass the optional qualitative reporting-unit fair value assessment and completed its annual quantitative test for goodwill impairment as of January 1, 2012. As of December 31, 2011, no reporting unit had a fair value less than its carrying value and the Company concluded that there was no need for any impairment of its goodwill balances.

Intangible assets

Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). The Company does not have material holdings of indefinite lived intangible assets. The Company's intangible assets are initially recorded at their fair values and are then amortized over their expected useful lives.

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given to a number of potential impairment indicators. Following the identification of any potential impairment indicators, to determine whether an impairment exists, the Company would calculate the estimated fair value of a finite-lived intangible asset using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. Once it is determined that an impairment exists, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

There were no material impairments of finite-lived intangible assets during the year ended December 31, 2011.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP Program (described below), health savings account deposits, deposits under the Medicare Part D program (see “Medicare Part D Pharmacy Benefits” above), accruals for premium rebate payments under the Health Reform Legislation, the current portion of future policy benefits and customer balances. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Underwriting gains or losses related to the AARP Program are directly 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. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF, losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. Changes in the RSF are reported in Medical Costs in the Consolidated Statement of Operations. As of December 31, 2011 and 2010, the balance in the RSF was $1.3 billion. The Company believes the RSF balance as of December 31, 2011 is sufficient to cover potential future underwriting and other risks and liabilities associated with the contract.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits and Reinsurance Receivable

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2011, the Company had an aggregate $1.9 billion reinsurance receivable, of which $125 million was recorded in Other Current Receivables and $1.8 billion was recorded in Other Assets in the Consolidated Balance Sheets. As of December 31, 2010, the Company had an aggregate $2.0 billion reinsurance receivable, of which $126 million was recorded in Other Current Receivables and $1.9 billion was recorded in Other Assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. Currently, the reinsurer is rated by A.M. Best as “A+.”

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be cancelled by the customer with at least 30 days notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to

expense as incurred.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted shares, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recent Accounting Standards

Recently Issued Accounting Standards. In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-06, “Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers a consensus of the FASB Emerging Issues Task Force” (ASU 2011-06). This update addresses the recognition and classification of an entity's share of the annual health insurance industry assessment (the fee) mandated by Health Reform Legislation. The fee will be levied on health insurers for each calendar year beginning on or after January 1, 2014 and is not deductible for income tax purposes. The fee will be allocated to health insurers based on the ratio of an entity's net health premiums written during the preceding calendar year to the total health insurance for any U.S. health risk that is written during the preceding calendar year. In accordance with the amendments in ASU 2011-06, the liability for the fee will be estimated and recorded in full once the Company provides qualifying health insurance in the applicable calendar year in which the fee is payable (first applicable in 2014) with a corresponding deferred cost that will be amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable.

Recently Adopted Accounting Standards. In September 2011, the FASB issued ASU No. 2011-08, “Intangibles - Goodwill and Other (Topic 350): Testing Goodwill for Impairment” (ASU 2011-08). This update intends to simplify how entities test goodwill for impairment by including an option for entities to first assess qualitative factors to determine whether it is more-likely-than-not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test on the subject reporting unit. The Company adopted the amendments in ASU 2011-08 for its annual goodwill impairment test as of January 1, 2012. The adoption of ASU 2011-08 did not have a material impact on the Company's Consolidated Financial Statements.

The Company has determined that there have been no other recently issued or adopted accounting standards that will have or had a material impact on its Consolidated Financial Statements.

3. Investments

A summary of short-term and long-term investments is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2011				
Debt securities - available-for-sale:				
U.S. government and agency obligations	$ 2,319	$ 54	$ —	$ 2,373
State and municipal obligations	6,363	403	(1)	6,765
Corporate obligations	5,825	205	(23)	6,007
U.S. agency mortgage-backed securities	2,279	74	—	2,353
Non-U.S. agency mortgage-backed securities	476	28	—	504
Total debt securities - available-for-sale	17,262	764	(24)	18,002
Equity securities - available-for-sale	529	23	(8)	544
Debt securities - held-to-maturity:				
U.S. government and agency obligations	166	7	—	173
State and municipal obligations	13	—	—	13
Corporate obligations	18	—	—	18
Total debt securities - held-to-maturity	197	7	—	204
Total investments	$ 17,988	$ 794	$ (32)	$ 18,750
December 31, 2010				
Debt securities - available-for-sale:				
U.S. government and agency obligations	$ 2,214	$ 28	$ (8)	$ 2,234
State and municipal obligations	6,007	183	(42)	6,148
Corporate obligations	5,111	210	(11)	5,310
U.S. agency mortgage-backed securities	1,851	58	(6)	1,903
Non-U.S. agency mortgage-backed securities	439	26	—	465
Total debt securities - available-for-sale	15,622	505	(67)	16,060
Equity securities - available-for-sale	508	22	(14)	516
Debt securities - held-to-maturity:				
U.S. government and agency obligations	167	5	—	172
State and municipal obligations	15	—	—	15
Corporate obligations	21	—	—	21
Total debt securities - held-to-maturity	203	5	—	208
Total investments	$ 16,333	$ 532	$ (81)	$ 16,784

Included in the Company's investment portfolio were securities collateralized by sub-prime home equity lines of credit with fair values of $2 million and $6 million as of December 31, 2011 and December 31, 2010, respectively. Also included were Alt-A securities with fair values of $9 million and $15 million as of December 31, 2011 and December 31, 2010, respectively.

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination as of December 31, 2011 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2011	$ 26	$ —	$ —	$ —	$ 26
2010	—	3	—	—	3
2007	93	—	—	3	96
2006	167	—	—	10	177
2005	136	—	—	3	139
Pre - 2005	60	—	3	—	63
U.S. agency mortgage-backed securities	2,353	—	—	—	2,353
Total	$ 2,835	$ 3	$ 3	$ 16	$ 2,857

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2011, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 2,629	$ 2,641
Due after one year through five years	5,631	5,808
Due after five years through ten years	4,439	4,763
Due after ten years	1,808	1,933
U.S. agency mortgage-backed securities	2,279	2,353
Non-U.S. agency mortgage-backed securities	476	504
Total debt securities - available-for-sale	$ 17,262	$ 18,002

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2011, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 43	$ 43
Due after one year through five years	124	127
Due after five years through ten years	21	22
Due after ten years	9	12
Total debt securities - held-to-maturity	$ 197	$ 204

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2011						
Debt securities - available-for-sale:						
State and municipal obligations	$ 85	$ (1)	$ 21	$ —	$ 106	$ (1)
Corporate obligations	1,496	(22)	28	(1)	1,524	(23)
Total debt securities - available-for-sale	$ 1,581	$ (23)	$ 49	$ (1)	$ 1,630	$ (24)
Equity securities - available-for-sale	$ 24	$ (7)	$ 3	$ (1)	$ 27	$ (8)
December 31, 2010						
Debt securities - available-for-sale:						
U.S. government and agency obligations	$ 548	$ (8)	$ —	$ —	$ 548	$ (8)
State and municipal obligations	1,383	(40)	18	(2)	1,401	(42)
Corporate obligations	949	(11)	14	—	963	(11)
U.S. agency mortgage-backed securities	355	(6)	—	—	355	(6)
Total debt securities - available-for-sale	$ 3,235	$ (65)	$ 32	$ (2)	$ 3,267	$ (67)
Equity securities - available-for-sale	$ 206	$ (14)	$ 11	$ —	$ 217	$ (14)

The unrealized losses from all securities as of December 31, 2011 were generated from 2,100 positions out of a total of 15,300 positions. The Company believes that it will collect the principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses on investments in state and municipal obligations and corporate obligations as of December 31, 2011 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality of the issuers and the credit ratings of the state and municipal obligations and the corporate obligations, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of December 31, 2011, the Company did not have the intent to sell any of the securities in an unrealized loss position.

As of December 31, 2011, the Company's holdings of non-U.S. agency mortgage-backed securities included $7 million of commercial mortgage loans in default. They represented less than 1% of the Company's total mortgage-backed security holdings as of December 31, 2011.

A portion of the Company's investments in equity securities and venture capital funds consists of investments held in various public and nonpublic companies concentrated in the areas of health care services and related information technologies. Market conditions that affect the value of health care and related technology stocks will likewise impact the value of the Company's equity portfolio. The equity securities and venture capital funds were evaluated for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains included in Investment and Other Income on the Consolidated Statements of Operations were from the following sources:

	For the Year Ended December 31,		
(in millions)	2011	2010	2009
Total OTTI	$ (12)	$ (23)	$ (64)
Portion of loss recognized in other comprehensive income	—	—	—
Net OTTI recognized in earnings	(12)	(23)	(64)
Gross realized losses from sales	(11)	(6)	(41)
Gross realized gains from sales	136	100	116
Net realized gains	$ 113	$ 71	$ 11

For the years ended December 31, 2011, 2010 and 2009, all of the recorded OTTI charges resulted from the Company's intent to sell certain impaired securities.

4. Fair Value

Certain assets and liabilities are measured at fair value in the financial statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by U.S. GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted (unadjusted) prices for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, volatilities, default rates); and
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The following table presents a summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis, excluding AARP related assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2011				
Cash and cash equivalents	$ 8,569	$ 860	$ —	$ 9,429
Debt securities - available-for-sale:				
U.S. government and agency obligations	1,551	822	—	2,373
State and municipal obligations	—	6,750	15	6,765
Corporate obligations	16	5,805	186	6,007
U.S. agency mortgage-backed securities	—	2,353	—	2,353
Non-U.S. agency mortgage-backed securities	—	497	7	504
Total debt securities - available-for-sale	1,567	16,227	208	18,002
Equity securities - available-for-sale	333	2	209	544
Total assets at fair value	$ 10,469	$ 17,089	$ 417	$ 27,975
Percentage of total assets at fair value	37%	61%	2%	100%
December 31, 2010				
Cash and cash equivalents	$ 8,069	$ 1,054	$ —	$ 9,123
Debt securities - available-for-sale:				
U.S. government and agency obligations	1,515	719	—	2,234
State and municipal obligations	—	6,148	—	6,148
Corporate obligations	31	5,146	133	5,310
U.S. agency mortgage-backed securities	—	1,903	—	1,903
Non-U.S. agency mortgage-backed securities	—	457	8	465
Total debt securities - available-for-sale	1,546	14,373	141	16,060
Equity securities - available-for-sale	306	2	208	516
Total cash, cash equivalents and investments at fair value	9,921	15,429	349	25,699
Interest rate swap assets	—	46	—	46
Total assets at fair value	$ 9,921	$ 15,475	$ 349	$ 25,745
Percentage of total assets at fair value	39%	60%	1%	100%
Interest rate swap liabilities	$ —	$ 104	$ —	$ 104

There were no transfers between Levels 1 and 2 during the years ended December 31, 2011 and 2010.

The Company elected to measure the entirety of the AARP Assets Under Management at fair value. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2011				
Cash and cash equivalents	$ 257	$ 10	$ —	$ 267
Debt securities:				
U.S. government and agency obligations	566	214	—	780
State and municipal obligations	—	25	—	25
Corporate obligations	—	1,048	—	1,048
U.S. agency mortgage-backed securities	—	436	—	436
Non-U.S. agency mortgage-backed securities	—	150	—	150
Total debt securities	566	1,873	—	2,439
Equity securities - available-for-sale	—	2	—	2
Total assets at fair value	$ 823	$ 1,885	$ —	$ 2,708
Other liabilities	$ 27	$ 49	$ —	$ 76
Total liabilities at fair value	$ 27	$ 49	$ —	$ 76
December 31, 2010				
Cash and cash equivalents	$ 115	$ —	$ —	$ 115
Debt securities:				
U.S. government and agency obligations	515	244	—	759
State and municipal obligations	—	15	—	15
Corporate obligations	—	1,129	—	1,129
U.S. agency mortgage-backed securities	—	393	—	393
Non-U.S. agency mortgage-backed securities	—	137	—	137
Total debt securities	515	1,918	—	2,433
Equity securities - available-for-sale	—	2	—	2
Total assets at fair value	$ 630	$ 1,920	$ —	$ 2,550
Other liabilities	$ —	$ —	$ 59	$ 59
Total liabilities at fair value	$ —	$ —	$ 59	$ 59

There were no transfers between Levels 1 and 2 during the years ended December 31, 2011 and 2010.

The table below includes fair values for certain financial instruments for which it is practicable to estimate fair value. The carrying values and fair values of these financial instruments were as follows:

	December 31, 2011		December 31, 2010	
(in millions)	Carrying Value	Fair Value	Carrying Value	Fair Value
Assets				
Debt securities - available-for-sale	$ 18,002	$ 18,002	$ 16,060	$ 16,060
Equity securities - available-for-sale	544	544	516	516
Debt securities - held-to-maturity	197	204	203	208
AARP Program-related investments	2,441	2,441	2,435	2,435
Interest rate swap assets	—	—	46	46
Liabilities				
Senior unsecured notes	11,638	13,149	10,212	10,903
Interest rate swap liabilities	—	—	104	104
AARP Program-related other liabilities	76	76	59	59

The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, accounts and other current receivables, unearned revenues, commercial paper, accounts payable and accrued liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services has not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2. The Company's Level 3 debt securities consist mainly of low income housing investments that are unique and non-transferable.

Fair value estimates for Level 1 and Level 2 publicly traded equity securities are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. The fair values of Level 3 investments in venture capital portfolios are estimated using market modeling approaches that rely heavily on management assumptions and qualitative observations. These investments totaled $168 million and $166 million as of December 31, 2011 and 2010, respectively. The fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The key inputs utilized in the Company's market modeling include, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; similar preferences in the capital structure; discounted cash flows; liquidation values and milestones established at initial funding; and the assumption that the values of the Company's venture capital investments can be inferred from these inputs. The Company's remaining Level 3 equity securities holdings of $41 million and $42 million as of December 31, 2011 and 2010, respectively, consist of preferred stock and other items for which there are no

active markets.

Throughout the procedures discussed above in relation to the Company's processes for validating third party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Interest Rate Swaps. Fair values of the Company's interest rate swaps were estimated using the terms of the swaps and publicly available market yield curves. Because the swaps were unique and not actively traded, the fair values were classified as Level 2.

AARP Program-related Investments. AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's other securities.

Senior Unsecured Notes. The fair values of the senior unsecured notes are estimated based on third-party quoted market prices for the same or similar issues.

AARP Program-related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2011			December 31, 2010			December 31, 2009		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 141	$ 208	$ 349	$ 120	$ 312	$ 432	$ 62	$ 304	$ 366
Purchases	92	35	127	43	45	88	76	25	101
Sales	—	(17)	(17)	(4)	(167)	(171)	—	(3)	(3)
Settlements	(25)	(7)	(32)	(20)	—	(20)	(12)	—	(12)
Net unrealized (losses) gains in accumulated other comprehensive income	—	(4)	(4)	—	9	9	—	7	7
Net realized (losses) gains in investment and other income	—	(6)	(6)	2	9	11	(6)	(21)	(27)
Balance at end of period	$ 208	$ 209	$ 417	$ 141	$ 208	$ 349	$ 120	$ 312	$ 432

Non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2011, 2010 and 2009.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2011	December 31, 2010
Land and improvements	$ 45	$ 38
Buildings and improvements	1,052	764
Computer equipment	1,345	1,418
Furniture and fixtures	274	224
Less accumulated depreciation	(1,424)	(1,417)
Property and equipment, net	1,292	1,027
Capitalized software	2,239	2,535
Less accumulated amortization	(1,016)	(1,362)
Capitalized software, net	1,223	1,173
Total property, equipment and capitalized software, net	$ 2,515	$ 2,200

Depreciation expense for property and equipment for 2011, 2010 and 2009 was $386 million, $398 million and $436 million, respectively. Amortization expense for capitalized software for 2011, 2010 and 2009 was $377 million, $349 million and $314 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2010 (a)	$ 17,851	$ 573	$ 1,463	$ 840	$ 20,727
Acquisitions	—	187	2,022	—	2,209
Impairments	—	—	(172)	—	(172)
Adjustments, net	(14)	—	(5)	—	(19)
Balance at December 31, 2010	17,837	760	3,308	840	22,745
Acquisitions	101	1,353	—	—	1,454
Dispositions	(2)	—	(214)	—	(216)
Adjustments, net	(4)	—	(4)	—	(8)
Balance at December 31, 2011	$ 17,932	$ 2,113	$ 3,090	$ 840	$ 23,975

(a) Prior period reportable segment financial information has been recast to conform to the 2011 presentation as discussed in Note 2 of Notes to the Consolidated Financial Statements.

In 2010, there was a decline in the economic environment and competitive landscape for the clinical trial support businesses within one of the OptumInsight reporting units. These businesses experienced unexpected declines in new business authorizations from historical levels including continued delays in and lengthening of the selling cycle. During this time the Company began evaluating strategic options with respect to the clinical trial support businesses. In December 2010, as part of the annual goodwill impairment analysis, the Company considered the aforementioned market conditions and operating results as well as indications of interest the Company began to receive on the clinical trial support businesses as the fair value of the reporting unit was evaluated. As a result of that analysis, the Company determined that the implied fair value of the reporting unit was less than its carrying value and an impairment charge of $172 million was recorded. The implied fair value of the reporting unit was determined by a combination of valuation techniques, including discounting future expected cash flows and expected sale proceeds. The Company sold a significant portion of this reporting unit in 2011 resulting in a reduction of goodwill upon disposal.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2011			December 31, 2010		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$ 3,766	$ (1,310)	$ 2,456	$ 3,623	$ (1,038)	$ 2,585
Trademarks and technology	368	(98)	270	505	(246)	259
Other	112	(43)	69	132	(66)	66
Total	$ 4,246	$ (1,451)	$ 2,795	$ 4,260	$ (1,350)	$ 2,910

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2011		2010	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$ 187	9 years	$ 786	14 years
Trademarks and technology	49	5 years	94	8 years
Other	5	15 years	14	9 years
Total acquired finite-lived intangible assets	$ 241	9 years	$ 894	13 years

Estimated full year amortization expense relating to intangible assets for each of the next five years is as follows:

(in millions)	Estimated Amortization Expense
2012	$ 361
2013	328
2014	316
2015	299
2016	277

Amortization expense relating to intangible assets for 2011, 2010 and 2009 was $361 million, $317 million and $241 million, respectively.

7. Medical Costs and Medical Costs Payable

For the year ended December 31, 2011, there was $720 million of net favorable medical cost development related to prior fiscal years. The favorable development in 2011 was primarily driven by continued improvements in claims submission timeliness, which results in higher completion factors, and lower than expected health system utilization levels.

For the year ended December 31, 2010, there was $800 million of net favorable medical cost development related to prior fiscal years. The favorable development in 2010 was primarily driven by lower than expected health system utilization levels; more efficient claims handling and processing, which results in higher completion factors; a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

No factor (e.g., medical trends/utilization, completion factors) was individually material to the $310 million of net favorable medical cost development for the year ended December 31, 2009.

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2011	2010	2009
Medical costs payable, beginning of period	$ 9,220	$ 9,362	$ 8,664
Acquisitions	155	—	252
Reported medical costs:			
Current year	75,052	69,641	65,599
Prior years	(720)	(800)	(310)
Total reported medical costs	74,332	68,841	65,289
Claim payments:			
Payments for current year	(65,763)	(60,949)	(57,109)
Payments for prior year	(8,145)	(8,034)	(7,734)
Total claim payments	(73,908)	(68,983)	(64,843)
Medical costs payable, end of period	$ 9,799	$ 9,220	$ 9,362

8. Commercial Paper and Long-Term Debt

Commercial paper and long-term debt consisted of the following:

(in millions)	December 31, 2011 Par Value	December 31, 2011 Carrying Value	December 31, 2011 Fair Value	December 31, 2010 Par Value	December 31, 2010 Carrying Value	December 31, 2010 Fair Value
Commercial paper	$ —	$ —	$ —	$ 930	$ 930	$ 930
Senior unsecured floating-rate notes due February 2011	—	—	—	250	250	250
5.3% senior unsecured notes due March 2011	—	—	—	705	712	711
5.5% senior unsecured notes due November 2012	352	363	366	352	372	377
4.9% senior unsecured notes due February 2013	534	540	556	534	541	568
4.9% senior unsecured notes due April 2013	409	421	427	409	425	437
4.8% senior unsecured notes due February 2014	172	184	185	172	186	184
5.0% senior unsecured notes due August 2014	389	423	424	389	425	423
4.9% senior unsecured notes due March 2015	416	458	460	416	456	444
5.4% senior unsecured notes due March 2016	601	678	689	601	666	661
1.9% senior unsecured notes due November 2016	400	397	400	—	—	—
5.4% senior unsecured notes due November 2016	95	95	110	95	95	105
6.0% senior unsecured notes due June 2017	441	499	518	441	484	491
6.0% senior unsecured notes due November 2017	156	173	183	156	167	174
6.0% senior unsecured notes due February 2018	1,100	1,123	1,308	1,100	1,065	1,249
3.9% senior unsecured notes due October 2020	450	442	478	450	413	429
4.7% senior unsecured notes due February 2021	400	419	450	—	—	—
3.4% senior unsecured notes due November 2021	500	497	517	—	—	—
Zero coupon senior unsecured notes due November 2022	1,095	619	696	1,095	588	677
5.8% senior unsecured notes due March 2036	850	844	1,017	850	844	862
6.5% senior unsecured notes due June 2037	500	495	636	500	495	552
6.6% senior unsecured notes due November 2037	650	645	834	650	645	729
6.9% senior unsecured notes due February 2038	1,100	1,084	1,475	1,100	1,085	1,281
5.7% senior unsecured notes due October 2040	300	298	359	300	298	299
6.0% senior unsecured notes due February 2041	350	348	430	—	—	—
4.6% senior unsecured notes due November 2041	600	593	631	—	—	—
Total commercial paper and long-term debt	$ 11,860	$ 11,638	$ 13,149	$ 11,495	$ 11,142	$ 11,833

Maturities of long-term debt for the years ending December 31 are as follows:

(in millions)	Maturities of Long-Term Debt
2012 (a)	$ 982
2013	961
2014	607
2015	458
2016	1,170
Thereafter	7,460

(a) The $1,095 million par, zero coupon senior unsecured notes due November 2022 have been included in current maturities of long-term debt in the Consolidated Balance Sheets as of December 31, 2011 and 2010 due to a current note holder option to “put” the note to the Company which began on November 15, 2010, and recurs each November 15 thereafter until 2022 (except 2014), at accreted value.

Commercial Paper and Bank Credit Facility

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

In December 2011, the Company amended and renewed its five-year revolving bank credit facility with 21 banks, which will mature in December 2016. The amendment included increasing the capacity to $3.0 billion. This facility supports the Company's commercial paper program and is available for general corporate purposes. There were no amounts outstanding under this facility as of December 31, 2011. The interest rate on borrowings is variable based on term and amount and is calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of December 31, 2011, the annual interest rate on this facility, had it been drawn, would have ranged from 1.2% to 1.7%.

Debt Covenants

The Company's bank credit facility contains various covenants including requiring the Company to maintain a debt-to-total-capital ratio, calculated as debt divided by the sum of debt and shareholders' equity, below 50%. The Company was in compliance with its debt covenants as of December 31, 2011.

Interest Rate Swap Contracts

During 2010, the Company entered into interest rate swap contracts to convert a portion of its interest rate exposure from fixed to floating rates. The interest rate swap contracts were benchmarked to LIBOR and were utilized to more closely align interest expense with interest income received on the Company's cash equivalent and investment balances. The swaps were designated as fair value hedges on fixed-rate debt issues maturing between November 2012 through March 2016 and June 2017 through October 2020. Since the specific terms and notional amounts of the swaps matched those of the debt being hedged, they were assumed to be highly effective hedges and all changes in fair value of the swaps were recorded on the Consolidated Balance Sheets with no net impact recorded in the Consolidated Statements of Operations.

The following table provides a summary of the effect of changes in fair value of fair value hedges, prior to their termination, on the Company's Consolidated Statements of Operations:

	December 31,	
(in millions)	**2011**	**2010**
Hedge gain recognized in interest expense	$ 190	$ (58)
Hedged item loss recognized in interest expense	(190)	58
Net impact on the Company's Consolidated Statements of Operations	$ —	$ —

In the second half of 2011, the Company terminated all of its interest rate swap fair value hedges ($5.4 billion notional amount). As of the swap contracts' termination dates, the aggregate favorable adjustments to the carrying value of the Company's debt of $132 million is being amortized as a reduction to interest expense over the remaining lives of the underlying debt obligations, which had in total a weighted-average life of 4.1 years. For the year ended December 31, 2011, the net impact of the gain amortization was not material. The purpose of the interest rate swap terminations was to lock-in the impact of low market floating interest rates and reduce the effective interest rate on hedged long-term debt.

9. Income Taxes

The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	**2011**	**2010**	**2009**
Current Provision:			
Federal	$ 2,608	$ 2,524	$ 1,924
State and local	150	180	78
Total current provision	2,758	2,704	2,002
Deferred provision	59	45	(16)
Total provision for income taxes	$ 2,817	$ 2,749	$ 1,986

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows:

(in millions, except percentages)	2011		2010		2009	
Tax provision at the U.S. federal statutory rate	$ 2,785	35.0%	$ 2,584	35.0%	$ 2,033	35.0%
State income taxes, net of federal benefit	136	1.7	129	1.7	66	1.1
Settlement of state exams, net of federal benefit	(29)	(0.4)	(3)	—	(40)	(0.7)
Tax-exempt investment income	(63)	(0.8)	(65)	(0.9)	(70)	(1.2)
Non-deductible compensation	10	0.1	64	0.9	—	—
Other, net	(22)	(0.2)	40	0.5	(3)	—
Provision for income taxes	$ 2,817	35.4%	$ 2,749	37.2%	$ 1,986	34.2%

The lower effective income tax rates for 2011 and 2009 as compared to 2010 resulted from the favorable resolution of various tax matters as well as higher effective income tax rates in 2010. The 2010 effective income tax rates were at higher levels due to the cumulative implementation of changes under the Health Reform Legislation.

The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2011	2010
Deferred income tax assets:		
Share-based compensation	$ 417	$ 385
Accrued expenses and allowances	259	233
Net operating loss carryforwards	247	285
Medical costs payable and other policy liabilities	166	102
Long term liabilities	155	147
Unearned revenues	56	78
Unrecognized tax benefits	44	62
Other	192	215
Subtotal	1,536	1,507
Less: valuation allowances	(184)	(247)
Total deferred income tax assets	1,352	1,260
Deferred income tax liabilities:		
Intangible assets	(1,148)	(1,104)
Capitalized software development	(465)	(450)
Net unrealized gains on investments	(275)	(161)
Depreciation and amortization	(256)	(140)
Prepaid expenses	(86)	(92)
Total deferred income tax liabilities	(2,230)	(1,947)
Net deferred income tax liabilities	$ (878)	$ (687)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $151 million expire beginning in 2019 through 2031, and state net operating loss carryforwards expire beginning in 2012 through 2031.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2011	2010	2009
Gross unrecognized tax benefits, beginning of period	$ 220	$ 220	$ 340
Gross increases:			
Current year tax positions	11	13	10
Prior year tax positions	10	30	11
Gross decreases:			
Prior year tax positions	(34)	—	(62)
Settlements	(25)	—	(61)
Statute of limitations lapses	(53)	(43)	(18)
Gross unrecognized tax benefits, end of period	$ 129	$ 220	$ 220

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During the year ended December 31, 2011, the Company recognized a tax benefit of $12 million generated from the net reduction in interest and penalties accrued. During the year ended December 31, 2010, the Company recognized $15 million of interest expense and penalties. During the year ended December 31, 2009, the Company recognized a tax benefit of $7 million generated from the net reduction in interest accrued. The Company had $41 million and $63 million of accrued interest and penalties for uncertain tax positions as of December 31, 2011 and 2010, respectively. These amounts are not included in the reconciliation above. As of December 31, 2011, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $90 million.

The Company currently files income tax returns in the U.S. federal jurisdiction, various states and foreign jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2010 and prior. The Company's 2011 tax year is under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to 2004. The Company does not believe any adjustments that may result from these examinations will be significant.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $73 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the National Association of Insurance Commissioners. 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. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as “ordinary dividends” and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an “extraordinary dividend” and must receive prior regulatory approval.

In 2011, based on the 2010 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends which could be paid was $3.4 billion. For the year ended December 31, 2011, the Company's regulated subsidiaries paid their parent companies dividends of $4.5 billion, including $1.1 billion of extraordinary dividends. For the year ended December 31, 2010, the Company's regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $686 million of extraordinary dividends. As of December 31, 2011, $1.6 billion of the Company's $9.4 billion of cash and cash equivalents was held by non-regulated entities.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of approximately $12 billion as of December 31, 2011; regulated entity statutory capital exceeded state minimum capital requirements.

OptumHealth Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered “Well Capitalized” under the capital adequacy rules to which it is subject. At December 31, 2011, the Company believes that OptumHealth Bank met the FDIC requirements

to be considered “Well Capitalized”.

Share Repurchase Program

Under its Board of Directors’ authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company’s capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In May 2011, the Board renewed the Company’s share repurchase program with an authorization to repurchase up to 110 million shares of its common stock. During 2011, the Company repurchased 65 million shares at an average price of approximately $46 per share and an aggregate cost of $3.0 billion. As of December 31, 2011, the Company had Board authorization to purchase up to an additional 65 million shares of its common stock.

Dividends

In May 2011, the Company’s Board of Directors increased the Company’s cash dividend to shareholders to an annual dividend rate of $0.65 per share, paid quarterly. Since June 2010, the Company had paid a quarterly dividend of $0.125 per share. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change. On February 8, 2012, the Company's Board of Directors approved a quarterly dividend of $0.1625 per share.

The following table provides details of the Company’s dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
2009	$ 0.0300	$ 36
2010	0.4050	449
2011	0.6125	651

11. Share-Based Compensation

In May 2011, the Company’s shareholders approved the 2011 Stock Incentive Plan (Plan). The Plan is intended to attract and retain employees and non-employee directors, offer them incentives to put forth maximum efforts for the success of the Company’s business and afford them an opportunity to acquire a proprietary interest in the Company. The Plan allows the Company to grant stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards or other stock-based awards to eligible employees and non-employee directors. The Plan incorporates the following plans adopted by the Company: 2002 Stock and Incentive Plan, 1991 Stock and Incentive Plan, 1998 Broad-Based Stock Incentive Plan and Non-employee Director Stock Option Plan. All outstanding stock options, restricted stock and other awards issued under the prior plans will remain subject to the terms and conditions of the plans under which they were issued.

As of December 31, 2011, the Company had 50 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, SARs and up to 23 million of awards in restricted shares. The Company’s outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares.

Stock Options and SARs

Stock options and SARs vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Stock option and SAR activity for the year ended December 31, 2011 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	112	$ 40		
Granted	1	44		
Exercised	(18)	29		
Forfeited	(4)	44		
Outstanding at end of period	91	42	4.7	$ 916
Exercisable at end of period	74	44	4.1	610
Vested and expected to vest end of period	91	42	4.7	905

To determine compensation expense related to the Company's stock options and SARs, the fair value of each award is estimated on the date of grant using a binomial option-pricing model. The principal assumptions the Company used in applying the option-pricing model were as follows:

	2011	2010	2009
Risk free interest rate	0.9% - 2.3%	1.0% - 2.1%	1.7%-2.4%
Expected volatility	44.3% - 45.1%	45.4% - 46.2%	41.3% - 46.8%
Expected dividend yield	1.0% - 1.4%	0.1% - 1.7%	0.1%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.9 - 5.0	4.6 - 5.1	4.4 - 5.1

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share dividend declared by the Company's Board of Directors. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

The weighted-average grant date fair value of stock options and SARs granted for 2011, 2010 and 2009 was approximately $15 per share, $13 per share and $10 per share, respectively. The total intrinsic value of stock options and SARs exercised during 2011, 2010 and 2009 was $327 million, $164 million and $282 million, respectively.

Restricted Shares

Restricted shares vest ratably over three to four years. Compensation expense related to restricted shares is based on the share price on date of grant. Restricted share activity for the year ended December 31, 2011 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	13	$ 31
Granted	8	42
Vested	(3)	32
Forfeitures	(1)	35
Nonvested at end of period	17	36

The weighted-average grant date fair value of restricted shares granted during 2011, 2010 and 2009 was approximately $42 per share, $32 per share and $29 per share, respectively. The total fair value of restricted shares vested during 2011, 2010 and 2009 was $113 million, $99 million and $56 million, respectively.

Employee Stock Purchase Plan

The Company's Employee Stock Purchase Plan (ESPP) is intended to enhance employee commitment to the goals of the Company, by providing a means of achieving stock ownership at advantageous terms to eligible employees of the Company. Eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. During 2011, 2010 and 2009, 3 million shares, 4 million shares and 4 million shares of common stock, respectively, were purchased under the ESPP. The compensation expense is included in the compensation expense amounts recognized and discussed below. As of December 31, 2011, there were 22 million shares of common stock available for issuance under the ESPP.

Share-Based Compensation Recognition

The Company recognizes compensation expense for share-based awards, including stock options, SARs and restricted shares, on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. For 2011, 2010 and 2009 the Company recognized compensation expense related to its share-based compensation plans of $401 million ($260 million net of tax effects), $326 million ($278 million net of tax effects) and $334 million ($220 million net of tax effects), respectively. Share-based compensation expense is recognized in Operating Costs in the Company's Consolidated Statements of Operations. As of December 31, 2011, there was $387 million of total unrecognized compensation cost related to share awards that is expected to be recognized over a weighted-average period of 1.0 year. For 2011, 2010 and 2009 the income tax benefit realized from share-based award exercises was $170 million, $78 million and $94 million, respectively.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for all employees. Compensation expense related to this plan was not material for the years 2011, 2010 and 2009.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within Long-Term Investments with an approximately equal amount in Other Liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $281 million and $258 million as of December 31, 2011 and 2010, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates through 2028. Rent expense under all operating leases for 2011, 2010 and 2009 was $295 million, $297 million and $303 million, respectively.

As of December 31, 2011, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2012	$ 279
2013	243
2014	212
2015	174
2016	129
Thereafter	564

The Company provides guarantees related to its performance under certain contracts. If standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. Amounts accrued for performance guarantees were not material as of December 31, 2011 and 2010.

As of December 31, 2011, the Company has outstanding, undrawn letters of credit with financial institutions of $72 million and surety bonds outstanding with insurance companies of $316 million, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, providers, customers and regulators, relating to the Company's management and administration of health benefit plans. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of probable costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

Out-of-Network Reimbursement Litigation. In 2000, a group of plaintiffs including the American Medical Association filed a lawsuit against the Company asserting a variety of claims challenging the Company's determination of reimbursement amounts for non-network health care services based on the Company's use of a database previously maintained by Ingenix, Inc. (now known as OptumInsight). The parties entered into a settlement agreement in 2009 and this class action lawsuit, along with a related industry-wide investigation by the New York Attorney General, is now resolved. The Company remains a party to a number of other lawsuits challenging the determination of out of network reimbursement amounts based on use of the same database, including putative class actions and multidistrict litigation brought on behalf of members of Aetna and WellPoint. The Company was dismissed as a party from a similar lawsuit involving Cigna and its members. These suits allege, among other things, that the database licensed to these companies by Ingenix was flawed and that Ingenix conspired with these companies to underpay their members' claims and seek unspecified damages and treble damages, injunctive and declaratory relief, interest, costs and attorneys fees. The Company is vigorously defending these suits. The Company cannot reasonably estimate the range of loss, if any, that may result from these matters due to the procedural status of the cases, motions to dismiss that are pending in several of the cases, the absence of class certification in any of the cases, the lack of a formal demand on the Company by the plaintiffs, and the involvement of other insurance companies as defendants.

California Claims Processing Matter. In 2007, the California Department of Insurance (CDI) examined the Company's PacifiCare health insurance plan in California. The examination findings related to the timeliness and accuracy of claims processing, interest payments, provider contract implementation, provider dispute resolution and other related matters. On January 25, 2008, the CDI issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations in connection with the CDI's examination findings. On June 3, 2009, the Company filed a Notice of Defense to the Order to Show Cause denying all material allegations and asserting certain defenses. The matter has been the subject of an administrative hearing before a California administrative law judge since December 2009. CDI amended its Order to Show Cause three times in 2010 to allege a total of 992,936 violations, the large majority of which relate to an alleged failure to include certain language in standard claims correspondence during a four month period in 2007. Although we believe that CDI has never issued an aggregate penalty in excess of $8 million, CDI has previously alleged in press reports and releases that the Company could theoretically be subject to penalties of up to $10,000 per violation. In October 2011, CDI stated that it is seeking an average penalty of approximately $326 per alleged violation. CDI has since reduced the number of alleged violations to 919,574 but has indicated that it is still seeking an aggregate penalty of approximately $325 million. The Company is vigorously defending against the claims in this matter and believes that the penalty requested by CDI is excessive and without merit. After the administrative law judge issues a ruling at the conclusion of the administrative proceeding, expected sometime in 2012, the California Insurance Commissioner may accept, reject or modify the administrative law judge's ruling, issue his own decision, and impose a fine or penalty. The Commissioner's decision is subject to challenge in court. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the novel legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting regulatory fines and penalties, and the various remedies and levels of judicial review available to the Company in the event a fine or penalty is assessed.

Government Regulation

The Company's business is regulated at federal, state, local and international levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been and is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor, the Federal Deposit Insurance Corporation and other governmental authorities. For example, in the fourth quarter of 2011, CMS conducted an audit of the Company's Medicare Advantage and Part D business. The Company is in the process of responding to preliminary findings. Other examples of audits include the risk adjustment data validation (RADV) audits discussed below and a review by the U.S. Department of Labor of the Company's administration of applicable customer employee benefit plans with respect to the Employee Retirement Income Security Act of 1974, as amended (ERISA) compliance.

Government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs and could have a material adverse effect on the Company's results of operations, financial position and cash flows.

Risk Adjustment Data Validation Audits. CMS adjusts capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers as well as, for Medicare Part D plans only, based on comparing costs predicted in the Company's annual bids to actual prescription drug costs. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

In 2008, CMS announced that it would perform RADV audits of selected Medicare Advantage health plans each year to validate the coding practices of and supporting documentation maintained by health care providers. These audits involve a review of medical records maintained by providers and may result in retrospective adjustments to payments made to health plans. Certain of the Company's health plans have been selected for audit. These audits are focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. Although these audits are ongoing, the Company does not believe they will have a material impact on the Company's results of operations, financial position or cash flows.

In December 2010, CMS published for public comment a new proposed RADV audit and payment adjustment methodology. The proposed methodology contains provisions allowing retroactive contract level payment adjustments for the year audited using an extrapolation of the "error rate" identified in audit samples. The Company has submitted comments to CMS regarding concerns the Company has with CMS' proposed methodology. These concerns include, among others, the fact that the proposed methodology does not take into account the "error rate" in the original Medicare fee-for-service data that was used to develop the risk adjustment system. Additionally, payments received from CMS, as well as benefits offered and premiums charged to members, are based on actuarially certified bids that did not include any assumption of retroactive audit payment adjustments. The Company believes that applying retroactive audit and payment adjustments after CMS acceptance of bids undermines the actuarial soundness of the bids. On February 3, 2011, CMS notified the Company that CMS was evaluating all comments received on the proposed methodology and that it anticipated making changes to the draft, based on input CMS had received. As of the date of this filing, CMS has not published the revised methodology. Depending on the methodology utilized, potential payment adjustments could have a material adverse effect on the Company's results of operations, financial position and cash flows.

The Office of Inspector General for HHS has audited our risk adjustment data for two local plans and has initially communicated its findings. While the Company does not believe OIG has governing authority to directly impose payment adjustments for risk adjustment audits of Medicare health plans operated under the regulatory authority of CMS, the OIG can recommend to CMS a proposed payment adjustment, and the Company is unable to predict the outcome of this audit process.

Guaranty Fund Assessments. Under state guaranty assessment laws, certain insurance companies (and health maintenance organizations in some states), including those issuing health (which includes long-term care), life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Assessments are generally based on premiums in the state compared to the premiums of other insurers, and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets.

The Pennsylvania Insurance Commissioner has placed Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. If Penn Treaty is liquidated, the Company's insurance entities and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through guaranty association assessments in future periods.

The Company has estimated a potential assessment of $250 million to $350 million related to this matter, and the Company would accrue the assessment in operating costs if and when the state court renders such a decision. The timing, actual amount and impact, if any, of any guaranty fund assessments will depend on several factors, including if and when the court declares Penn Treaty insolvent, the amount of the insolvency, the availability and amount of any potential offsets, such as an offset of any premium taxes otherwise payable by the Company, and the impact of any such assessments on potential premium rebate payments under the Health Reform Legislation.

13. Segment Financial Information

Factors used in determining the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision-maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined.

The following is a description of the types of products and services from which each of the Company's reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State because they have similar economic characteristics, products and services, customers, distribution methods and operational processes and operate in a similar regulatory environment. These businesses also share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State provides health plans and care programs to beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs.
- *OptumHealth* serves the physical, emotional and financial needs of individuals, enabling consumer health management and collaborative care delivery through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers personalized health management services, decision support services, access to networks of care provider specialists, well-being solutions, behavioral health management solutions, financial services and clinical services.
- *OptumInsight* is a health information, technology, services and consulting company providing software and information products, advisory consulting services, and business process outsourcing to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system work with OptumInsight to reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.
- *OptumRx* offers a multitude of pharmacy benefit management services including providing prescribed medications, patient support and clinical programs. OptumRx also provides claims processing, retail network contracting, rebate contracting and management and clinical programs, such as step therapy, formulary management and disease/drug therapy management programs to achieve a low-cost, high-quality pharmacy benefit.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2 of Notes to the Consolidated Financial Statements). Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings sold to UnitedHealthcare customers by OptumHealth, and medical benefits cost, quality and utilization data and predictive modeling sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has at least minimum specified levels of regulatory capital or working capital for non-regulated businesses. Substantially all of the Company's assets are held and operations are conducted in the United States.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 28% for the year ended December 31, 2011 and 27% for both the years ended December 31, 2010 and 2009, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment.

Prior period reportable segment financial information has been recast to conform to the 2011 presentation as discussed in Note 2 of Notes to the Consolidated Financial Statements. Corporate and intersegment eliminations are presented to reconcile the reportable segment results to the consolidated results. The following table presents reportable segment financial information:

		Optum					
(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Total Optum	Corporate and Intersegment Eliminations	Consolidated
2011							
Revenues - external customers:							
Premiums	$ 90,487	$ 1,496	$ —	$ —	$ 1,496	$ —	$ 91,983
Services	4,291	628	1,616	78	2,322	—	6,613
Products	—	24	96	2,492	2,612	—	2,612
Total revenues - external customers	94,778	2,148	1,712	2,570	6,430	—	101,208
Total revenues - intersegment	—	4,461	958	16,708	22,127	(22,127)	—
Investment and other income	558	95	1	—	96	—	654
Total revenues	$ 95,336	$ 6,704	$ 2,671	$ 19,278	$ 28,653	$ (22,127)	$ 101,862
Earnings from operations	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ —	$ 8,464
Interest expense	—	—	—	—	—	(505)	(505)
Earnings before income taxes	$ 7,203	$ 423	$ 381	$ 457	$ 1,261	$ (505)	$ 7,959
Total Assets	$ 52,618	$ 6,756	$ 5,308	$ 3,503	$ 15,567	$ (296)	$ 67,889
Purchases of property, equipment and capitalized software	$ 635	$ 168	$ 175	$ 89	$ 432	$ —	$ 1,067
Depreciation and amortization	$ 680	$ 154	$ 195	$ 95	$ 444	$ —	$ 1,124
2010							
Revenues - external customers:							
Premiums	$ 84,158	$ 1,247	$ —	$ —	$ 1,247	$ —	$ 85,405
Services	4,021	331	1,403	64	1,798	—	5,819
Products	—	19	93	2,210	2,322	—	2,322
Total revenues - external customers	88,179	1,597	1,496	2,274	5,367	—	93,546
Total revenues - intersegment	—	2,912	845	14,449	18,206	(18,206)	—
Investment and other income	551	56	1	1	58	—	609
Total revenues	$ 88,730	$ 4,565	$ 2,342	$ 16,724	$ 23,631	$ (18,206)	$ 94,155
Earnings from operations	$ 6,740	$ 511	$ 84	$ 529	$ 1,124	$ —	$ 7,864
Interest expense	—	—	—	—	—	(481)	(481)
Earnings before income taxes	$ 6,740	$ 511	$ 84	$ 529	$ 1,124	$ (481)	$ 7,383
Total Assets	$ 50,913	$ 3,897	$ 5,435	$ 3,087	$ 12,419	$ (269)	$ 63,063
Purchases of property, equipment and capitalized software	$ 525	$ 117	$ 156	$ 80	$ 353	$ —	$ 878
Depreciation and amortization	$ 725	$ 100	$ 159	$ 80	$ 339	$ —	$ 1,064
Goodwill impairment	$ —	$ —	$ 172	$ —	$ 172	$ —	$ 172

(in millions)	UnitedHealthcare	Optum				Corporate and Intersegment Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Total Optum		
2009							
Revenues - external customers:							
Premiums	$ 78,251	$ 1,064	$ —	$ —	$ 1,064	$ —	$ 79,315
Services	3,941	274	1,042	49	1,365	—	5,306
Products	—	16	90	1,819	1,925	—	1,925
Total revenues - external customers	82,192	1,354	1,132	1,868	4,354	—	86,546
Total revenues - intersegment	—	2,805	691	12,532	16,028	(16,028)	—
Investment and other income	538	53	—	1	54	—	592
Total revenues	$ 82,730	$ 4,212	$ 1,823	$ 14,401	$ 20,436	$ (16,028)	$ 87,138
Earnings from operations	$ 4,833	$ 599	$ 246	$ 681	$ 1,526	$ —	$ 6,359
Interest expense	—	—	—	—	—	(551)	(551)
Earnings before income taxes	$ 4,833	$ 599	$ 246	$ 681	$ 1,526	$ (551)	$ 5,808
Total Assets	$ 49,920	$ 3,190	$ 2,775	$ 3,092	$ 9,057	$ 68	$ 59,045
Purchases of property, equipment and capitalized software	$ 482	$ 71	$ 129	$ 57	$ 257	$ —	$ 739
Depreciation and amortization	$ 679	$ 105	$ 128	$ 79	$ 312	$ —	$ 991

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2011 and 2010 is as follows:

(in millions, except per share data)	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2011				
Revenues	$ 25,432	$ 25,234	$ 25,280	$ 25,916
Operating costs	23,211	23,135	23,210	23,842
Earnings from operations	2,221	2,099	2,070	2,074
Net earnings	1,346	1,267	1,271	1,258
Basic net earnings per common share	1.24	1.18	1.19	1.19
Diluted net earnings per common share	1.22	1.16	1.17	1.17
2010				
Revenues	$ 23,193	$ 23,264	$ 23,668	$ 24,030
Operating costs	21,177	21,363	21,523	22,228
Earnings from operations	2,016	1,901	2,145	1,802
Net earnings	1,191	1,123	1,277	1,043
Basic net earnings per common share	1.04	1.00	1.15	0.95
Diluted net earnings per common share	1.03	0.99	1.14	0.94

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2011. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2011.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control over Financial Reporting as of December 31, 2011

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2011. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control - Integrated Framework*. Based on our assessment and those criteria, we believe that, as of December 31, 2011, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2011, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal controls over financial reporting as of December 31, 2011.

/s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Executive Officer

/s/ DAVID S. WICHMANN

David S. Wichmann
Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations

/s/ ERIC S. RANGEN

Eric S. Rangen
Senior Vice President and Chief Accounting Officer

February 8, 2012

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2011, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2011. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on the criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2011 of the Company and our reports dated February 8, 2012 expressed an unqualified opinion on those consolidated financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 8, 2012

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2011, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights [3] (in millions)	(b) Weighted-average exercise price of outstanding options, warrants and rights [3]	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (in millions)
Equity compensation plans approved by shareholders [1]	77	$ 39	72 [4]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	77	$ 39	72

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended, and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended. Includes 0.4 million options to acquire shares of common stock that were originally issued under the United HealthCare Corporation 1998 Broad-Based Stock Incentive Plan, as amended, which was not approved by the Company's shareholders, but the shares issuable under the 1998 Broad-Based Stock Incentive Plan were subsequently included in the number of shares approved by the Company's shareholders when approving the 2011 Stock Incentive Plan.

(2) Excludes 0.3 million shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average exercise price of $30 and an average remaining term of approximately 2.7 years. The options are administered pursuant to the terms of the plan under which the option originally was granted. No future awards will be granted under these acquired plans.

(3) Excludes stock appreciation rights (SARs) to acquire 14 million shares of common stock of the Company with exercise prices above $50.68, the closing price of a share of our common stock as reported on the NYSE on December 31, 2011.

(4) Includes 22 million shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2011, and 50 million shares available under the 2011 Stock Incentive Plan as of December 31, 2011.

Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 23 million of these shares are available for future grants of awards other than stock options or SARs.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2011 and 2010.
- Consolidated Statements of Operations for the years ended December 31, 2011, 2010 and 2009.
- Consolidated Statements of Changes in Shareholders' Equity for the years ended December 31, 2011, 2010 and 2009.
- Consolidated Statements of Cash Flows for the years ended December 31, 2011, 2010 and 2009.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

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

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.3	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.4	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.5	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.6	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.7	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.8	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.9	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.10	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.11	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.12	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 31, 2006)
*10.13	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.14	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.16	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
*10.17	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
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101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2010, filed on February 8, 2012, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Changes in Shareholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

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

Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the “Company”) as of December 31, 2011 and 2010, and for each of the three years in the period ended December 31, 2011, and the Company's internal control over financial reporting as of December 31, 2011, and have issued our reports thereon dated February 8, 2012; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 8, 2012

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2011	December 31, 2010
Assets		
Current assets:		
Cash and cash equivalents	$ 1,506	$ 916
Deferred income taxes	82	57
Prepaid expenses and other current assets	97	207
Total current assets	1,685	1,180
Equity in net assets of subsidiaries	38,688	36,246
Other assets	77	110
Total assets	$ 40,450	$ 37,536
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 351	$ 301
Note payable to subsidiary	145	130
Commercial paper and current maturities of long-term debt	982	2,480
Total current liabilities	1,478	2,911
Long-term debt, less current maturities	10,656	8,662
Deferred income taxes and other liabilities	24	138
Total liabilities	12,158	11,711
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value - 3,000 shares authorized; 1,039 and 1,086 issued and outstanding	10	11
Retained earnings	27,821	25,562
Accumulated other comprehensive income (loss):		
Net unrealized gains on investments, net of tax effects	476	280
Foreign currency translation loss	(15)	(28)
Total shareholders' equity	28,292	25,825
Total liabilities and shareholders' equity	$ 40,450	$ 37,536

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Operations

	Year Ended December 31,		
(in millions)	**2011**	**2010**	**2009**
Revenues:			
Investment and other income	$ 3	$ 2	$ 10
Total revenues	3	2	10
Operating costs:			
Operating costs	25	54	5
Interest expense	451	433	509
Total operating costs	476	487	514
Loss before income taxes	(473)	(485)	(504)
Benefit for income taxes	167	180	172
Loss of parent company	(306)	(305)	(332)
Equity in undistributed income of subsidiaries	5,448	4,939	4,154
Net earnings	$ 5,142	$ 4,634	$ 3,822

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

	Year Ended December 31,		
(in millions)	**2011**	**2010**	**2009**
Operating activities			
Cash flows from operating activities	$ 5,560	$ 3,731	$ 5,065
Investing activities			
Capital contributions to subsidiaries	(171)	(104)	(90)
Cash paid for acquisitions	(2,081)	(2,470)	(1,045)
Cash flows used for investing activities	(2,252)	(2,574)	(1,135)
Financing activities			
Common stock repurchases	(2,994)	(2,517)	(1,801)
Proceeds from common stock issuance	381	272	282
Dividends paid	(651)	(449)	(36)
(Repayments of) proceeds from commercial paper, net	(933)	930	(99)
Proceeds from issuance of long term debt	2,234	747	—
Repayments of long-term debt	(955)	(1,583)	(1,350)
Interest rate swap termination	132	—	513
Proceeds from issuance of note to subsidiary	15	30	—
Other	53	20	(10)
Cash flows used for financing activities	(2,718)	(2,550)	(2,501)
Increase (decrease) in cash and cash equivalents	590	(1,393)	1,429
Cash and cash equivalents, beginning of period	916	2,309	880
Cash and cash equivalents, end of period	$ 1,506	$ 916	$ 2,309
Supplemental cash flow disclosures			
Cash paid for interest	$ 418	$ 459	$ 485
Cash paid for income taxes	$ 2,739	$ 2,725	$ 2,048

See Notes to the Condensed Financial Statements of Registrant.

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements
For the Years Ended December 31, 2011, 2010 and 2009

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in the Summary of Significant Accounting Policies in Note 2 of Notes to the Consolidated Financial Statements.

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.6 billion, $4.3 billion and $5.4 billion in 2011, 2010 and 2009, respectively.

3. Commercial Paper and Long-Term Debt

Further discussion of maturities of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements.

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 8, 2012

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY
Stephen J. Hemsley
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director, President and Chief Executive Officer (principal executive officer)	February 8, 2012
/s/ DAVID S. WICHMANN **David S. Wichmann**	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations (principal financial officer)	February 8, 2012
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 8, 2012
* **William C. Ballard, Jr.**	Director	February 8, 2012
* **Richard T. Burke**	Director	February 8, 2012
* **Robert J. Darretta**	Director	February 8, 2012
* **Michele J. Hooper**	Director	February 8, 2012
* **Rodger A. Lawson**	Director	February 8, 2012
* **Douglas W. Leatherdale**	Director	February 8, 2012
* **Glenn M. Renwick**	Director	February 8, 2012
Kenneth I. Shine	Director	
* **Gail R. Wilensky**	Director	February 8, 2012

*By /s/ RICHARD N. BAER
Richard N. Baer,
As Attorney-in-Fact

EXHIBIT INDEX**

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, effective May 23, 2011 (incorporated by reference to Exhibit A to UnitedHealth Group Incorporated's Definitive Proxy Statement dated April 13, 2011)
*10.2	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.3	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.4	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.5	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.6	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.7	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.8	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, effective as of May 24, 2011 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K dated May 24, 2011)
*10.9	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.10	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.11	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010**

OR

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

Commission file number: 1-10864

UNITEDHEALTH GROUP INCORPORATED

(Exact name of registrant as specified in its charter)

MINNESOTA	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UNITEDHEALTH GROUP CENTER 9900 BREN ROAD EAST MINNETONKA, MINNESOTA	**55343**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (952) 936-1300

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
(Do not check if a smaller reporting company)	

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2010 was $31,467,360,829 (based on the last reported sale price of $28.40 per share on June 30, 2010, on the New York Stock Exchange).*

As of January 31, 2011, there were 1,093,694,629 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we incorporate by reference certain information from our Definitive Proxy Statement for the 2011 Annual Meeting of Shareholders. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

*Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the Company have been excluded in determining this number.

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company, whose focus is on improving the overall health and well-being of the people we serve and their communities and enhancing the performance of the health system (the terms "we," "our," "us" "UnitedHealth Group" or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries). We work with health care professionals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost; support the physician/patient relationship; and empower people with the information, guidance and tools they need to make personal health choices and decisions.

During 2010, we managed approximately $125 billion in aggregate health care spending on behalf of the constituents and consumers we served across our various businesses. Our primary focus is on improving the 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 professionals, 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 information; and health care resource organization and care facilitation to help make health care work better. These core competencies are focused in two market areas, health benefits and health services. Health benefits are offered in the individual and employer markets and the public and senior markets through our UnitedHealthcare Employer & Individual (formerly UnitedHealthcare), UnitedHealthcare Medicare & Retirement (formerly Ovations), and UnitedHealthcare Community & State (formerly AmeriChoice) businesses. Health services are provided to the participants in the health system itself, ranging from consumers, employers and health plans to physicians and life sciences companies through our OptumHealth, Ingenix and Prescription Solutions businesses. In aggregate, these businesses have more than two dozen distinct business units that address specific end markets. Each of these business units focuses on the key goals in health and well-being: access, affordability, quality and simplicity as they apply to their specific market.

Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. We have four reporting segments:

- Health Benefits, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State;
- OptumHealth;
- Ingenix; and
- Prescription Solutions.

For our financial results and the presentation of certain other financial information by segment, see Note 14 of Notes to the Consolidated Financial Statements.

2011 Business Realignment

On January 1, 2011, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. For example, in 2011 OptumHealth's results of operations will include our clinical services assets, including Southwest Medical multi-specialty clinics in

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Nevada and our Evercare nurse practitioners serving the frail and elderly, which had historically been reported in UnitedHealthcare Employer & Individual and UnitedHealthcare Medicare & Retirement, respectively. UnitedHealthcare Employer & Individual's results of operations will include OptumHealth Specialty Benefits, including dental, vision, life and disability. There were no changes to our reportable segments as a result of these changes. Our periodic filings beginning with our first quarter 2011 Form 10-Q will include historical segment results restated to reflect the effect of this realignment.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

DESCRIPTION OF REPORTING SEGMENTS

Health Benefits

The financial results of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & State have been aggregated in the Health Benefits reporting segment due to their similar economic characteristics, products and services, types of customers, distribution methods, operational processes and regulatory environment. These businesses also share significant common assets, including our contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. Health Benefits utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as prescription drug services, behavioral health services and fraud and abuse prevention and detection. Health Benefits arranges for discounted access to care through networks that include a total of 730,000 physicians and other health care professionals and 5,300 hospitals across the United States.

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Employer & Individual facilitated access to health care services on behalf of approximately 25 million Americans as of December 31, 2010. With its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate per individual served for a one-year

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period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependants, UnitedHealthcare Employer & Individual receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependants, while UnitedHealthcare Employer & Individual provides coordination and facilitation of medical services, customer and health care professional services and access to a contracted network of physicians, hospitals and other health care professionals. Large employer groups, such as those serviced by UnitedHealthcare Employer & Individual National Accounts, typically use self-funded arrangements. As of December 31, 2010, UnitedHealthcare Employer & Individual National Accounts served 372 large employer groups under these arrangements, including 144 of the *Fortune 500* companies. Small employer groups are more likely to purchase risk-based products because they are less willing or able to bear a greater potential liability for health care expenditures. UnitedHealthcare Employer & Individual also offers a variety of non-employer based insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families.

UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs). UnitedHealthcare Employer & Individual's product strategy centers on several principles: consumer choice, broad access to health professionals, and use of data and science to promote better outcomes, quality service, transparency and affordability. Integrated wellness programs and services help individuals make informed decisions, maintain healthy lifestyles and optimize health outcomes by coordinating access to care services and providing personalized, targeted education and information services.

Individuals served by UnitedHealthcare Employer & Individual have access to approximately 90% of the physicians and other health care professionals and 96% of the hospitals through the UnitedHealth Group networks. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals. Directly or through UnitedHealth Group's family of companies, UnitedHealthcare Employer & Individual offers:

- A comprehensive range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;
- Affordability across a broad set of price points and a wide product line, from offerings covering essential needs to comprehensive benefit plans, all of which offer access to our broad-based proprietary network of contracted physicians, hospitals and other health care professionals with economic benefits reflective of the aggregate purchasing capacity of our organization;
- Innovative clinical programs that are built around an extensive clinical data set and principles of evidence-based medicine;
- Consumer access to information about physician and hospital performance against quality and cost efficiency criteria based on claims data assessment through the UnitedHealth Premium Designation Program and the UnitedHealth Hospital Comparison Program;
- Physician and facility access to performance feedback information to support continuous quality improvement;
- Care facilitation services that use several identification tools, including proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risks for potential health problems, and then facilitate appropriate interventions;
- Disease and condition management programs to help individuals address significant, complex disease states, including disease-specific benefit offerings such as the Diabetes Health Plan; and
- Convenient self-service tools for health transactions and information.

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UnitedHealthcare Employer & Individual's regional and national access to broad, affordable and quality networks of health care professionals has advanced over the past several years, with significant increases in access to services throughout the United States. UnitedHealthcare Employer & Individual has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

UnitedHealthcare Employer & Individual's innovation distinguishes its product offerings from its competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare Employer & Individual has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. To provide consumers with the necessary resources and information to make more informed choices when managing their health, data-driven networks and clinical management are organized through clinical lines of service such as cardiology, oncology, neuroscience, orthopedics, women's health, primary care and emergency services. UnitedHealthcare Employer & Individual also offers comprehensive and integrated pharmaceutical management services that promote lower costs by using formulary programs that drive better unit costs for drugs, benefit designs that encourage consumers to use drugs that offer better value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare Employer & Individual provides innovative programs that give consumers more financial control of their spending decisions for health care. These products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs), or health savings accounts (HSAs), which are offered on a self-funded and fully-insured basis. UnitedHealthcare Employer & Individual provided these products to approximately 32,000 employer-sponsored benefit plans during 2010, including approximately 160 employers in the large group self-funded market.

UnitedHealthcare Employer & Individual's distribution system consists primarily of brokers and direct and internet sales in the individual market, brokers in the small employer group market, and brokers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare Employer & Individual's direct distribution efforts are generally limited to the individual market, portions of the large employer group and public sector markets, and cross-selling of specialty products to existing customers.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to this market segment, as it provides products and services in all 50 states, the District of Columbia, and most U.S. territories. UnitedHealthcare Medicare & Retirement participates nationally in the Medicare program, offering a wide-ranging spectrum of Medicare products, including Medigap products that supplement traditional fee-for-service coverage, more traditional health-plan-type programs under Medicare Advantage, Medicare Part D prescription drug coverage, and special offerings for beneficiaries who are chronically ill and/or Medicaid and Medicare dual-eligible. Premium revenues from the Centers for Medicare & Medicaid Services (CMS) were 27% of our total consolidated revenues for the year ended December 31, 2010, most of which were generated by UnitedHealthcare Medicare & Retirement under a number of contracts.

UnitedHealthcare Medicare & Retirement has extensive capabilities and experience with distribution, including direct marketing to consumers on behalf of its key clients – AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, state and U.S. government agencies and employer groups. UnitedHealthcare Medicare & Retirement also has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to risk-based health products and services in the senior and geriatric markets.

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UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Special Needs Plans, Point-of-Service (POS) plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, UnitedHealthcare Medicare & Retirement provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside; demographic factors such as age, gender, and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement offers Medicare Advantage products in all 50 states and the District of Columbia. As of December 31, 2010, UnitedHealthcare Medicare & Retirement had approximately 2.1 million enrolled individuals in its Medicare Advantage products.

Additionally, UnitedHealthcare Medicare & Retirement provides the Medicare prescription drug benefit (Part D) to beneficiaries throughout the United States and its territories. Among the several Part D plans it offers, UnitedHealthcare Medicare & Retirement provides Medicare Part D coverage plans with the AARP brand. UnitedHealthcare Medicare & Retirement provides Part D drug coverage through its Medicare Advantage program, Special Needs Plans (covering individuals who live in an institutional long-term care setting, individuals dual-eligible for Medicaid and Medicare services or individuals with severe or disabling chronic conditions) and stand-alone Part D plans. As of December 31, 2010, UnitedHealthcare Medicare & Retirement had enrolled approximately 6.5 million members in the Part D program, including approximately 4.5 million members in the stand-alone Part D plans and approximately 2.0 million members in Medicare Advantage plans incorporating Part D coverage.

In association with AARP, UnitedHealthcare Medicare & Retirement provides a range of member funded standardized Medicare supplement and hospital indemnity insurance offerings from its insurance company affiliates to approximately 3.7 million AARP members. Additional UnitedHealthcare Medicare & Retirement services include a nurse healthline service, a lower cost standardized Medicare supplement offering that provides consumers with a national hospital network, 24-hour access to health care information, and access to discounted health services from a network of physicians.

UnitedHealthcare Medicare & Retirement also provides complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. UnitedHealthcare Medicare & Retirement serves approximately 196,000 individuals enrolled in Medicare Advantage products across the nation in long-term care settings including nursing homes, community-based settings and private homes. UnitedHealthcare Medicare & Retirement offers innovative care management and clinical programs, integrating federal, state and personal funding through a continuum of products from Special Needs Plans to hospice care. UnitedHealthcare Medicare & Retirement serves people in 30 states and in the District of Columbia in home, community and nursing home settings serving members primarily through nurse practitioners, nurses and care managers.

UnitedHealthcare Medicare & Retirement also offers a comprehensive eldercare service program providing service coordination, consultation, claim management and information resources nationwide. Proprietary, automated medical record software enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings for high-risk populations. UnitedHealthcare Medicare & Retirement also operates hospice and palliative care programs in 15 local markets in 11 states.

UnitedHealthcare Community & State

UnitedHealthcare Community & State provides solutions to states that care for the economically disadvantaged, the medically underserved, and those without benefit of employer-funded health care coverage in exchange for a monthly premium per member from the applicable state. As of December 31, 2010, UnitedHealthcare Community & State offers health plans in 23 states and the District of Columbia, serving over 3.3 million beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP),

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Special Needs Plans and other federal and state health care programs. UnitedHealthcare Community & State's health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities, and people with higher risk medical, behavioral and social conditions. UnitedHealthcare Community & State's approach leverages the national capabilities of UnitedHealthcare and delivers them through public programs at the local market level to support effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes, and the ability to adapt to a changing market environment.

For more than 20 years, UnitedHealthcare Community & State has served the needs of underserved, economically disadvantaged, and vulnerable individuals in multiple and diverse geographic markets. UnitedHealthcare Community & State focuses on addressing medical issues, as well as the social, behavioral and economic barriers individuals face in improving or maintaining their health status. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care. For example, the Personal Care Model establishes an ongoing relationship between health care professionals and individuals who have serious and chronic health conditions to help them maintain the best possible health and functional status, whether care is delivered in an acute care setting, long-term care facility or at home.

UnitedHealthcare Community & State's programs for families and children focus on high-prevalence and debilitating chronic illnesses such as hypertension and cardiovascular disease, asthma, sickle cell disease, diabetes, HIV/AIDS and high-risk pregnancies. Programs for the long-term care population focus on dementia, depression, coronary disease and functional-use deficiencies that impede daily living.

OptumHealth

OptumHealth serves more than 63 million unique individuals with its diversified offering of health, financial and ancillary benefit services, and products that assist consumers in navigating the health care system, accessing health services based on their needs, supporting their emotional health and well-being, providing ancillary insurance benefits and helping people finance their health care needs through account-based programs. OptumHealth seeks to simplify the consumer health care experience and facilitate the efficient and effective delivery of care. Its capabilities can be deployed individually or integrated to provide a comprehensive solution oriented around a broad base of consumer needs within the health care system.

OptumHealth's simple, modular service designs can be easily integrated to meet varying employer, payer, public sector and consumer needs at a wide range of price points. OptumHealth offers its products on an administrative fee basis where it manages and administers benefit claims for self-insured customers in exchange for a fixed fee per individual served, and on a risk basis, where OptumHealth assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products through three markets: employer (which includes the sub-markets of large, mid and small employers), payer (which includes the sub-markets of health plans, third party administrators, underwriter/stop-loss carriers and individual market intermediaries) and public sector (which includes Medicaid, Medicare and Federal procurement).

OptumHealth is one brand, organized into four major operating groups: OptumHealth Care Solutions; OptumHealth Financial Services; OptumHealth Behavioral Solutions; and OptumHealth Specialty Benefits, whose results of operations will be reflected in UnitedHealthcare Employer & Individual in 2011.

Care Solutions. Care Solutions serves more than 39 million individuals through personalized health management that improves people's health and well-being, improves clinical outcomes and workforce productivity and

reduces health care costs. Programs include wellness and prevention, disease management, case management, physical health programs, complex condition management, specialized provider networks, personalized health portals and consumer marketing services.

Care Solutions also provides benefit administration and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services through its national network consisting of 26,000 chiropractors, 16,000 physical and occupational therapists and 9,000 complementary and alternative health professionals.

Financial Services. Financial Services provides health-based financial services for consumers, employers, payers and health care professionals. Financial Services is comprised of OptumHealth Bank, which is a member of the Federal Deposit Insurance Corporation (FDIC), a TPA and a transaction processing service for the health care industry. Financial Services' account-based offerings include HSA, HRA, and Flexible Spending Accounts in addition to other reimbursement accounts products. As of December 31, 2010 Financial Services had $1.1 billion in customer assets under management. Additionally, Financial Services provides electronic payments and statements services for health care professionals and payers. In 2010, Financial Services processed $43.5 billion in medical payments to physicians and other health care providers.

Behavioral Solutions. Behavioral Solutions serves approximately 50 million individuals with its employee assistance programs, work/life offerings, and clinically driven behavioral health, substance abuse and psychiatric disability management programs. Its consumer-focused programs incorporate state-of-the-art predictive modeling, outcomes management and evidence-based best practices, which result in better care and a reduction in overall health care costs. Behavioral Solutions customers have access to a national network of 91,000 clinicians and counselors and 3,100 facilities in 6,300 locations nationwide.

Specialty Benefits. Specialty Benefits includes dental, vision, life, critical illness, disability and stop-loss product offerings delivered through an integrated platform that enhances efficiency and effectiveness. Specialty Benefits covers nearly 23 million individuals and includes a network of more than 33,000 vision professionals in private and retail settings, and more than 154,000 dental providers. Stop-loss insurance is marketed throughout the United States through a network of TPAs, brokers and consultants. In 2011, these specialty benefits will be reflected in UnitedHealthcare Employer & Individual's results of operations.

Ingenix

Ingenix offers database and data management services, software products, publications, consulting and actuarial services, business process outsourcing services and pharmaceutical data consulting and research services in conjunction with the development of pharmaceutical products on a nationwide and international basis. As of December 31, 2010, Ingenix's customer base included 6,200 hospital facilities, 246,000 health care professionals or groups, 2,000 payers and intermediaries, 205 *Fortune 500* companies, 2,200 life sciences companies, 270 government entities, and 150 United Kingdom Government Payers, as well as other UnitedHealth Group businesses.

Ingenix offers information and technology to simplify health care administration. Ingenix helps customers accurately and efficiently manage the information flowing through the health care system. Ingenix uses data to help advance transparency on cost and quality and help customers streamline their processes to make health care more efficient. Ingenix is a leader in contract research services, and pharmacoeconomics, epidemiology and safety and outcomes (including comparative effectiveness) research through its i3 businesses.

Ingenix's products and services are sold primarily through a direct sales force focused on specific customers and market segments across the pharmaceutical, biotechnology, employer, government, hospital, physician, payer and property and casualty insurance market segments. Ingenix's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

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Many of Ingenix's contract research services, consulting arrangements and software and related information services are performed over an extended period, often several years. Ingenix maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. Ingenix's aggregate backlog at December 31, 2010 was $2.8 billion, of which $2.0 billion is expected to be realized within the next 12 months. This includes $0.8 billion related to intersegment agreements all of which are included in the current portion. Backlog amounts do not include approximately $500 million for the portion of the i3 business that is being divested, which is discussed below. Ingenix cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services and the potential for cancellation or early termination of service arrangements.

The Ingenix companies are divided into two groups: Information Services and i3.

Information Services. Information Services' diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trend management, physician practice revenue cycle management, including integrated electronic medical record systems, revenue and payment cycle management for payer and health care professional organizations, payment accuracy solutions, decision-support portals for evaluation of health benefits and treatment options, risk management solutions, connectivity solutions and claims management tools to reduce administrative errors and support fraud recovery services. Information Services uses proprietary software applications that manage clinical and administrative data across diverse information technology environments. Information Services also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets. Information Services offers comprehensive Electronic Data Interchange (EDI) services helping health care professionals and payers decrease costs of claims transmission, payment and reimbursement through both networked and direct connection services. Information Services provides computer assisted coding, publishes print and electronic media products that provide customers with information regarding medical claims coding, reimbursement, billing and compliance issues.

Information Services provides other services, such as medical necessity compliance services, verification of physician credentials, health care professional directories, Healthcare Effectiveness Data and Information Set (HEDIS) reporting, and fraud and abuse detection and prevention services. Information Services also offers consulting services, including actuarial and financial advisory work through its Ingenix Consulting division and health care policy research, implementation, strategy and management consulting through its subsidiary, The Lewin Group, as well as product development, health care professional contracting and medical policy management.

i3. i3 uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical and biotechnology development. i3 provides services on a nationwide and international basis, helping customers effectively and efficiently get drug data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. i3's capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services – pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology and safety and outcomes (including comparative effectiveness) research. i3's global contract research services include regulatory assistance, project management, data management, biostatistical analysis, quality assurance, medical writing and staffing resource services. i3's contract research services are therapeutically focused on oncology, the central nervous system, respiratory, infectious and pulmonary diseases and endocrinology.

In January 2011, we announced that as part of focusing on its distinct life sciences competencies, Ingenix is exiting certain portions of the clinical trial support business and intends to sell these businesses. The businesses to be sold include those that mainly provide services in connection with the clinical trials that help pharmaceutical companies get a compound approved by the U. S. Food and Drug Administration and other

applicable drug regulatory agencies outside of the United States. The services provided include monitoring, project management, data management and clinical staffing services. These services are generally performed in connection with Phase I, Phase II and Phase III clinical trials.

The remaining portion of i3 will be organized into a new Life Sciences division that will focus Ingenix's capabilities in assisting life sciences clients to identify, analyze and measure the value of their products that have received regulatory approval. The products and services provided by the Life Sciences division include health economics outcomes and late phase research, market access and reimbursement informatics products and services, epidemiology and certain drug safety services, products and services relating to patient reported outcomes and regulatory consulting services.

Prescription Solutions

Prescription Solutions provides a comprehensive suite of integrated pharmacy benefit management (PBM) services to more than 12 million people nationwide through its network of more than 66,000 retail pharmacies and two mail service facilities, processing nearly 350 million adjusted retail, mail service and specialty drug prescriptions annually. Prescription Solutions is dedicated to helping its customers achieve a low-cost, high-quality pharmacy benefit. Prescription Solutions does this by working closely with customers to create customized solutions that are designed to improve quality and safety, increase compliance and adherence, and reduce fraud and waste.

Prescription Solutions' integrated PBM services include retail network pharmacy contracting and management, claims processing, mail order pharmacy services, specialty pharmacy services, benefit design consultation, rebate contracting and management, drug utilization review, formulary management programs, disease therapy management and adherence programs. The mail order and specialty pharmacy fulfillment capabilities of Prescription Solutions are an important strategic component in serving employers, commercial health plans, Medicaid plans and Medicare-contracted businesses, including Part D prescription drug plans. In addition to PBM services, Prescription Solutions' Consumer Health Products division delivers diabetic testing and other specialized medical supplies, over the counter items, vitamins and supplements directly to members' homes.

Prescription Solutions provides PBM services to customers in our Health Benefits segment, as well as external employer groups, union trusts, managed care organizations, Medicare-contracted plans, Medicaid plans and TPAs, including mail service only, rebate services only and pharmacy carve-out accounts. Prescription Solutions' distribution system consists primarily of health insurance brokers and other health care consultants or direct sales.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated by federal and state regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. In the first quarter of 2010, the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Reform Legislation, were signed into law. The Health Reform Legislation, portions of which are summarized below, alters the regulatory environment in which we operate, in some cases to a significant degree. Federal and state governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, could negatively affect our business.

We believe we are in compliance in all material respects with applicable laws, regulations and rules. In the event we fail to comply with, or we fail to respond quickly and appropriately to changes in, applicable laws, regulations

and rules, our business, financial condition and results of operations could be materially adversely affected. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal and state laws and regulations.

Health Care Reforms

The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system. Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. The Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury Department have issued regulations (or proposed regulations) on a number of aspects of Health Reform Legislation, but we await final rules and interim guidance on other key aspects of the legislation.

Certain aspects of the Health Reform Legislation are also being challenged in federal court, with the proponents of such challenges seeking to limit the scope of or have all or portions of the Health Reform Legislation declared unconstitutional. For example, on January 31, 2011, in a case brought on behalf of 26 state attorneys general and/or governors and certain other parties, the United States District Court for the Northern District of Florida ruled that the provision in the Health Reform Legislation that requires individuals to purchase health insurance (or be subject to penalties), along with the entire legislation, is unconstitutional. The United States District Court for the Eastern District of Virginia has held that the individual mandate and certain related provisions are unconstitutional, but without declaring the entire legislation unconstitutional. In contrast, federal district court judges in Virginia and Michigan have upheld the constitutionality of the individual mandate and the Health Reform Legislation. There are other cases challenging aspects of the Health Reform Legislation that remain pending and have not yet been decided. Judicial proceedings are subject to appeal and could last for an extended period of time, and we cannot predict the results of any of these proceedings. Congress may also withhold the funding necessary to implement the Health Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether.

The following outlines certain provisions of the Health Reform Legislation that have taken or will take effect in the coming years, assuming the legislation is implemented in its current form.

Effective 2010: The Health Reform Legislation mandated the expansion of dependent coverage to include adult children until age 26; eliminated certain annual and lifetime caps on the dollar value of certain essential health benefits; eliminated pre-existing condition limits for enrollees under 19; prohibited certain policy rescissions; prohibited plans and issuers from charging higher cost sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network; and included a requirement to provide coverage for preventive services without cost to members (for non-grandfathered plans).

The Health Reform Legislation also mandated certain changes to coverage determination and appeals processes, including expanding the definition of "adverse benefit determination" to include rescissions; extending external review rights of adverse benefit determinations to insured and self-funded plans; requiring urgent care coverage determinations to be made and communicated within 24 hours; and improving the clarity of and expanding the types of information in adverse benefit determination notices.

Effective 2011: Beginning in 2011, commercial fully insured health plans in the large employer group, small employer group and individual markets with medical loss ratios below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals, calculated under the definitions in the Health Reform Legislation and regulations) will be required to rebate ratable portions of their premiums to their customers annually. Rebate payments, if any, for 2011 would be made in mid 2012. A state can request a waiver of the individual market medical loss ratio for up to three years if the state petitions and provides to HHS certain supporting data, and HHS determines that the requirement is disruptive to the market in that state. In addition, effective in 2011, the Health Reform Legislation mandates consumer discounts of 50% on brand name prescription drugs and 7% on generic prescription drugs for Part D plan participants in the coverage gap.

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In addition, the Health Reform Legislation required HHS to maintain an annual review process of "unreasonable" increases in premiums for commercial health plans. HHS recently issued a proposed regulation that defines a review threshold of annual premium rate increases generally at or above 10% for rate increases filed or effective July 1, 2011 or later. The proposed rule also clarifies that HHS review will not supersede existing state review and approval processes. The proposed regulation further requires health plans to provide to the states and HHS extensive information supporting any premium rate increase of 10% or more, regardless of whether such increase ultimately is or is not deemed "unreasonable." This information is expected to be made public by the states and/or HHS.

Effective 2011/2012: As part of the Health Reform Legislation, Medicare Advantage payment rates for 2011 were frozen at 2010 levels. Separately, CMS implemented a reduction in Medicare Advantage reimbursements of 1.6% for 2011. Beginning in 2012, additional cuts to Medicare Advantage plans will take effect (plans will ultimately receive 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), with changes being phased-in over two to six years, depending on the level of payment reduction in a county. In addition to other measures, quality bonuses may partially offset these anticipated rate reductions as CMS quality rating bonuses are phased in over three years beginning in 2012.

Effective 2013: Effective beginning in 2013 with respect to services performed after 2009, the Health Reform Legislation limits the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code for insurance providers if at least 25% of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements.

Effective 2013/2014: The Health Reform Legislation provides for an increase in Medicaid fee-for-service and managed care program reimbursements for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014, and provides 100% federal financing for the difference in rates based on rates applicable on July 1, 2009.

Effective 2014: Effective starting in 2014, a number of the provisions of the Health Reform Legislation are scheduled to take effect, including the following: an annual insurance industry assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter), which is not deductible for income tax purposes; expansion of Medicaid eligibility for all individuals and families with incomes up to 133% of the federal poverty level (states can early adopt the expansion without increased federal funding prior to 2014); states receive full federal matching in 2014 through 2016; all individual and group health plans must offer coverage on a guaranteed issue and guaranteed renewal basis during annual open enrollment and special enrollment periods and cannot apply pre-existing condition exclusions or health status rating adjustments; elimination of annual limits on essential benefits coverage on certain plans; establishment of state-based exchanges for individuals and small employers (with up to 100 employees) as well as certain CHIP eligibles; introduction of plan designs based on set actuarial values to increase comparability of competing products on the exchanges; and establishment of minimum medical loss ratio of 85% for Medicare Advantage plans.

The Health Reform Legislation and the related federal and state regulations will impact how we do business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase our medical and administrative costs, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business. In addition, our results of operations, financial position, including our ability to maintain the value of our goodwill, and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known. See also Item 1A, "Risk Factors" for a discussion of the risks related to the Health Reform Legislation and related matters.

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Other Federal Laws and Regulation

We are subject to various levels of federal regulation. CMS regulates our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State Medicare and Medicaid businesses, as well as certain aspects of our OptumHealth business. CMS has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care given to Medicare beneficiaries. See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K for a discussion of audits of our risk adjustment data for several of our plans.

Our Health Benefits reporting segment, through UnitedHealthcare Community & State, also has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance, and the regulatory environment with respect to these programs has become and will continue to become increasingly complex as a result of the Health Reform Legislation. When we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. In addition, certain of Ingenix's businesses, such as its high acuity software products and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration, and the clinical research activities are also subject to laws and regulations outside of the United States that regulate clinical trials. Laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust also affect us.

HIPAA, GLBA and Other Privacy and Security Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. HIPAA requires guaranteed health care coverage for small employers and certain eligible individuals. It also requires guaranteed renewability for employers and individuals and limits exclusions based on pre-existing conditions. Federal regulations related to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may also apply to us.

Federal privacy and security requirements change frequently because of legislation, regulations and judicial or administrative interpretation. For example, the U.S. Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), which significantly amends, and adds new, privacy and security provisions to HIPAA and imposes additional requirements on uses and disclosures of health information. AARA includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. HHS has indicated that it will issue regulations this year on key aspects of HIPAA, primarily ARRA amendments to HIPAA. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personal identifiable information. The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with HIPAA, GLBA and other privacy-related regulations.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of

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laws and regulations that is subject to periodic interpretation by the DOL as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL provide additional rules for claims payment and member appeals under health care plans governed by ERISA. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

FDIC. The FDIC has federal regulatory authority over OptumHealth Bank and performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements. In addition to such annual examinations, the FDIC performs periodic examinations of the bank's compliance with applicable federal banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subject to increased operational expenses and capital requirements, governmental oversight and monetary penalties.

Financial Reform. Our business may be impacted by the Dodd-Frank Wall Street Reform and Consumer Protection Act which became law on July 21, 2010. The act reshapes and restructures the supervision and regulation of the financial services industry. The act calls for extensive rulemaking, including debit card interchange fees restrictions, and network exclusivity and routing requirements. Depending on rulemaking and implementation activities, the act could subject us to additional regulation, increase operational costs and reduce revenue. The full impact of the law and future regulations on our results of operations and business strategy may not be known for some time.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners (NAIC) to adopt elements substantially similar to the Sarbanes-Oxley Act of 2002, we expect that these states will continue to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. In addition, the states were very active in 2010 and passed various laws to implement, limit and, in the majority of instances, expand the entitlements set forth in the federal Health Reform Legislation. We expect the states to continue to introduce and pass similar laws in 2011, and this will affect our operations and our financial results.

Health plans and insurance companies are also regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

In addition, some of our business and related activities may be subject to other health care-related regulations and requirements, including PPO, managed care organization (MCO), utilization review (UR) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, and may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing unnecessary medical services and improper marketing. Our UnitedHealthcare Community & State and UnitedHealthcare Medicare & Retirement

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Medicaid businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits by UnitedHealthcare Community & State to its Medicaid and CHIP beneficiaries and by UnitedHealthcare Medicare & Retirement to its dually-eligible Medicaid beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies (and HMOs in some states), including those issuing health (which includes long-term care), life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Assessments generally are based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets. See Note 13 of Notes to the Consolidated Financial Statements for a discussion of a matter involving Penn Treaty Network American Insurance Company and its subsidiary (Penn Treaty), which have been placed in rehabilitation.

Pharmacy Regulation. Prescription Solutions' mail order pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, "Risk Factors" for a discussion of the risks related to our PBM businesses.

Privacy and Security Laws. States have adopted regulations to implement provisions of the GLBA. Like HIPAA, GLBA allows states to adopt more stringent requirements governing privacy protection. A number of states have also adopted other laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure and protection of social security numbers and sensitive health information. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy-related regulations.

UDFI. The Utah State Department of Financial Institutions (UDFI) has state regulatory and supervisory authority over OptumHealth Bank and in conjunction with federal regulators performs annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements. In addition to such annual examinations, the UDFI in conjunction with federal regulators performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subjected to increased operational expenses and capital requirements, governmental oversight and monetary penalties.

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Corporate Practice of Medicine and Fee-Splitting Laws. Certain businesses within OptumHealth are subject to laws and regulations that may differ from those that apply to our businesses of providing managed care and health insurance products. Some states have corporate practice of medicine laws that prohibit certain entities from practicing medicine, employing physicians to practice medicine or exercising control over medical decisions by physicians. Additionally, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be a matter of judicial or regulatory interpretation. These laws, regulations and interpretations have, in certain states, been subject to limited judicial and regulatory interpretation and are subject to change.

Audits and Investigations

We have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the Internal Revenue Service, the U.S. DOL, the FDIC and other governmental authorities. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. See Note 13 of Notes to the Consolidated Financial Statements for details. In addition, disclosure of any adverse investigation, audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services and retain our current business.

International Regulation

Some of our business units have international operations. These international operations are subject to different legal and regulatory requirements in different jurisdictions, including various tax, tariff and trade regulations, as well as employment, intellectual property, privacy and investment rules and laws. These international operations are also subject to United States laws that regulate activities of U.S.-based businesses abroad.

COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to directly contract with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our Health Benefits businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas. For our Prescription Solutions businesses, competitors include Medco Health Solutions, Inc., CVS Caremark Corporation and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a broad and diverse set of other businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales, marketing and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected. See Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

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EMPLOYEES

As of December 31, 2010, we employed approximately 87,000 individuals. We believe our employee relations are generally positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 10, 2011, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	58	President and Chief Executive Officer
David S. Wichmann	48	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations
Gail K. Boudreaux	50	Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare
George L. Mikan III	39	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Health Services
William A. Munsell	58	Executive Vice President of UnitedHealth Group
Eric S. Rangen	54	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	57	Executive Vice President
Lori K. Sweere	52	Executive Vice President of Human Capital
Reed V. Tuckson, M.D.	59	Executive Vice President and Chief of Medical Affairs
Christopher J. Walsh	45	Executive Vice President, General Counsel and Assistant Secretary
Anthony Welters	55	Executive Vice President
Mitchell E. Zamoff	43	Executive Vice President, General Counsel and Assistant Secretary

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. Mr. Hemsley served as President and Chief Operating Officer from January 2006 to November 2006.

Mr. Wichmann is Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since January 2011. Mr. Wichmann has served as Executive Vice President and President of UnitedHealth Group Operations since April 2008. From December 2006 to April 2008, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of the Commercial Markets Group (now UnitedHealthcare Employer & Individual). From January 2006 to December 2006, Mr. Wichmann served as President and Chief Operating Officer of UnitedHealthcare.

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since January 2011. Ms. Boudreaux has overall responsibility for all UnitedHealthcare health benefits businesses. Ms. Boudreaux served as Executive Vice President of UnitedHealth Group and President of UnitedHealthcare from May 2008 to January 2011. Prior to joining UnitedHealth Group, Ms. Boudreaux served as Executive Vice President of Health Care Services Corporation (HCSC) from January 2006 to May 2008.

Mr. Mikan is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Health Services and has served in that capacity since January 2011. Mr. Mikan is responsible for oversight of UnitedHealth Group's health services platform. Mr. Mikan served as Executive Vice President and Chief Financial Officer from November 2006 to January 2011 and Senior Vice President of Finance of UnitedHealth Group from February 2006 to November 2006. From January 2006 to February 2006, Mr. Mikan served as Chief Financial Officer of UnitedHealthcare and as President of UnitedHealth Networks.

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Mr. Munsell is Executive Vice President of UnitedHealth Group and has served in that capacity since January 2011. Mr. Munsell focuses on enterprise-wide initiatives, including emerging growth and expansion opportunities; public, regulatory and governmental affairs and representation; reputation and market image efforts, and external relationships and alliances for the enterprise. Mr. Munsell served as Executive Vice President of UnitedHealth Group and President of the Enterprise Services Group from September 2007 to January 2011. From December 2006 to August 2007, Mr. Munsell served as Executive Vice President of UnitedHealth Group. From January 2006 to December 2006, Mr. Munsell served as Chief Executive Officer of Specialized Care Services (now OptumHealth).

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006. From November 2006 to December 2006, Mr. Rangen was Senior Vice President of UnitedHealth Group. Mr. Rangen joined UnitedHealth Group in November 2006. Prior to joining UnitedHealth Group, Mr. Rangen served as Executive Vice President and Chief Financial Officer of Alliant Techsystems Inc. from January 2006 to March 2006.

Mr. Renfro is Executive Vice President of UnitedHealth Group and has served in that capacity since January 2011. Mr. Renfro focuses on enterprise-wide initiatives, including emerging growth and expansion opportunities; public, regulatory and governmental affairs and representation; reputation and market image efforts, and external relationships and alliances for the enterprise. Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group from October 2009 to January 2011. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations. Prior to joining UnitedHealth Group, Mr. Renfro served as President of Fidelity Developing Businesses at Fidelity Investments and as a member of the Fidelity Executive Committee from June 2008 to January 2009. From January 2006 to May 2008, Mr. Renfro held several senior positions at AARP Services Inc., including President and Chief Executive Officer of AARP Services Inc., Chief Operating Officer of AARP Services Inc., President and Chief Executive Officer of AARP Financial and President of the AARP Funds.

Ms. Sweere is Executive Vice President of Human Capital of UnitedHealth Group and has served in that capacity since June 2007. Prior to joining UnitedHealth Group, Ms. Sweere served as Executive Vice President of Human Resources of CNA Financial Corporation from January 2006 to May 2007.

Dr. Tuckson is Executive Vice President and Chief of Medical Affairs of UnitedHealth Group and has served in that capacity since December 2006. Dr. Tuckson served as Senior Vice President, Consumer Health and Medical Care Advancement from January 2006 to December 2006.

Mr. Walsh is Executive Vice President, General Counsel and Assistant Secretary of UnitedHealth Group and has served in that capacity since October 2009. From August 2007 to October 2009, Mr. Walsh served as Senior Vice President and Deputy General Counsel of UnitedHealth Group, and from January 2009 to October 2009, Mr. Walsh served also as interim Co-Chief Legal Officer of UnitedHealth Group. Mr. Walsh joined UnitedHealth Group in August 2007. Prior to joining UnitedHealth Group, Mr. Walsh was a partner at Hogan and Hartson from January 2006 to August 2007.

Mr. Welters is Executive Vice President of UnitedHealth Group and has served in that capacity since January 2011. Mr. Welters focuses on enterprise-wide initiatives, including emerging growth and expansion opportunities; public, regulatory and governmental affairs and representation; reputation and market image efforts, and external relationships and alliances for the enterprise. Mr. Welters served as Executive Vice President of UnitedHealth Group and President of the Public and Senior Market Group from September 2007 to January 2011. Mr. Welters was named Executive Vice President of UnitedHealth Group in November 2006. From January 2006 to November 2006, Mr. Welters was President and Chief Executive Officer of AmeriChoice.

Mr. Zamoff is Executive Vice President, General Counsel and Assistant Secretary of UnitedHealth Group and has served in that capacity since October 2009. From March 2008 to October 2009, Mr. Zamoff served as General

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Counsel of UnitedHealthcare, and from January 2009 to October 2009, Mr. Zamoff served also as interim Co-Chief Legal Officer of UnitedHealth Group. Mr. Zamoff joined UnitedHealth Group in March 2008. Prior to joining UnitedHealth Group, Mr. Zamoff was a partner at Hogan and Hartson from January 2006 to March 2008.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 "believe," "expect," "intend," "estimate," "anticipate," "plan," project," "should" or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. 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. We do not undertake to address or update forward-looking statements in future filings or communications regarding our business or results of operations, 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 past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or 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. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in this report or any of our prior communications.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products could decline and could materially adversely affect our future financial results.

Under our risk-based product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our risk-based products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, the Health Reform Legislation requires HHS to maintain an annual review process of "unreasonable" increases in premiums for commercial health plans, and states have a variety of premium review and approval processes that are receiving increased scrutiny.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue on commercial policies is typically at a fixed rate per individual served for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. We base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period; however, medical cost inflation, regulation and other factors may cause actual costs to exceed what was estimated and reflected in premiums or bids. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly

treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical costs on our financial results, relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for commercial insured products, our annual net earnings for 2010 would have been reduced by approximately $190 million.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, they will have a negative impact on our future results.

Our business activities are highly regulated; new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially adversely affect our results of operations, financial position and cash flows.

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. For example, in the first quarter of 2010, the Health Reform Legislation was signed into law, legislating broad-based changes to the U.S. health care system. See Item 1, “Business – Government Regulation” for a discussion of the Health Reform Legislation.

The broad latitude that is given to the agencies administering regulations governing our business, as well as future laws and rules, and interpretation of those laws and rules by governmental enforcement authorities, 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. For example, in October 2008 Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires insurers to provide mental health and substance use disorder benefits under terms that are no more restrictive than those applied to medical and surgical benefits. The MHPAEA specifically directed the Secretaries of Labor, Health and Human Services and the Treasury to issue regulations to implement the legislation. Although regulations regarding how the MHPAEA was to be implemented were issued on February 2, 2010 in the form of an interim final rule, final regulations have not yet been published and interpretative guidance from the regulators has been limited to date. Because of the broad range of treatment limitations to which parity is expected to apply under the regulations, the regulations will likely lead to an increase in the costs associated with both insured and self-insured plans for behavioral health benefits and services and impact our market for carve-out health benefit administration, which could have an adverse effect on our earnings from operations.

We must also obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions, including integration of certain acquisitions. Delays in obtaining approvals or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

Under state guaranty fund laws, certain insurance companies (and HMOs in some states), including those issuing health (which includes long-term care), life and accident insurance policies, doing business in those states can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business. Changes in these laws or the interpretation thereof, or insolvency by another insurer, could have an adverse effect on our results of operations. See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K for a discussion of a matter involving Penn Treaty, which has been placed in rehabilitation.

Certain OptumHealth businesses are also subject to regulatory and other risks and uncertainties that may differ from the risks of our businesses of providing managed care and health insurance products. For example, the businesses are subject to federal and state anti-kickback and other laws and regulations, such as those that govern

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so-called corporate practice of medicine and fee-splitting, which govern their relationships with physicians, hospitals and customers.

Additionally, our financial services business may be impacted by the Dodd-Frank Wall Street Reform and Consumer Protection Act which became law on July 21, 2010. The act calls for extensive rulemaking, including debit card interchange fees restrictions, and network exclusivity and routing requirements, and depending on rulemaking and implementation activities, could subject us to additional regulation, increase operational costs and reduce revenue.

We are also involved in various governmental investigations, audits and reviews. These regulatory activities include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor, the FDIC and other governmental authorities. For example, in 2007, the California Department of Insurance examined our PacifiCare health insurance plan in California. The examination findings related to the timeliness and accuracy of claims processing, interest payments, provider contract implementation, provider dispute resolution and other related matters. The matter is now the subject of an administrative proceeding before an administrative law judge. See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K for a discussion of this matter. See also the risk factor below relating to our activities as a payer in various government health care programs for a discussion of audits of data used in determining CMS payment rates.

Reviews and investigations of this sort can lead to government actions, which can result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, and could have a material adverse effect on our business and results of operations.

In addition, the health care industry is regularly subject to negative publicity. Negative publicity, including negative publicity surrounding routine governmental investigations or the political environment, may adversely affect our stock price, damage our reputation in various markets and result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by adversely affecting our ability to market our products and services, requiring us to change our products and services, or increasing the regulatory burdens under which we operate.

For a discussion of various federal and state laws and regulations governing our businesses, see Item 1, “Business — Government Regulation.”

The enactment or implementation of health care reforms could materially adversely affect the manner in which we conduct business and our revenues, financial position and results of operations.

In the first quarter of 2010, the Health Reform Legislation was signed into law. The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs and CHIP and other aspects of the health care system. Among other things, the Health Reform Legislation includes guaranteed coverage requirements, eliminates pre-existing condition exclusions and annual and lifetime maximum limits, restricts the extent to which policies can be rescinded, establishes minimum medical loss ratios, creates a federal premium review process, imposes new requirements on the format and content of communications (such as explanations of benefits, or EOBs) between health insurers and their members, grants to members new and additional appeal rights, imposes new and significant taxes on health insurers and health care benefits, reduces the Medicare Part D coverage gap and reduces payments to private plans offering Medicare Advantage.

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Certain provisions of the Health Reform Legislation have already taken effect, and other provisions become effective at various dates over the next several years. HHS, the DOL and the Treasury Department have issued regulations (or proposed regulations) on a number of aspects of Health Reform Legislation, but we await final rules and interim guidance on other key aspects of the legislation. Due to the complexity of the Health Reform Legislation, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

For example, the Health Reform Legislation established minimum medical loss ratios for all commercial health plans in the large employer group, small employer group and individual markets (85% for large employer groups, 80% for small employer groups and 80% for individuals, calculated under the definitions in the Health Reform Legislation and regulations). Companies with medical loss ratios below these targets will be required to rebate ratable portions of their premiums to their customers annually. Depending on the results of the calculation and the manner in which we adjust our business model in light of this requirement, there could be meaningful disruptions in local health care markets, and our market share, revenues and results of operations could be materially adversely affected. In addition, the Health Reform Legislation requires the establishment of state-based health insurance exchanges for individuals and small employers by 2014. The types of exchange participation requirements ultimately enacted by each state, the availability of federal premium subsidies within exchanges, the potential for differential imposition of state benefit mandates inside and outside the exchanges, and the possibility that certain states may restrict the ability of health plans to continue to offer coverage to individuals and small employers outside of the exchanges, could result in disruptions in local health care markets and our revenues, financial position and results of operations could be materially adversely affected.

Several of the provisions in the Health Reform Legislation will likely increase our medical cost trends. Examples of these provisions are the excise tax on medical devices, annual fees on prescription drug manufacturers, enhanced coverage requirements and the prohibition of pre-existing condition exclusions. The annual insurance industry assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter), which is not deductible for income tax purposes, will increase our operating costs. Premium increases will be necessary to offset the impact these and other provisions will have on our medical and operating costs. These premium increases are oftentimes subject to state regulatory approval, and, as required under the Health Reform Legislation, HHS recently issued proposed rules that, if implemented, would establish a federal premium rate review process for annual premium rate increases, generally of 10% or more. If we are not able to secure approval for adequate premium increases to offset increases in our cost structure, our results of operations could be materially adversely affected. In addition, plans deemed to have a history of "unreasonable" rate increases may be prohibited from participating in the state-based exchanges that become active under the Health Reform Legislation in 2014.

The Congressional Budget Office has estimated that up to 32 million new individuals may eventually gain insurance coverage if the Health Reform Legislation is implemented broadly in its current form. In addition, we expect that implementation of the Health Reform Legislation will increase the demand for products and capabilities offered by our Health Services businesses. We have made and will continue to make strategic decisions and investments based, in part, on these assumptions, and our results of operations or financial position could be adversely affected if fewer individuals gain coverage under the Health Reform Legislation than estimated or we are unable to attract these new individuals to our Health Benefits offerings, or if the demand for our Health Services businesses does not increase.

Certain aspects of the Health Reform Legislation are also being challenged in federal court, with the proponents of such challenges seeking to limit the scope of or have all or portions of the Health Reform Legislation declared unconstitutional. For example, on January 31, 2011, in a case brought on behalf of 26 state attorneys general and/or governors and certain other parties, the United States District Court for the Northern District of Florida ruled that the provision in the Health Reform Legislation that requires individuals to purchase health insurance (or be subject to penalties), along with the entire legislation, is unconstitutional. The United States District Court for the Eastern District of Virginia has held that the individual mandate and certain related provisions are unconstitutional, but without declaring the entire legislation unconstitutional. Congress may also withhold the funding necessary to implement the Health Reform Legislation, or may attempt to replace the legislation with

amended provisions or repeal it altogether. Any partial or complete repeal or amendment or implementation difficulties, or uncertainty regarding such events, could adversely impact our ability to capitalize on the opportunities presented by the Health Reform Legislation or may cause us to incur additional costs of compliance. For example, if the individual mandate is declared unconstitutional without corresponding changes to other provisions of the Health Reform Legislation to protect against the risk of adverse selection (such as revisions to the guaranteed issue and renewal requirements, prohibition on pre-existing condition exclusions, and rating restrictions), our financial position and results of operations may be materially adversely affected.

Congress is also considering additional health care reform measures, and a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets. The effects of the Health Reform Legislation and recently adopted state laws, and the regulations that have been and will be promulgated thereunder, are difficult to predict, and we cannot predict whether any other federal or state proposals will ultimately become law. Such laws and rules could force us to materially change how we do business, restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, change the nature of our contracted network relationships, increase our medical and administrative costs and capital requirements, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business. In addition, our results of operations, our market share, our financial position, including our ability to maintain the value of our goodwill, and our cash flows could be materially adversely affected by such changes.

For additional information regarding the Health Reform Legislation, see Item 1, “Business — Government Regulation” and Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Executive Overview — Business Trends — Health Care Reforms.”

As a payer in various government health care programs, we are exposed to additional risks associated with program funding, enrollments, payment adjustments and audits that could adversely affect our revenues, cash flows and results of operations.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive revenues from these programs. These programs generally are subject to frequent changes, 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 medical costs under such programs. For example, in 2009, CMS implemented a reduction in Medicare Advantage reimbursements of approximately 5% for 2010, and as part of the Health Reform Legislation, Medicare Advantage payment rates for 2011 were frozen at 2010 levels. Separately, CMS implemented a reduction in Medicare Advantage reimbursements of 1.6% for 2011. Beginning in 2012, additional cuts to Medicare Advantage plans will take effect, with changes being phased-in over two to six years, depending on the level of payment reduction in a county.

Although we have adjusted members’ benefits and premiums on a selective basis, terminated benefit plans in certain counties, and intensified both our medical and operating cost management in response to these rate reductions, there can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage program. As part of the Health Reform Legislation, CMS has developed a system whereby plans that meet certain quality ratings will be entitled to various quality bonus payments, and there can be no assurance that our plans will meet these quality ratings. Our results of operations, financial position and cash flows could be materially adversely affected by funding reductions, or if our plans do not meet the requirements to receive quality bonus payments.

Our participation in the Medicare Advantage, Medicare Part D, and various Medicaid and CHIP programs occurs through bids that are submitted periodically. Revenues for these programs are dependent upon periodic funding from the federal government or applicable state governments and allocation of the funding through various

payment mechanisms. Funding for these government programs is dependent upon many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level, and general political issues and priorities. A reduction or less than expected increase in government funding for these programs or change in allocation methodologies may adversely affect our revenues and results of operations.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers. In 2008, CMS announced that it will perform risk adjustment data validation (RADV) audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. These audits may result in retrospective adjustments to payments made to health plans. In December 2010, CMS published for public comment a new proposed RADV audit and payment adjustment methodology. The proposed methodology contains provisions allowing retroactive contract level payment adjustments for the year audited using an extrapolation of the "error rate" identified in audit samples. Depending on the methodology utilized, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

In addition, we are in discussions with the Office of Inspector General for HHS regarding audits of our risk adjustment data for two local plans. We are unable to predict the outcome of these audits and discussions. However, any payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows. See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K for additional information regarding these audits.

In 2009, as part of ARRA and in an effort to relieve pressure resulting from state fiscal problems and rising Medicaid enrollments, Congress increased the Federal Medical Assistance Percentage (FMAP), temporarily increasing federal funding for state Medicaid programs. The enhanced FMAP was set to expire at the end of 2010. Federal legislation was passed in August 2010 that extended additional enhanced FMAP funding through June 2011. The ability of states to sustain their Medicaid programs may be adversely affected if Congress does not continue the enhanced FMAP beyond June 2011, which could result in a reduction of the scope of the programs, member disenrollment, rate reductions or other adverse actions.

Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a threshold, which is calculated by the government after our bids are submitted. If the enrollee premium is not below the government threshold, we risk losing the members who were auto-assigned to us and we will not have additional members auto-assigned to us. For example, we lost approximately 650,000 of our auto-enrolled low-income subsidy members in 2008 because certain of our bids exceeded thresholds set by the government. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Medicare program or other programs on which we bid, or our competitors submit bids that are more favorable than our bids, our results of operations could be materially affected.

If we fail to comply with requirements of privacy and security regulations, including taking steps to ensure that our third-party service providers who obtain access to sensitive personal information maintain its confidentiality and security, our reputation and business operations could be materially adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information by our businesses are regulated at the international, federal and state levels. These laws and rules are subject to change by legislation or administrative or judicial interpretation. Various state laws address the use and disclosure of sensitive personal information to the extent they are more restrictive than those contained in the

privacy and security provisions in the federal GLBA and in HIPAA. HIPAA now requires business associates as well as covered entities to comply with certain privacy and security requirements. See Item 1, "Business — Government Regulation" for a discussion of various federal and state privacy laws and regulations governing our businesses.

Even though we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we still have limited control over their actions and practices. Privacy and security requirements regarding sensitive personal information are also imposed on us through controls with our customers. In addition, despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems and those of our third-party service providers may be vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with new privacy and security laws, requirements, and new regulations, such as ARRA, will result in cost increases due to necessary systems changes (including further implementation of encryption and other data protection standards), new limitations or constraints on our business models, the development of new administrative processes, the effects of potential noncompliance by our third-party service providers, and increased enforcement actions and fines and penalties. They also may impose further restrictions on our collection, disclosure and use of sensitive personal information that is housed in one or more of our administrative databases. We are awaiting final HHS regulations for many key aspects of the ARRA amendments to HIPAA.

Noncompliance with any privacy or security laws and regulations or any security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our business, reputation and results of operations, including mandatory disclosure to the media, significant increase in the number and cost of managing and remediating data security incidents, increased enforcement actions, material fines and penalties, compensatory, special, punitive, and statutory damages, litigation, consent orders regarding our privacy and security practices, adverse actions against our licenses to do business, and injunctive relief.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our Prescription Solutions and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry that could adversely affect current industry practices, including the receipt or required disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices. See Item 1, "Business — Government Regulation" for a discussion of various federal and state laws and regulations governing our PBM businesses.

Our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or entering into certain prohibited transactions.

Prescription Solutions also conducts business as a mail order pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. The failure to adhere to these laws and regulations could expose Prescription Solutions to civil and criminal penalties. Further, Prescription Solutions is subject to the Payment Card Industry Data Security Standards, which is a multifaceted security standard that includes requirements for security management, policies, procedures, network architecture, software design and other critical protective measures to protect customer account data as mandated by the credit card brands. The failure to adhere to such standards could expose Prescription Solutions to liability or impact their ability to process credit card transactions.

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In addition, our PBM businesses would be adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order or specialty pharmacies due to failure of technology or any other failure or disruption to these systems or to the infrastructure due to fire, electrical outage, natural disaster, acts of terrorism or some other catastrophic event could reduce our ability to process and dispense prescriptions and provide products and services to customers.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which we operate. We compete with other companies on the basis of many factors, including price of benefits offered and cost and risk of alternatives, location and choice of health care providers, quality of customer service, comprehensiveness of coverage offered, reputation for quality care, financial stability and diversity of product offerings. For our Health Benefits reporting segment, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas or market segments such as Medicare specialty services. For our Prescription Solutions business, competitors include Medco Health Solutions, Inc., CVS/Caremark Corporation and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a broad and diverse set of other businesses.

In particular markets, competitors may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; existing business relationships; or other factors that give such competitors a competitive advantage. In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers (including hospitals, physician groups and other care professionals) in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or advance profitability. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect, if membership or demand for other services declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products, our business and results of operations could be materially adversely affected.

Adverse economic conditions could adversely affect our revenues and our results of operations.

Adverse economic conditions may continue to impact demand for certain of our products and services. For example, decreases in employment have caused and could continue to cause lower enrollment in our employer group plans, lower enrollment in our non-employer individual plans and a higher number of employees opting out of our employer group plans. Adverse economic conditions have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, adverse economic conditions could continue to negatively impact our employer group renewal prospects and our ability to increase premiums and could result in cancellation of products and services by our customers. All of these could lead to a decrease in our membership levels and premium and fee revenues and could adversely affect our results of operations. In addition, a prolonged adverse economic environment could negatively impact the financial position of hospitals and other care providers, which could adversely affect our contracted rates with these parties and increase our medical costs or adversely affect their ability to purchase our service offerings.

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During a prolonged adverse economic environment, state and federal budgets could be adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to payments already negotiated and/or received from the government and could adversely affect our revenues and results of operations. In addition, the state and federal budgetary pressures could cause the government to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and health maintenance organizations and surcharges on select fee-for-service and capitated medical claims, and could adversely affect our results of operations.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices and services. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices and services. Failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could adversely affect our business and results of operations.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be adversely affected.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the health care provider receives a fixed percentage of premium to cover all or a defined portion of the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the professional. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. There can be no assurance that health care providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have an adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, it is either not defined or it is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example, we are involved in litigation with out-of-network providers that is described in more detail in “Litigation Matters” in Note 13 of Notes to the Consolidated Financial Statements.

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The success of certain OptumHealth businesses depends on maintaining physician relationships. The primary care physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. If we are unable to maintain satisfactory relationships with primary care physicians, or to retain enrollees following the departure of a physician, our revenues and results of operations could be adversely affected.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Health Services businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could adversely affect our business and results of operations.

Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of independent third-party brokers, consultants and agents.

Our products are sold in part through independent brokers, consultants and agents who assist in the production and servicing of business. We typically do not have long-term contracts with our independent brokers, consultants and agents, who generally are not exclusive to us and who typically also recommend and/or market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be adversely affected if we are unable to attract or retain independent brokers, consultants and agents or if we do not adequately provide support, training and education to them regarding our product portfolio, or if our sales strategy is not appropriately aligned across distribution channels.

Because broker and agent commissions are included as health insurer administrative expenses under the medical loss ratio requirements of the Health Reform Legislation, these expenses will be under the same cost reduction pressures as other health insurer administrative costs. Our relationships with brokers and agents could be adversely impacted by changes in our businesses practices to address these pressures, including potential reductions in commissions and changes in the treatment of consulting fees.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling these companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practice, which could adversely impact our ability to market our products.

Our relationship with AARP is important and the loss of such relationship could have an adverse effect on our business and results of operations.

Under our agreements with AARP, we provide AARP-branded Medicare Supplement insurance, hospital indemnity insurance and other products to AARP members and Medicare Part D prescription drug plans to AARP members and non-members. One of our agreements with AARP expands the relationship to include AARP-branded Medicare Advantage plans for AARP members and non-members. Our agreements with AARP contain commitments regarding corporate governance, corporate social responsibility, diversity and measures intended to improve and simplify the health care experience for consumers. The AARP agreements may be terminated early under certain circumstances, including, depending on the agreement, a material breach by either party, insolvency of either party, a material adverse change in our financial condition, material changes in the Medicare programs, material harm to AARP caused by us, and by mutual agreement. The success of our AARP arrangements depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, meet our corporate governance, corporate social responsibility, and diversity commitments, and respond effectively to federal and state regulatory changes. The loss of our AARP relationship could have an adverse effect on our business and results of operations.

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Because of the nature of our business, we are routinely subject to various litigation actions, which, if resolved unfavorably, could result in substantial penalties and/or monetary damages and adversely affect our financial position, results of operations and cash flows.

Periodically, 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, medical malpractice, shareholder suits, and intellectual property-related litigation. In addition, because of the nature of our business, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. These matters include, among others, claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort, contract disputes and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups.

We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters; however, it is possible that the level of actual losses will exceed the liabilities recorded.

A description of significant legal actions in which we are currently involved is included in Note 13 of Notes to the Consolidated Financial Statements. We cannot predict the outcome of these actions with certainty, and we are incurring expenses in resolving these matters. Therefore, these legal actions could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

Our investment portfolio may suffer losses, which could materially adversely affect our results of operations.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2010. Relatively low interest rates on investments, such as those experienced during recent years, have negatively impacted our investment income, and a prolonged low interest rate environment could further adversely affect our investment income. In addition, defaults by issuers, primarily from investments in liquid corporate and municipal bonds, who fail to pay or perform on their obligations, could reduce our net investment income as we may be required to write down the value of our investments, which would adversely affect our profitability and shareholders' equity.

We also allocate a small proportion of our portfolio to equity investments, which are subject to greater volatility than fixed income investments. General economic conditions, stock market conditions, and many other factors beyond our control can adversely affect the value of our equity investments and may result in investment losses.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, illiquidity or otherwise, could have a negative effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have an adverse effect on our results of operations and the capital position of regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and debt ratings could be materially adversely affected.

Goodwill and other intangible assets were $25.7 billion as of December 31, 2010, representing 41% of our total assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the

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manner in or the extent to which the Health Reform Legislation is implemented may impact our ability to maintain the value of our goodwill and other intangible assets in our business. In addition, from time to time we divest businesses as part of our business strategy, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Large-scale medical emergencies may result in significant medical costs and may have a material adverse effect on our business, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. Such emergencies could materially and adversely affect the U.S. economy in general and the health care industry specifically. For example, in the event of a natural disaster, bioterrorism attack, pandemic or other extreme events, we could face, among other things, significant medical costs and increased use of health care services. Any such disaster or similar event could have a material adverse effect on our business, financial condition and results of operations.

If we fail to properly maintain the integrity or availability of our data or to strategically implement new or upgrade or consolidate existing information systems, or if our technology products do not operate as intended, our business could be materially adversely affected.

Our ability to adequately price our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to accurately report our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we have been consolidating and integrating the number of systems we operate and have upgraded and expanded our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, and changing customer patterns. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, have regulatory sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, protecting and enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially impact our business, financial condition and results of operations.

In addition, certain of our businesses sell and install hardware and software products, and these products may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could adversely affect our revenues and our results of operations.

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If we are not able to protect our proprietary rights to our databases and related products, our ability to market our knowledge and information-related businesses could be hindered and our business could be adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our revenues and results of operations could be adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by states' departments of insurance. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts. In addition, we normally notify the state departments of insurance prior to making payments that do not require approval. An inability of our regulated subsidiaries to pay dividends to their parent companies could impact the scale to which we could reinvest in our business through capital expenditures or business acquisitions, and could adversely affect our ability to maintain our corporate quarterly dividend payment cycle, repurchase of shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

Any failure by us to manage and complete acquisitions and other significant transactions successfully could harm our results of operations, business and prospects.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our results of operations could be adversely affected.

Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically and there can be no assurance that current credit ratings will be maintained in the

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future. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2010, we owned and/or leased real properties totaling approximately 15.7 million square feet to support our business operations in the United States and other countries. Our facilities are primarily located in the United States. Of this total, we owned approximately 1 million aggregate square feet of space and leased the remainder. Our leases expire at various dates through September 30, 2028. Our various reporting segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K, which is incorporated by reference in this report.

ITEM 4. (REMOVED AND RESERVED)

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PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On February 4, 2011, there were 17,563 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE were as follows:

	High	Low	Cash Dividends Declared
2011			
First quarter (through February 9, 2011)	$44.09	$36.37	$ 0.125
2010			
First quarter	$36.07	$30.97	$ 0.030
Second quarter	$34.00	$27.97	$ 0.125
Third quarter	$35.94	$27.13	$ 0.125
Fourth quarter	$38.06	$33.94	$ 0.125
2009			
First quarter	$30.25	$16.18	$ 0.030
Second quarter	$29.69	$19.85	$ 0.000
Third quarter	$30.00	$23.69	$ 0.000
Fourth quarter	$33.25	$23.50	$ 0.000

DIVIDEND POLICY

In May 2010, our Board of Directors increased our cash dividend to shareholders and moved us to a quarterly dividend payment cycle of $0.125 per share. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change. Prior to May 2010, our policy had been to pay an annual dividend of $0.030 per share.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2010

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
October 31, 2010	9,228,998(b)	$ 35.57	9,226,858	56,164,494
November 30, 2010	4,160,667	$ 36.05	4,160,667	52,003,827
December 31, 2010	4,049,602	$ 36.25	4,049,602	47,954,225
Total	17,439,267	$ 35.84	17,437,127	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In February 2010, the Board renewed and increased our share repurchase program and authorized us to repurchase up to 120 million shares of our common stock at prevailing market prices. There is no established expiration date for the program.

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(b) Represents 9,226,858 shares of our common stock repurchased during the period and 2,140 shares of our common stock withheld by us, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

PERFORMANCE GRAPHS

The following two performance graphs compare our total return to shareholders with indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain *Fortune 50* companies (the "*Fortune 50* Group"), for the five-year period ended December 31, 2010. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2010. We are not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2005 in our common stock and in each index, and that dividends were reinvested when paid.

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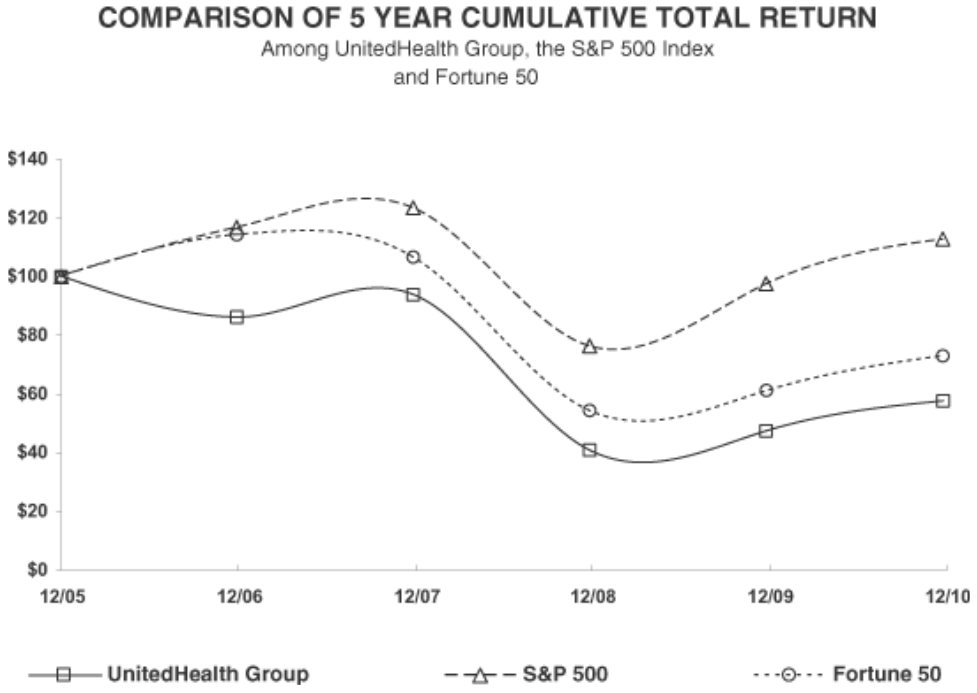
Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.



	12/05	12/06	12/07	12/08	12/09	12/10
UnitedHealth Group	**$100.00**	**$ 86.51**	**$ 93.76**	**$42.89**	**$49.22**	**$ 58.95**
S&P 500	**100.00**	**115.80**	**122.16**	**76.96**	**97.33**	**111.99**
Fortune 50 Group	**100.00**	**113.40**	**106.04**	**55.84**	**62.44**	**73.77**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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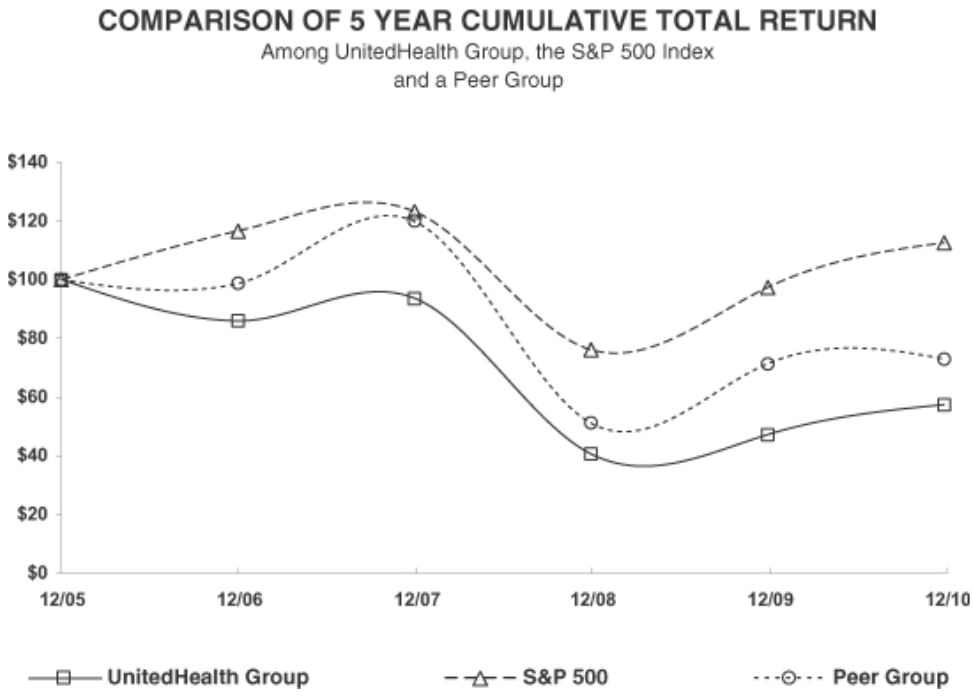
Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc. and WellPoint, Inc. We believe that this peer group reflects publicly traded peers to our Health Benefits businesses.



	12/05	12/06	12/07	12/08	12/09	12/10
UnitedHealth Group	$100.00	$ 86.51	$ 93.76	$42.89	$49.22	$ 58.95
S&P 500	100.00	115.80	122.16	76.96	97.33	111.99
Peer Group	100.00	98.73	119.11	53.10	72.33	73.98

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(in millions, except percentages and per share data)	For the Year Ended December 31, 2010	2009	2008	2007	2006
Consolidated operating results					
Revenues	$94,155	$87,138	$81,186	$75,431	$71,542
Earnings from operations	7,864	6,359	5,263	7,849	6,984
Net earnings	4,634	3,822	2,977	4,654	4,159
Return on shareholders' equity (a)	18.7%	17.3%	14.9%	22.4%	22.2%
Basic net earnings per common share	$ 4.14	$ 3.27	$ 2.45	$ 3.55	$ 3.09
Diluted net earnings per common share	4.10	3.24	2.40	3.42	2.97
Common stock dividends per share	0.405	0.030	0.030	0.030	0.030
Consolidated cash flows from (used for)					
Operating activities	$ 6,273	$ 5,625	$ 4,238	$ 5,877	$ 6,526
Investing activities	(5,339)	(976)	(5,072)	(4,147)	(2,101)
Financing activities	(1,611)	(2,275)	(605)	(3,185)	474
Consolidated financial condition					
(As of December 31)					
Cash and investments	$25,902	$24,350	$21,575	$22,286	$20,582
Total assets	63,063	59,045	55,815	50,899	48,320
Total commercial paper and long-term debt	11,142	11,173	12,794	11,009	7,456
Shareholders' equity	25,825	23,606	20,780	20,063	20,810
Debt-to-total-capital ratio	30.1%	32.1%	38.1%	35.4%	26.4%

(a) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

Financial Highlights should be read with the accompanying Management's Discussion and Analysis of Financial Condition and Results of Operations and Consolidated Financial Statements and Notes to the Consolidated Financial Statements.

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or PSLRA. 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. A description of some of the risks and uncertainties can be found in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company, whose focus is on improving the overall health and well-being of the people we serve and their communities and enhancing the performance of the health system. We work with health care professionals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost; support the physician/patient relationship; and empower people with the information, guidance and tools they need to make personal health choices and decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to help make health care work better. These core competencies are focused in two market areas, health benefits and health services. Health benefits are offered in the individual and employer markets and the public and senior markets through our UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & State businesses. Health services are provided to the participants in the health system itself, ranging from employers and health plans to physicians and life sciences companies through our OptumHealth, Ingenix and Prescription Solutions businesses. In aggregate, these businesses have more than two dozen distinct business units that address specific end markets. Each of these business units focuses on the key goals in health and well-being: access, affordability, quality and simplicity as they apply to their specific market.

Revenues

Our revenues are primarily comprised of premiums derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and we assume the economic risk of funding our customers' health care benefits and related administrative costs. We also generate revenues from fee-based services performed for customers that self-insure the health care costs of their employees and employees' dependants. For both risk-based and fee-based health care benefit arrangements, we provide coordination and facilitation of medical services; transaction processing; health care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. We also generate service revenues from Ingenix health intelligence and consulting businesses. Product revenues are mainly comprised of products sold by our Prescription Solutions pharmacy benefit management business and sales of Ingenix publishing and software products. We derive investment income primarily from interest earned on our investments in debt securities. Our investment income also includes gains or losses when the securities are sold, or other-than-temporarily impaired.

Operating Costs

Medical Costs. Our operating results depend in large part on our ability to effectively estimate, price for and manage our medical costs through underwriting criteria, product design, negotiation of favorable care provider

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contracts and care coordination programs. Controlling medical costs requires a comprehensive and integrated approach to organize and advance the full range of interrelationships among patients/consumers, health professionals, hospitals, pharmaceutical/technology manufacturers and other key stakeholders.

Medical costs include estimates of our obligations for medical care services rendered on behalf of insured consumers for which we neither have received nor processed claims, and our estimates for physician, hospital and other medical cost disputes. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Our medical care ratio, calculated as medical costs as a percentage of premium revenues, reflects the combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts. We seek to sustain a stable medical care ratio for an equivalent mix of business. However, changes in business mix, such as expanding participation in comparatively higher medical care ratio government-sponsored public sector programs and recently enacted Health Reform Legislation may impact our premiums, medical costs and medical care ratio.

In 2011, we expect consumer usage of the health system to increase, resuming its upward growth pattern from the recent moderation in utilization growth. We will work to manage medical cost trends through affordable network relationships, pay-for-performance reimbursement programs for care providers, and targeted clinical initiatives around improving quality and affordability. However, an increase in utilization will likely result in increased medical costs and an increase in our medical care ratio.

Operating Costs. Operating costs are primarily comprised of costs related to employee compensation and benefits, agent and broker commissions, premium taxes and assessments, professional fees, advertising and occupancy costs. We seek to improve our operating cost ratio, calculated as operating costs as a percentage of total revenues, for an equivalent mix of business. However, changes in business mix, such as increases in the size of our health services businesses may impact our operating costs and operating cost ratio.

Cash Flows

We generate cash primarily from premiums, service and product revenues and investment income, as well as proceeds from the sale or maturity of our investments. Our primary uses of cash are for payments of medical claims and operating costs, payments on debt, purchases of investments, acquisitions, dividends to shareholders and common stock repurchases. For more information on our cash flows, see “Liquidity” below.

2011 Business Realignment

On January 1, 2011, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. For example, in 2011 OptumHealth’s results of operations will include our clinical services assets, including Southwest Medical multi-specialty clinics in Nevada and our Evercare nurse practitioners serving the frail and elderly, which had historically been reported in UnitedHealthcare Employer & Individual and UnitedHealthcare Medicare & Retirement, respectively. UnitedHealthcare Employer & Individual’s results of operations will include OptumHealth Specialty Benefits, including dental, vision, life and disability. There were no changes to our reportable segments as a result of these changes. Our periodic filings beginning with our first quarter 2011 Form 10-Q will include historical segment results restated to reflect the effect of this realignment.

Business Trends

Our businesses participate in the U.S. health economy, which comprises approximately 18% of U.S. gross domestic product and which has grown consistently for many years. We expect overall spending on health care in

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the U.S. to continue to rise in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the U.S. population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms, which could also impact our results of operations.

Health Care Reforms. In the first quarter of 2010, the Health Reform Legislation was signed into law. The Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, the Medicaid and Medicare programs, CHIP and other aspects of the health care system. HHS, the DOL and the Treasury Department have issued regulations (or proposed regulations) on a number of aspects of Health Reform Legislation, but we await final rules and interim guidance on other key aspects of the legislation, all of which have a variety of effective dates.

We operate a diversified set of businesses that focus on health care, and our business model has been intentionally designed to address a multitude of market sectors. The Health Reform Legislation and the related federal and state regulations will impact how we do business and could restrict growth in certain products and market segments, restrict premium rate increases for certain products and market segments, increase our medical and administrative costs or expose us to an increased risk of liability, any or all of which could have a material adverse effect on us. We also anticipate that the Health Reform Legislation will further increase attention on the need for health care cost containment and improvements in quality, as well as in prevention, wellness and disease management. We believe demand for many of our service offerings, such as consulting services, data management, information technology and related infrastructure construction, disease management, and population-based health and wellness programs will continue to grow.

Beginning in 2011, health plans with medical loss ratios on fully insured products, as calculated under the definitions in the Health Reform Legislation and regulations, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for individuals) will be required to rebate ratable portions of their premiums to their customers annually. Rebate payments, if any, for 2011 would be made in mid 2012. The potential for and size of the rebates will be measured at the market level, by state and by licensed subsidiary. This disaggregation of insurance pools into much smaller pools will likely decrease the predictability of results for any given pool and could lead to variation over time in estimates of rebates owed in total. In the aggregate, the rebate regulations cap the level of margin that can be attained.

Depending on the results of the calculation, there is a broad range of potential rebate and other business impacts and there could be meaningful disruption in local health care markets if companies decide to adjust their offerings in response to these requirements. For example, companies could elect to change pricing, modify product features or benefits, adjust their mix of business or even exit segments of the market. Companies could also seek to adjust their operating costs to support reduced premiums by making changes to their distribution arrangements or decreasing spending on non-medical product features and services. Companies continue to face a significant amount of uncertainty given the breadth of possible changes, including changes in the competitive environment, state rate approval, fluctuations in medical costs, the statistical variation that results from assessing business by state, by license and by market and the potential for meaningful market disruption in 2011 and 2012. We have made changes to reduce our product distribution costs in the individual market in response to this legislation, including reducing broker commissions, and are evaluating changes to distribution in the large group insured market segment. These changes could impact future growth in these products. Other market participants could also implement changes to their business practices in response to this legislation, which could positively or negatively impact our growth and market share.

The Health Reform Legislation also requires HHS to maintain an annual review of "unreasonable" increases in premium rates for commercial health plans. HHS recently proposed a regulation that defines a review threshold of annual premium rate increases generally at or above 10%, and the proposed rule clarifies that the HHS review will not supersede existing state review and approval processes. The proposed regulation further requires health plans to provide to the states and HHS extensive information supporting any rate increase of 10% or more. The

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Federal government is encouraging states to intensify their reviews of requests for rate increases and providing funding to assist in those state-level reviews. Ultimately, rate approval responsibility still lies with the states under the proposed regulation. Depending on the level of anticipated increased scrutiny by the states, there is a broad range of potential business impacts. For example, it may become more difficult to price our commercial risk business consistent with expected underlying cost trends, leading to the risk of operating margin compression.

Effective in 2011, the Health Reform Legislation mandates consumer discounts of 50% on brand name prescription drugs and 7% on generic prescription drugs for Part D plan participants in the coverage gap. This statutory reduction in drug prices for seniors in the coverage gap may cause people who may have had difficulty affording their medications to increase their pharmaceutical usage. The change in pricing could also have secondary effects, such as changing the mix of brand name and generic drug usage by seniors. We have incorporated the anticipated impact of these changes in our 2011 product pricing and pharmacy benefit management business plan.

As part of the Health Reform Legislation, Medicare Advantage payment rates for 2011 were frozen at 2010 levels. Separately, CMS implemented a reduction in Medicare Advantage reimbursements of 1.6% for 2011. We expect the 2011 rates will be outpaced by underlying medical trends, placing continued importance on effective medical management and ongoing improvements in administrative costs. Beginning in 2012, additional cuts to Medicare Advantage plans will take effect (plans will ultimately receive 95% of Medicare fee-for-service rates in high cost areas to 115% in low cost areas), with changes being phased-in over two to six years, depending on the level of payment reduction in a county. All of these changes could result in reduced enrollment or reimbursement or payment levels. There are a number of annual adjustments we can make to our operations, which may partially offset any impact from these rate reductions. For example, we can adjust members' benefits, decide on a county-by-county basis which geographies to participate in and seek to intensify our medical and operating cost management. Additionally, achieving high quality scores from CMS for improving upon certain clinical and operational performance standards will impact future quality bonuses. Quality bonus payments may further offset these anticipated rate reductions as CMS quality rating bonus payments are phased in over three years beginning in 2012. We also may be able to mitigate the effects of reduced funding on margins by increasing enrollment due to the anticipated increase in the number of people eligible for Medicare in coming years. Longer term, market wide decreases in the availability or relative quality of Medicare Advantage products may increase demand for other senior health benefits products such as our Medicare Part D and Medicare Supplement insurance offerings.

The Health Reform Legislation presents additional opportunities and challenges over the longer term, including the assessment of an annual $8 billion insurance industry assessment beginning in 2014, the operation of state-based exchanges for individuals and small businesses beginning in 2014, and numerous other commercial and governmental plan requirements. Individual states may also accelerate their procurement of Medicaid managed care services for sizeable groups of Medicaid program beneficiaries in order to even their administrative workloads when Medicaid market expansions take place in 2014. The law could increase near-term business growth opportunities for UnitedHealthcare Community & State. Due to the complexity of the health care system and the numerous changes that are taking place, the longer term effect of the new legislation remains difficult to assess.

Court proceedings related to the Health Reform Legislation, such as the ruling by the United States District Court for the Northern District of Florida (in a case brought on behalf of 26 state attorneys general and/or governors) that declared the entire legislation unconstitutional, and the potential for Congressional action to impede implementation, create additional uncertainties with respect to the law. For additional information regarding the Health Reform Legislation and the related risk factors, see Item 1, "Business — Government Regulation" and Item 1A, "Risk Factors."

Adverse Economic Conditions. The current U.S. economic environment has impacted demand for some of our products and services. For example, decreases in employment have reduced the number of workers and dependants offered health care benefits by our customers, and have put pressure on our overall growth and

operating profitability. If the current economic environment continues for a prolonged period, federal and state governments may decrease funding for various health care government programs in which we participate and/or impose new or higher levels of taxes or assessments. Government funding pressure, coupled with adverse economic conditions, will impact the financial positions of hospitals, physicians and other care providers and could therefore increase medical cost trends experienced by our businesses. Our revenues are also impacted by U.S. monetary and fiscal policy. In response to current economic conditions, the U.S. Federal Reserve has maintained the target federal funds rate at a range of zero to 25 basis points. For additional discussions regarding how the adverse economic conditions could affect our business, see Item 1A, "Risk Factors" in Part I.

RESULTS SUMMARY

(in millions, except percentages and per share data)	2010	2009	2008	Change 2010 vs. 2009		Change 2009 vs. 2008	
Revenues:							
Premiums	$85,405	$79,315	$73,608	$6,090	8 %	$5,707	8 %
Services	5,819	5,306	5,152	513	10	154	3
Products	2,322	1,925	1,655	397	21	270	16
Investment and other income	609	592	771	17	3	(179)	(23)
Total revenues	94,155	87,138	81,186	7,017	8	5,952	7
Operating costs:							
Medical costs	68,841	65,289	60,359	3,552	5	4,930	8
Operating costs	14,270	12,734	13,103	1,536	12	(369)	(3)
Cost of products sold	2,116	1,765	1,480	351	20	285	19
Depreciation and amortization	1,064	991	981	73	7	10	1
Total operating costs	86,291	80,779	75,923	5,512	7	4,856	6
Earnings from operations	7,864	6,359	5,263	1,505	24	1,096	21
Interest expense	(481)	(551)	(639)	(70)	(13)	(88)	(14)
Earnings before income taxes	7,383	5,808	4,624	1,575	27	1,184	26
Provision for income taxes	(2,749)	(1,986)	(1,647)	763	38	339	21
Net earnings	$ 4,634	$ 3,822	$ 2,977	$ 812	21 %	$ 845	28 %
Diluted net earnings per common share	$ 4.10	$ 3.24	$ 2.40	$ 0.86	27 %	$ 0.84	35 %
Medical care ratio	80.6 %	82.3 %	82.0 %		(1.7)%		0.3 %
Operating cost ratio	15.2	14.6	16.1		0.6		(1.5)
Operating margin	8.4	7.3	6.5		1.1		0.8
Tax rate	37.2	34.2	35.6		3.0		(1.4)
Net margin	4.9	4.4	3.7		0.5		0.7
Return on equity (a)	18.7 %	17.3 %	14.9 %		1.4 %		2.4 %

(a) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

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2010 RESULTS OF OPERATIONS COMPARED TO 2009 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues for 2010 were primarily due to strong organic growth in risk-based benefit offerings in our public and senior markets businesses and commercial premium rate increases reflecting underlying medical cost trends. Growth in customers served by our health services businesses, particularly through pharmaceutical benefit management programs, increased revenues from public sector behavioral health programs and increased sales of health care technology software and services also contributed to our revenue growth.

Medical Costs and Medical Care Ratio

Medical costs for 2010 increased primarily due to growth in our public and senior markets risk-based businesses and medical cost inflation, which were partially offset by net favorable development of prior period medical costs.

For 2010 and 2009, there was $800 million and $310 million, respectively, of net favorable medical cost development related to prior fiscal years. The favorable development in 2010 was primarily driven by lower than expected health system utilization levels; more efficient claims handling and processing, which results in higher completion factors; a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

The medical care ratio decreased due to a moderation in overall demand for medical services, successful clinical engagement and management and the increase in prior period favorable development discussed previously.

Operating Costs

Operating costs for 2010 increased due to acquired and organic growth in health services businesses, which are generally more operating cost intensive than our benefits businesses, goodwill impairment and charges for a business line disposition at Ingenix, which is discussed in more detail below, an increase in staffing and selling expenses primarily due to the change in the Medicare Advantage annual enrollment period, costs related to increased employee headcount and compensation, increased advertising costs, and the absorption of new business development and start-up costs.

Income Tax Rate

The increase in our effective income tax rate for 2010 as compared to 2009 resulted from a benefit in the 2009 tax rate from the resolution of various historical state income tax matters and an increase in the 2010 rate related to limitations on the future deductibility of certain compensation related to the Health Reform Legislation.

Reporting Segments

We have four reporting segments:

- Health Benefits, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & State;
- OptumHealth;
- Ingenix; and
- Prescription Solutions.

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See Note 14 of Notes to the Consolidated Financial Statements for a description of the types and services from which each of these reporting segments derives its revenues.

Transactions between reporting segments principally consist of sales of pharmacy benefit products and services to Health Benefits customers by Prescription Solutions, certain product offerings sold to Health Benefits customers by OptumHealth, and medical benefits cost, quality and utilization data and predictive modeling sold to Health Benefits by Ingenix. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation.

The following summarizes the operating results of our reporting segments:

(in millions, except percentages)	2010	2009	2008	Change 2010 vs. 2009		Change 2009 vs. 2008	
Revenues							
Health Benefits	$ 87,442	$ 81,341	$ 75,857	$ 6,101	8 %	$ 5,484	7 %
OptumHealth	5,849	5,528	5,225	321	6	303	6
Ingenix	2,341	1,823	1,552	518	28	271	17
Prescription Solutions	16,776	14,452	12,573	2,324	16	1,879	15
Eliminations	(18,253)	(16,006)	(14,021)	(2,247)	nm	(1,985)	nm
Consolidated revenues	$ 94,155	$ 87,138	$ 81,186	$ 7,017	8 %	$ 5,952	7 %
Earnings from operations							
Health Benefits	$ 6,636	$ 4,788	$ 5,068	$ 1,848	39 %	$ (280)	(6)%
OptumHealth	610	636	718	(26)	(4)	(82)	(11)
Ingenix	84	246	229	(162)	(66)	17	7
Prescription Solutions	534	689	363	(155)	(22)	326	90
Corporate	0	0	(1,115)	0	nm	1,115	nm
Consolidated earnings from operations	$ 7,864	$ 6,359	$ 5,263	$ 1,505	24 %	$ 1,096	21 %
Operating margin							
Health Benefits	7.6 %	5.9 %	6.7 %		1.7 %		(0.8)%
OptumHealth	10.4	11.5	13.7		(1.1)		(2.2)
Ingenix	3.6	13.5	14.8		(9.9)		(1.3)
Prescription Solutions	3.2	4.8	2.9		(1.6)		1.9
Consolidated operating margin	8.4 %	7.3 %	6.5 %		1.1 %		0.8 %

nm = not meaningful

The following summarizes the number of individuals served by our Health Benefits businesses, by major market segment and funding arrangement, at December 31:

(in thousands, except percentages)	2010	2009	2008	Change 2010 vs. 2009		Change 2009 vs. 2008	
Commercial risk-based	9,405	9,415	10,360	(10)	(0)%	(945)	(9)%
Commercial fee-based	15,405	15,210	15,985	195	1	(775)	(5)
Total commercial	24,810	24,625	26,345	185	1	(1,720)	(7)
Medicare Advantage	2,070	1,790	1,495	280	16	295	20
Medicaid	3,320	2,900	2,515	420	14	385	15
Standardized Medicare supplement	2,770	2,680	2,540	90	3	140	6
Total public and senior	8,160	7,370	6,550	790	11	820	13
Total Health Benefits – medical	32,970	31,995	32,895	975	3	(900)	(3)
Medicare Part D stand-alone	4,530	4,300	4,060	230	5	240	6
Total Health Benefits	37,500	36,295	36,955	1,205	3 %	(660)	(2)%

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Health Benefits

The revenue growth in Health Benefits for 2010 was primarily due to growth in the number of individuals served by our public and senior markets businesses and commercial premium rate increases reflecting underlying medical cost trends, partially offset by Medicare Advantage premium rate decreases. In 2010, revenues were $41.2 billion for UnitedHealthcare Employer & Individual; $35.9 billion for UnitedHealthcare Medicare & Retirement; and $10.4 billion for UnitedHealthcare Community & State. In 2009, revenues were $40.8 billion for UnitedHealthcare Employer & Individual; $32.1 billion for UnitedHealthcare Medicare & Retirement; and $8.4 billion for UnitedHealthcare Community & State.

Health Benefits earnings from operations and operating margins for 2010 increased over the prior year due to factors that increased revenues described above, continued cost management disciplines on behalf of our commercial and governmental customers, a general moderation in year-over-year growth in demand for medical services and the effect of increased net favorable development in prior period medical costs.

OptumHealth

Increased revenues in OptumHealth for 2010 were driven by new business development in large scale public sector programs and increased sales of benefits and services to external employer markets, partially offset by a loss of some smaller specialty benefits customers.

The operating margin for 2010 decreased due to growth in lower margin public sector business, new market development and startup costs and costs related to the implementation of the Mental Health Parity Act.

Ingenix

Increased revenues in Ingenix for 2010 were primarily due to the impact of acquisitions and growth in health information technology offerings and services focused on cost and data management and regulatory compliance.

The decrease in operating margin for 2010 was primarily due to a goodwill impairment and charges for a business line disposition of certain i3-branded clinical trial service businesses. In addition, increases in the mix of lower margin business, continued margin pressure in the pharmaceutical services business and continued investments in new growth areas also contributed to the decrease in operating margin in 2010. See Note 6 of Notes to the Consolidated Financial Statements for further detail on the goodwill impairment.

Prescription Solutions

The increased Prescription Solutions revenues for 2010 were primarily due to growth in customers served through Medicare Part D prescription drug plans by our UnitedHealthcare Medicare & Retirement business and higher prescription volumes. Intersegment revenues eliminated in consolidation were $14.5 billion and $12.6 billion for 2010 and 2009, respectively.

Prescription Solutions operating margin for 2010 decreased due to changes in performance-based pricing contracts with Medicare Part D plan sponsors, which were partially offset by prescription volume growth, increased usage of mail service and generic drugs by consumers and effective operating cost management.

2009 RESULTS OF OPERATIONS COMPARED TO 2008 RESULTS

Consolidated Financial Results

Revenues

Consolidated revenues for 2009 increased primarily due to the increase in premium revenues in the Health Benefits reporting segment. The increase in premium revenues was primarily due to strong organic growth in

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risk-based offerings in our public and senior markets businesses and premium rate increases in response to growth in underlying medical costs, partially offset by a decline in the number of people served in the commercial market. The effect of 2008 Health Benefits acquisitions also contributed to the increase in premium revenues during 2009.

Medical Costs

Medical costs for 2009 increased primarily due to growth in public and senior markets risk-based businesses, elevated medical costs due to the H1N1 influenza virus, unemployment-related benefit continuation programs due to an increased level of national unemployment, medical cost inflation and increased utilization of medical services.

For 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 periods, resulting from more complete claim information identified in the current period, are included in total medical costs reported for the current period. For 2009 and 2008, medical costs included $310 million and $230 million, respectively, of net favorable medical cost development related to prior fiscal years.

Operating Costs

Operating costs for 2009 decreased due to certain expenses incurred in 2008 as discussed below and disciplined operating cost management, which were partially offset by increased costs due to acquired and organic business growth and from an increase in state insurance assessments levied against premiums, a portion of which was in lieu of state income taxes in one of the states in which we operate.

Operating costs for 2008 included $882 million for settlement of two class action lawsuits related to our historical stock option practices and related legal costs, $350 million for the settlement of class action litigation related to reimbursement for out-of-network medical services, $50 million related to estimated costs to conclude a legal matter and $46 million for employee severance related to operating cost reduction initiatives and other items, partially offset by a $185 million reduction in operating costs for proceeds from the sale of certain assets and membership in the individual Medicare Advantage business in Nevada in May 2008.

Income Tax Rate

Our income tax rate for 2009 decreased primarily due to the favorable resolution of various historical state income tax matters and the change to a premium tax in lieu of an income tax in one of the states in which we operate, which increased operating costs and decreased income taxes.

Reporting Segments

Health Benefits

Revenue growth in Health Benefits for 2009 was primarily due to growth in the number of individuals served by our public and senior markets businesses and premium rate increases, partially offset by a decline in individuals served through commercial products and a decrease in investment and other income driven by lower short-term investment yields. 2009 revenues were $40.8 billion for UnitedHealthcare Employer & Individual; $32.1 billion for UnitedHealthcare Medicare & Retirement; and $8.4 billion for UnitedHealthcare Community & State. 2008 revenues were $41.8 billion for UnitedHealthcare Employer & Individual; $28.1 billion for UnitedHealthcare Medicare & Retirement; and $6.0 billion for UnitedHealthcare Community & State.

The decrease in Health Benefits earnings from operations for 2009 was primarily due to a $166 million reduction in investment and other income and a decrease in commercial business, partially offset by the growth in lower margin public and senior markets businesses. Health Benefits' operating margins decreased due to the factors that decreased earnings from operations.

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OptumHealth

Increased OptumHealth revenues for 2009 were primarily driven by new business development in large-scale public sector care and behavioral health programs for state clients, which were partially offset by a decline in individuals served through commercial products.

Earnings from operations and operating margins for 2009 decreased due to the decrease in commercial membership described above, start-up costs for new large contracts and lower investment income, partially offset by earnings growth from expanding services in the public sector and disciplined operating cost management.

Ingenix

Improvements in Ingenix revenues and earnings from operations for 2009 were primarily due to the impact of improved performance in the payer business, new internal service offerings and the effect of 2009 acquisitions. The decreases in operating margins for 2009 were primarily due to investments in services offerings, including outsourcing services for pharmaceutical customers and costs for international expansion, hospital revenue cycle management and data privacy and security.

Prescription Solutions

The increased Prescription Solutions revenues for 2009 were primarily due to growth in customers served through Medicare Part D prescription drug plans by our UnitedHealthcare Medicare & Retirement business, which is the largest customer of this reporting segment. Intersegment revenues eliminated in consolidation were $12.6 billion and $11.0 billion for 2009 and 2008, respectively.

Prescription Solutions earnings from operations for 2009 increased primarily due to prescription volume growth, strong success under performance-based purchasing arrangements, gains in mail service drug fulfillment and a continuing favorable mix shift to generic pharmaceuticals.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short- and long-term obligations of our businesses while maintaining liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before non-cash expenses. The risk of decreased operating cash flow from a decline in earnings is partially mitigated by the diversity of our businesses, geographies and customers; our disciplined underwriting and pricing processes for our risk-based businesses; and continued productivity improvements in our operating costs.

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 exceeds our expected short-term obligations in longer term, liquid, investment-grade, debt securities to improve our overall investment return. We make these investments pursuant to our Board of Directors' approved investment policy, which focuses on preservation of capital, credit quality, diversification, income and duration. The policy also generally governs return objectives, regulatory limitations, tax implications and risk tolerances.

Our regulated subsidiaries are subject to regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the 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. Except in

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the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2010, based on the 2009 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends which could be paid was $3.2 billion. For the year ended December 31, 2010, our regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $686 million of extraordinary dividends. For the year ended December 31, 2009, our regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $2.5 billion of extraordinary dividends. The total dividends received in both 2010 and 2009 included all of the ordinary dividend capacity of $3.2 billion and $3.1 billion, respectively. In some cases, ordinary dividends were classified as extraordinary dividends due to their increased size and/or accelerated timing.

Our non-regulated businesses also generate cash flows from operations for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of commercial paper and long-term debt, as well as the availability of our committed credit facility, further strengthen our operating and financial flexibility. We generally use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, or return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Results

A summary of our major sources and uses of cash is reflected in the table below:

	Year Ended December 31,		
(in millions)	2010	2009	2008
Sources of cash:			
Cash provided by operating activities	$ 6,273	$ 5,625	$ 4,238
Sales of investments	2,593	4,040	5,568
Maturities of investments	3,105	2,675	3,030
Proceeds from customer funds administered	974	204	0
Proceeds from issuance of commercial paper, net	930	0	0
Proceeds from issuance of long-term debt	747	0	2,981
Interest rate swap termination	0	513	0
Other	299	342	1,770
Total sources of cash	14,921	13,399	17,587
Uses of cash:			
Purchases of investments	(7,855)	(6,466)	(9,251)
Cash paid for acquisitions, net of cash assumed and disposition	(2,304)	(486)	(3,813)
Retirement of long-term debt	(1,583)	(1,350)	(500)
Common stock repurchases	(2,517)	(1,801)	(2,684)
Purchases of property, equipment and capitalized software	(878)	(739)	(791)
Dividends paid	(449)	(36)	(37)
Repayments of commercial paper, net	0	(99)	(1,346)
Other	(12)	(48)	(604)
Total uses of cash	(15,598)	(11,025)	(19,026)
Net (decrease) increase in cash	$ (677)	$ 2,374	$ (1,439)

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2010 Cash Flows Compared to 2009 Cash Flows

Cash flows from operating activities increased $648 million, or 12%, for 2010. Factors that increased cash flows from operating activities were growth in net earnings, an acceleration of certain 2011 premium payments, and an increase in pharmacy rebate collections which were partially offset by a mandated acceleration in the claim payment cycle associated with the Medicare Part D program and payment for the settlement of the American Medical Association class action litigation related to reimbursement for out-of-network medical services. We anticipate lower cash flows from operations in 2011 as compared to 2010 as a result of an anticipated decrease in net earnings and the early receipt of certain 2011 premium payments in late 2010.

Cash flows used for investing activities increased $4.4 billion, primarily due to acquisitions completed in 2010, decreases in sales of investments due to a more stable market environment and uses of operating cash to purchase investments.

Cash flows used for financing activities decreased $664 million, or 29%, primarily due to proceeds from the issuance of commercial paper and long-term debt partially offset by increases in common stock repurchases and cash dividends paid on our common stock.

2009 Cash Flows Compared To 2008 Cash Flows

Cash flows from operating activities increased $1.4 billion, or 33%, primarily due to the payment in 2008 of $573 million, net of taxes, for the settlement of two class action lawsuits related to our historical stock option practices, the 2009 increase in medical costs payable driven by membership growth in risk-based products in the public and senior markets businesses, and the effect of changes to our receivable and payable balances with CMS related to Medicare Part D. Additionally, we paid less taxes in 2009 due to tax law changes that took effect in 2008. Operating cash flows in 2008 included payment of 2007 taxes due under the prior tax law, while the 2009 payment did not include prior year amounts.

Cash flows used for investing activities decreased $4.1 billion, or 81%, primarily due to acquisitions completed in 2008 and decreases in the usage of cash in 2009 for purchases of investments, which more than offset the 2009 decreases in sales and maturities of investments.

Cash flows used for financing activities increased $1.7 billion due to the issuance of long-term debt in 2008 and the effect of our change in intent with respect to offsetting cash balances in excess of bank deposits in 2008. These items were partially offset by decreases in common stock repurchases in 2009 and the 2009 proceeds from our terminated interest rate swap contracts.

Financial Condition

As of December 31, 2010, our cash, cash equivalent and available-for-sale investment balances of $25.7 billion included $9.1 billion of cash and cash equivalents (of which $974 million was held by non-regulated entities), $16.1 billion of debt securities and $516 million of investments in equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity. The use of different market assumptions or valuation methodologies, primarily used in valuing our Level 3 equity securities, may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our $2.5 billion bank credit facility, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements for further detail of our fair value measurements.

Our cash equivalent and investment portfolio has a weighted-average duration of 2.2 years and a weighted-average credit rating of “AA” as of December 31, 2010. Included in the debt securities balance are $2.7 billion of

state and municipal obligations that are guaranteed by a number of third parties. We do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of these securities both with and without the guarantee is "AA" as of December 31, 2010.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a commercial paper program, which facilitates the issuance of senior unsecured debt through third-party broker-dealers. The commercial paper program is supported by the $2.5 billion bank credit facility described below. We had $930 million of commercial paper outstanding as of December 31, 2010. Our issuance of commercial paper in 2010 was to maintain ample liquidity at the holding company level.

Bank Credit Facility. We have a $2.5 billion five-year revolving bank credit facility with 23 banks, which matures in May 2012. This facility supports our commercial paper program and is available for general corporate purposes. We had no amounts outstanding under this facility as of December 31, 2010. The interest rate is variable based on term and amount and is calculated based on LIBOR plus a spread. As of December 31, 2010, the annual interest rate on this facility, had it been drawn, would have ranged from 0.5% to 0.7%.

Our bank credit facility contains various covenants, including requiring us to maintain a debt-to-total-capital ratio below 50%. Our debt-to-total-capital ratio, calculated as debt divided by the sum of debt and shareholders' equity, was 30.1% and 32.1% as of December 31, 2010 and 2009, respectively. We were in compliance with our debt covenants as of December 31, 2010.

Debt Issuance. In October 2010, we issued $750 million in senior unsecured notes under our February 2008 S-3 shelf registration statement. The issuance included $450 million of 3.875% fixed-rate notes due October 2020 and $300 million of 5.700% fixed-rate notes due October 2040. We intend to use the proceeds for general corporate purposes.

Credit Ratings. Our credit ratings at December 31, 2010 were as follows:

	Moody's		Standard & Poor's		Fitch (a)		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	Baa1	Stable	A-	Stable	A-	Negative	bbb+	Stable
Commercial paper	P-2	n/a	A-2	n/a	F1	n/a	AMB-2	n/a

(a) On January 12, 2011, Fitch updated their ratings outlook on our senior unsecured debt to "stable".

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have therefore adopted strategies and actions to maintain financial flexibility and mitigate the impact of such factors on our ability to raise capital.

Share Repurchases. Under our Board of Directors' authorization, we maintain a common share repurchase program. Repurchases may be made from time to time at prevailing prices in the open market, subject to certain preset parameters. In February 2010, the Board renewed and increased our share repurchase program, and authorized us to repurchase up to 120 million shares of our common stock. In 2010, we repurchased 76 million shares at an average price of approximately $33 per share and an aggregate cost of $2.5 billion. As of December 31, 2010, we had Board authorization to purchase up to an additional 48 million shares of our common stock.

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Debt Tender. In February 2010, we completed cash tender offers for $775 million aggregate principal amount of certain of our outstanding notes. We believe this debt repurchase will improve the matching of floating rate assets and liabilities on our balance sheet and reduce our debt service cost. We used cash on hand to fund the purchase of the notes.

Dividends. In May 2010, our Board of Directors increased our cash dividend to shareholders and moved us to a quarterly dividend payment cycle. Declaration and payment of future quarterly dividends are at the discretion of the Board and may be adjusted as business needs or market conditions change. Prior to May 2010, our policy had been to pay an annual dividend.

The following table provides details of our dividend payments:

Year	Aggregate Amount per Share	Total Amount Paid (in millions)
2008	$ 0.030	$ 37
2009	0.030	36
2010	0.405	449

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2010, under our various contractual obligations and commitments:

(in millions)	2011	2012 to 2013	2014 to 2015	Thereafter	Total
Debt (a)	$3,008	$ 2,228	$ 1,780	$ 11,360	$18,376
Operating leases	259	431	285	579	1,554
Purchase obligations (b)	264	114	5	1	384
Future policy benefits (c)	126	356	380	1,625	2,487
Unrecognized tax benefits (d)	20	0	0	147	167
Other liabilities recorded on the Consolidated Balance Sheet (e)	364	100	0	2,268	2,732
Other obligations (f)	76	88	72	12	248
Total contractual obligations	$4,117	$ 3,317	$ 2,522	$ 15,992	$25,948

(a) Includes interest coupon payments and maturities at par or put values. Coupon payments have been calculated using stated rates from the debt agreements and assuming amounts are outstanding through their contractual term. For variable-rate obligations, we used the rates in place as of December 31, 2010 to estimate all remaining contractual payments. See Note 8 of Notes to the Consolidated Financial Statements for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2010.

(c) Estimated payments required under life and annuity contracts and health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica, but we remain liable to the policyholders if they are unable to pay. We have recorded a corresponding reinsurance receivable from OneAmerica in our Consolidated Financial Statements.

(d) Since the timing of future settlements is uncertain, the long-term portion has been classified as “Thereafter.”

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(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, charitable contributions related to the PacifiCare acquisition, interest rate swaps and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as “Thereafter”.
(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

We do not have other significant contractual obligations 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.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2010, we were not involved in any off-balance sheet arrangements (as that phrase is defined by SEC rules applicable to this report) which have or are reasonably likely to have a material adverse effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

We have determined that there have been no recently issued accounting standards that will have a material impact on our Consolidated Financial Statements, or apply to our operations.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

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, health care professional 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 professional and type of service, the typical billing lag for services can be up to 90 days from the 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 liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement actions.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust 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). Medical costs in 2010, 2009 and 2008, included net favorable medical cost development related to prior periods of $800 million, $310 million and $230 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. This approach is consistently applied from period to period.

Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2010:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs Payable (in millions)
(0.75)%	$ 186
(0.50)	124
(0.25)	62
0.25	(61)
0.50	(122)
0.75	(183)

Medical cost PMPM trend factors are the most significant factors we use in developing our medical costs payable estimates for the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2010:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs Payable (in millions)
3%	$ 366
2	244
1	122
(1)	(122)
(2)	(244)
(3)	(366)

The analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2010, developed using consistently applied actuarial methods. Management believes

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the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2010; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our December 31, 2010 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance, 2010 net earnings would increase or decrease by $51 million and diluted net earnings per common share would increase or decrease by $0.05 per share.

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 coordinating care with physicians and other health care professionals and rate discounts from physicians and other health care professionals. Through contracts with physicians and other health care professionals, 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 professionals 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.

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 period 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. Beginning in 2011, premium revenue subject to the medical loss ratio rebates of the Health Reform Legislation will be recognized based on the estimated premium earned net of the projected rebates over the period of the contract, if that amount can be reasonably estimated. The estimated premium will be revised each period to reflect current experience. We revise estimates of revenue adjustments each period and record changes in the period they become known.

CMS deploys a risk adjustment model, which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. We and other health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of our plans is subject to audit by regulators. See Note 13 of Notes to the Consolidated Financial Statements in this Form 10-K for additional information regarding these audits.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. To determine whether

goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows. To determine fair values we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Where available and appropriate, comparative market multiples are used to corroborate the results of our discounted cash flow test.

We completed our annual assessment of goodwill as of January 1, 2011, which considered our business realignment, and determined that other than the $172 million impairment related to certain of Ingenix's businesses, no goodwill impairment existed as of December 31, 2010. Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, there is uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, "Business — Government Regulation". For additional discussions regarding how the enactment or implementation of health care reforms could affect our business, see Item 1A, "Risk Factors" in Part I.

Intangible assets. Finite lived intangible assets are acquired in a business combination and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts and trademarks). We do not have material holdings of indefinite lived intangible assets. Intangible assets are amortized over their expected useful lives and are subject to impairment tests when events or circumstances indicate that a finite lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. If the carrying value exceeds its estimated fair value, an impairment would be recorded.

We calculate the estimated fair value of finite lived intangible assets using undiscounted cash flows that are expected to result from the use of the intangible asset or group of assets. We consider many factors, including estimated future utility to estimate cash flows. There were no material impairments of finite lived intangible assets during the current year.

Investments

As of December 31, 2010, we had investments with a carrying value of $16.8 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from earnings and report net unrealized gains or losses, 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, 2010, our investments had gross unrealized gains of $527 million and gross unrealized losses of $81 million. We evaluate investments for impairment considering the length of time and extent to which market value has been less than cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and our intent to sell the security or the likelihood that we will be required to sell the

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security before recovery of the entire amortized cost. For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income. For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in net earnings. New information and the passage of time can change these judgments. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements. Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes.

We have established a net valuation allowance against certain deferred tax assets for which the ultimate realization of future benefits is uncertain. After application of the valuation allowances, we anticipate that no limitations will apply with respect to utilization of any of the other net deferred income tax assets. We believe that our estimates for the valuation allowances against deferred tax assets and tax contingency reserves are appropriate based on current facts and circumstances.

According to U.S. Generally Accepted Accounting Principles (GAAP), a tax benefit from an uncertain tax position may be recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits.

We have established an estimated liability for federal, state and non-U.S. income tax exposures that arise and meet the criteria for accrual under U.S. GAAP. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax contingencies due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2010 earnings before income taxes would have caused the provision for income taxes to change by $74 million.

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, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters. It is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions.

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LEGAL MATTERS

A description of our legal proceedings is included in Note 13 of Notes to the Consolidated Financial Statements and is incorporated by reference in this report.

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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, 2010, we had an aggregate $2.0 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as "A." As of December 31, 2010, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate financial investments and debt and (b) changes in equity prices that impact the value of our equity investments.

As of December 31, 2010, $9.1 billion of our financial investments was classified as cash and cash equivalents on which interest rates received vary with market interest rates, which may materially impact our investment income. Also, $7.1 billion of our debt as of December 31, 2010 was at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate financial investments and debt also varies with market interest rates. As of December 31, 2010, $16.3 billion of our investments was fixed-rate debt securities and $4.0 billion of our debt was fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities and interest rate indices, as well as endeavoring to match our floating rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. As part of our risk management strategy, we enter into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements converted a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. Additional information on our derivative financial instruments is included in Note 8 of Notes to the Consolidated Financial Statements.

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The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% or 2% as of December 31, 2010 on our investment income and interest expense per annum, and the fair value of our financial investments and debt (in millions):

Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Investments	Fair Value of Debt
2%	$ 182	$ 163	$ (1,177)	$ (860)
1	91	82	(602)	(471)
(1)	(10)	(21)	613	560
(2)	nm	nm	1,227	1,240

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating rate assets and liabilities as of December 31, 2010, the assumed hypothetical change in interest rates does not reflect the full 1% point reduction in interest income or interest expense as the rate cannot fall below zero.

As of December 31, 2010, we had $516 million of investments in equity securities and venture capital funds, a portion of which were invested 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 investments.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2010 and 2009, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2010. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2010, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2010, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 10, 2011 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2011

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UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2010	December 31, 2009
Assets		
Current assets:		
Cash and cash equivalents	$ 9,123	$ 9,800
Short-term investments	2,072	1,239
Accounts receivable, net of allowances of $241 and $220	2,061	1,954
Assets under management	2,550	2,383
Deferred income taxes	403	448
Other current receivables, net of allowances of $66 and $28	1,643	1,838
Prepaid expenses and other current assets	541	538
Total current assets	18,393	18,200
Long-term investments	14,707	13,311
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,779 and $2,738	2,200	2,140
Goodwill	22,745	20,727
Other intangible assets, net of accumulated amortization of $1,350 and $1,038	2,910	2,381
Other assets	2,108	2,286
Total assets	$ 63,063	$ 59,045
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$ 9,220	$ 9,362
Accounts payable and accrued liabilities	6,488	6,283
Other policy liabilities	3,979	3,137
Commercial paper and current maturities of long-term debt	2,480	2,164
Unearned revenues	1,533	1,217
Total current liabilities	23,700	22,163
Long-term debt, less current maturities	8,662	9,009
Future policy benefits	2,361	2,325
Deferred income taxes and other liabilities	2,515	1,942
Total liabilities	37,238	35,439
Commitments and contingencies (Note 13)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	0	0
Common stock, $0.01 par value — 3,000 shares authorized; 1,086 and 1,147 issued and outstanding	11	11
Retained earnings	25,562	23,342
Accumulated other comprehensive income (loss):		
Net unrealized gains on investments, net of tax effects	280	277
Foreign currency translation losses	(28)	(24)
Total shareholders' equity	25,825	23,606
Total liabilities and shareholders' equity	$ 63,063	$ 59,045

See Notes to the Consolidated Financial Statements

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UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Year Ended December 31, 2010	2009	2008
Revenues:			
Premiums	$85,405	$79,315	$73,608
Services	5,819	5,306	5,152
Products	2,322	1,925	1,655
Investment and other income	609	592	771
Total revenues	94,155	87,138	81,186
Operating costs:			
Medical costs	68,841	65,289	60,359
Operating costs	14,270	12,734	13,103
Cost of products sold	2,116	1,765	1,480
Depreciation and amortization	1,064	991	981
Total operating costs	86,291	80,779	75,923
Earnings from operations	7,864	6,359	5,263
Interest expense	(481)	(551)	(639)
Earnings before income taxes	7,383	5,808	4,624
Provision for income taxes	(2,749)	(1,986)	(1,647)
Net earnings	$ 4,634	$ 3,822	$ 2,977
Basic net earnings per common share	$ 4.14	$ 3.27	$ 2.45
Diluted net earnings per common share	$ 4.10	$ 3.24	$ 2.40
Basic weighted-average number of common shares outstanding	1,120	1,168	1,214
Dilutive effect of common stock equivalents	11	11	27
Diluted weighted-average number of common shares outstanding	1,131	1,179	1,241
Anti-dilutive shares excluded from the calculation of dilutive effect of common stock equivalents	94	107	90
Cash dividends per common share	$ 0.405	$ 0.030	$ 0.030

See Notes to the Consolidated Financial Statements

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UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
Balance at January 1, 2008	**1,253**	**$ 13**	**$ 1,023**	**$18,929**	**$ 98**	**$ 20,063**
Net earnings				2,977		2,977
Unrealized holding losses on investment securities during the period, net of tax benefit of $76					(132)	(132)
Reclassification adjustment for net realized losses included in net earnings, net of tax benefit of $2					4	4
Foreign currency translation loss					(22)	(22)
Comprehensive income						2,827
Issuances of common stock, and related tax benefits	20	0	272			272
Common stock repurchases	(72)	(1)	(1,596)	(1,087)		(2,684)
Share-based compensation, and related tax benefits			339			339
Common stock dividend				(37)		(37)
Balance at December 31, 2008	**1,201**	**$ 12**	**$ 38**	**$20,782**	**$ (52)**	**$ 20,780**
Net earnings				3,822		3,822
Unrealized holding gains on investment securities during the period, net of tax expense of $187					314	314
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $4					(7)	(7)
Foreign currency translation loss					(2)	(2)
Comprehensive income						4,127
Issuances of common stock, and related tax benefits	20	0	221			221
Common stock repurchases	(74)	(1)	(574)	(1,226)		(1,801)
Share-based compensation, and related tax benefits			315			315
Common stock dividend				(36)		(36)
Balance at December 31, 2009	**1,147**	**$ 11**	**$ 0**	**$23,342**	**$ 253**	**$ 23,606**
Net earnings				4,634		4,634
Unrealized holding gains on investment securities during the period, net of tax expense of $26					48	48
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $26					(45)	(45)
Foreign currency translation loss					(4)	(4)
Comprehensive income						4,633
Issuances of common stock, and related tax benefits	15	0	207			207
Common stock repurchases	(76)	0	(552)	(1,965)		(2,517)
Share-based compensation, and related tax benefits			345			345
Common stock dividend				(449)		(449)
Balance at December 31, 2010	**1,086**	**$ 11**	**$ 0**	**$25,562**	**$ 252**	**$ 25,825**

See Notes to the Consolidated Financial Statements

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UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2010	2009	2008
Operating activities			
Net earnings	$ 4,634	$ 3,822	$ 2,977
Noncash items:			
Depreciation and amortization	1,064	991	981
Deferred income taxes	45	(16)	(166)
Share-based compensation	326	334	305
Other	203	23	(122)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(16)	100	(219)
Other assets	84	(250)	(48)
Medical costs payable	(88)	424	(41)
Accounts payable and other liabilities	(341)	99	708
Other policy liabilities	10	104	(170)
Unearned revenues	352	(6)	33
Cash flows from operating activities	6,273	5,625	4,238
Investing activities			
Cash paid for acquisitions, net of cash assumed	(2,323)	(486)	(4,012)
Cash received from disposition	19	0	199
Purchases of property, equipment and capitalized software	(878)	(739)	(791)
Proceeds from disposal of property, equipment and capitalized software	0	0	185
Purchases of investments	(7,855)	(6,466)	(9,251)
Sales of investments	2,593	4,040	5,568
Maturities of investments	3,105	2,675	3,030
Cash flows used for investing activities	(5,339)	(976)	(5,072)
Financing activities			
Proceeds from (repayments of) commercial paper, net	930	(99)	(1,346)
Proceeds from issuance of long-term debt	747	0	2,981
Payments for retirement of long-term debt	(1,583)	(1,350)	(500)
Proceeds from interest rate swap termination	0	513	0
Common stock repurchases	(2,517)	(1,801)	(2,684)
Proceeds from common stock issuances	272	282	299
Share-based compensation excess tax benefit	27	38	62
Customer funds administered	974	204	(461)
Dividends paid	(449)	(36)	(37)
Checks outstanding	(5)	22	1,224
Other	(7)	(48)	(143)
Cash flows used for financing activities	(1,611)	(2,275)	(605)
(Decrease) increase in cash and cash equivalents	(677)	2,374	(1,439)
Cash and cash equivalents, beginning of period	9,800	7,426	8,865
Cash and cash equivalents, end of period	$ 9,123	$ 9,800	$ 7,426
Supplemental cash flow disclosures			
Cash paid for interest	$ 509	$ 527	$ 621
Cash paid for income taxes	$ 2,725	$ 2,048	$ 1,882

See Notes to the Consolidated Financial Statements

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UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Description of Business

UnitedHealth Group Incorporated (also referred to as "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to making health care work better. The Company emphasizes enhancing the performance of the health system and improving the overall health and well-being of the people it serves and their communities. The Company helps people get the care they need at an affordable cost; supports the physician/patient relationship; and empowers people with the information, guidance and tools they need to make personal health choices and decisions.

The Company's primary focus is on improving the 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 professionals, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through its diversified family of businesses, the Company leverages core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The Company has eliminated intercompany balances and transactions.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs, medical costs payable, revenues, goodwill, other intangible assets, investments, income taxes and contingent liabilities. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs. The Company recognizes premium revenues in the period in which eligible individuals are entitled to receive health care benefits. The Company records health care premium payments received from its customers in advance of the service period as unearned revenues.

Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this

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risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for certain of the Company's plans is subject to audit by regulators. See Note 13 of Notes to the Consolidated Financial Statements for additional information regarding these audits.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependants. Under service fee contracts, the Company recognizes revenue in the period the related services are performed based upon the fee charged to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependants, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. Since the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals.

Through the Company's Prescription Solutions pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized always exclude the member's applicable co-payment. Product revenues are recognized upon sale or shipment based on contract terms. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis. Product revenues also include sales of Ingenix publishing and software products that are recognized as revenue upon estimated delivery date.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers but for which the Company has either not yet received or processed claims, and for liabilities for physician, hospital and other medical cost disputes. The Company develops estimates for medical costs 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, care professional contract rate changes, medical care consumption and other medical cost trends. The Company estimates 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, 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 estimates recorded in prior periods become more exact, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, the Company's operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

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Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

The Company had checks outstanding in excess of bank deposits of $1.3 billion as of December 31, 2010 and $1.2 billion as of December 31, 2009, which were classified as Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets and the changes have been reflected as Checks Outstanding within financing activities in the Consolidated Statements of Cash Flows.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings and reports them, net of income tax effects, as a separate component of shareholders' equity. The Company evaluates investments for impairment by considering the length of time and extent to which market value has been less than cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost. For debt securities, if the Company intends to either sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in earnings. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income. For equity securities, the Company recognizes impairments in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the impairment in net earnings. New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy. To calculate realized gains and losses on the sale of investments, the Company uses the specific cost or amortized cost of each investment sold.

Assets Under Management

The Company administers certain aspects of AARP's insurance program (see Note 12 of Notes to the Consolidated Financial Statements). Pursuant to the Company's agreement, AARP assets are managed separately from its general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon transfer of the AARP contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with the AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings.

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Other Current Receivables

Other current receivables include amounts due from pharmacy rebates, CMS for Medicare Part D, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of whom provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of Product Revenue. The Company generally receives rebates between two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits Contract" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivables" below.

Medicare Part D Pharmacy Benefits Contract

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are six separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions

requires the Company to consider factors that may not be certain, including member eligibility status differences with CMS. The Company records risk-share adjustments to Premium Revenues in the Consolidated Statements of Operations and Other Policy Liabilities or Other Current Receivables in the Consolidated Balance Sheets.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and therefore are recorded as Premium Revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in Unearned Revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are not reflected as premium revenues, but rather are accounted for as deposits. However, as of December 31, 2009, the amounts received for these subsidies were insufficient to cover the costs incurred for these contract elements; therefore, the Company recorded a receivable in Other Current Receivables in the Consolidated Balance Sheets. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in Medical Costs and Operating Costs, respectively, in the Consolidated Statements of Operations.

The final 2010 risk-share amount is expected to be settled during the second half of 2011, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2010		December 31, 2009	
(in millions)	CMS Subsidies (a)	Risk-Share	CMS Subsidies (a)	Risk-Share
Other current receivables	$ 0	$ 0	$ 271	$ 0
Other policy liabilities	475	265	0	268

(a) Includes the Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy.

As of January 1, 2011, certain changes were made to the Medicare Part D coverage by CMS, including:

- The initial coverage limit increased to $2,840 from $2,830 in 2010.
- The catastrophic coverage begins at $6,448 as compared to $6,440 in 2010.
- The annual out-of-pocket maximum remained at $4,550 for 2011.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. The Company reviews property, equipment and capitalized software for events or changes in circumstances that would indicate that it might not recover their carrying value. If the Company determines that an asset may not be recoverable, an impairment charge is recorded.

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The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	7 years or length of lease term, whichever is shorter
Capitalized software	3 to 5 years

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. To determine whether goodwill is impaired, the Company performs a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, the Company would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

The Company calculates the estimated fair value of our reporting units using discounted cash flows. To determine fair values the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (includes significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Where available and appropriate, comparative market multiples are used to corroborate the results of our discounted cash flow test.

The Company completed its annual assessment of goodwill as of January 1, 2011 and determined that other than the $172 million impairment related to the Ingenix business discussed in Note 6 of Notes to Consolidated Financial Statements, no impairment existed as of December 31, 2010. Although the Company believes that the financial projections used are reasonable and appropriate for all of its reporting units, there is uncertainty inherent in those projections. That uncertainty is increased by potential health care reforms, as any passed legislation may significantly change the forecasts and long-term growth rate assumptions for some or all of its reporting units.

Intangible assets

Finite lived intangible assets are acquired in a business combination and are assets that represent future expected benefits but lack physical substance (e.g., membership lists, customer contracts, and trademarks). The Company does not have material holdings of indefinite lived intangible assets. Intangible assets are amortized over their expected useful lives and are subject to impairment tests when events or circumstances indicate that a finite lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. If the carrying value exceeds its estimated fair value, an impairment would be recorded.

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The Company calculates the estimated fair value of finite lived intangible assets using undiscounted cash flows that are expected to result from the use of the intangible asset or group of assets. The Company considers many factors, including estimated future utility to estimate cash flows. There were no material impairments of finite lived intangible assets during the year ended December 31, 2010.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP program (see Note 12 of Notes to the Consolidated Financial Statements), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits Contract" above), and the current portion of future policy benefits. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits and Reinsurance Receivables

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation (Golden Rule) subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2010, the Company had an aggregate $2.0 billion reinsurance receivable, of which $126 million was recorded in Other Current Receivables and $1.9 billion was recorded in Other Assets in the Consolidated Balance Sheets. As of December 31, 2009, the Company had an aggregate $2.0 billion reinsurance receivable, of which $139 million was recorded in Other Current Receivables and $1.9 billion was recorded in Other Assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery. Currently, the reinsurer is rated by A.M. Best as "A." As of December 31, 2010, there were no other significant concentrations of credit risk

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be cancelled by the customer with at least 30 days notice. Costs related to the acquisition and renewal of short duration customer contracts are charged to expense as incurred.

Share-Based Compensation

Share-based compensation expense is measured at the grant date fair values of the awards and is recognized as expense over the period in which the share-based compensation vests.

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Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted stock and restricted stock units (collectively, restricted shares), using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted shares, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recent Accounting Standards

Recently Adopted Accounting Standards. In January 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2010-06, "Improving Disclosures about Fair Value Measurements" (ASU 2010-06). This update amends the fair value guidance of the FASB Accounting Standards Codification (ASC) to require additional disclosures regarding (i) transfers in and out of Level 1 and Level 2 fair value measurements and (ii) activity in Level 3 fair value measurements. ASU 2010-06 also clarifies existing disclosure requirements regarding (i) the level of asset and liability disaggregation and (ii) fair value measurement inputs and valuation techniques. The new disclosures and clarifications of existing disclosures were effective for the Company's fiscal year 2010, except for the disclosures about purchases, sales, issuances and settlements in the roll forward of activity in Level 3 fair value measurements, which will be effective for the Company's fiscal year 2011. The Company's fair value disclosures, including the new disclosures effective in 2010, have been included in Note 4 of Notes to the Consolidated Financial Statements.

The Company has determined that there have been no recently issued accounting standards that will have a material impact on its Consolidated Financial Statements, or materially apply to its operations.

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3. Investments

A summary of short-term and long-term investments is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2010				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,214	$ 28	$ (8)	$ 2,234
State and municipal obligations	6,007	183	(42)	6,148
Corporate obligations	5,111	210	(11)	5,310
U.S. agency mortgage-backed securities	1,851	58	(6)	1,903
Non-U.S. agency mortgage-backed securities	439	26	0	465
Total debt securities — available-for-sale	15,622	505	(67)	16,060
Equity securities — available-for-sale	508	22	(14)	516
Debt securities — held-to-maturity:				
U.S. government and agency obligations	167	5	0	172
State and municipal obligations	15	0	0	15
Corporate obligations	21	0	0	21
Total debt securities — held-to-maturity	203	5	0	208
Total investments	$ 16,333	$ 532	$ (81)	$16,784
December 31, 2009				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,566	$ 12	$ (11)	$ 1,567
State and municipal obligations	6,080	248	(11)	6,317
Corporate obligations	3,278	149	(6)	3,421
U.S. agency mortgage-backed securities	1,870	64	(3)	1,931
Non-U.S. agency mortgage-backed securities	535	8	(5)	538
Total debt securities — available-for-sale	13,329	481	(36)	13,774
Equity securities — available-for-sale	579	12	(14)	577
Debt securities — held-to-maturity:				
U.S. government and agency obligations	158	4	0	162
State and municipal obligations	17	0	0	17
Corporate obligations	24	0	0	24
Total debt securities — held-to-maturity	199	4	0	203
Total investments	$ 14,107	$ 497	$ (50)	$14,554

Included in the Company's investment portfolio were securities collateralized by sub-prime home equity lines of credit with fair values of $6 million and $9 million as of December 31, 2010 and 2009, respectively. Also included were Alt-A securities with fair values of $15 million and $19 million as of December 31, 2010 and 2009, respectively.

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The fair values of the Company's mortgage-backed securities by credit rating and non-U.S. agency mortgage-backed securities by origination as of December 31, 2010 were as follows:

(in millions)	AAA	AA	A	Non-Investment Grade	Total Fair Value
2010	$ 8	$0	$0	$ 0	$ 8
2007	73	0	0	3	76
2006	123	0	0	14	137
2005	140	0	0	3	143
Pre-2005	98	1	1	1	101
U.S. agency mortgage-backed securities	1,903	0	0	0	1,903
Total	$2,345	$1	$1	$ 21	$ 2,368

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2010, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 2,251	$ 2,260
Due after one year through five years	5,195	5,401
Due after five years through ten years	3,860	3,984
Due after ten years	2,026	2,047
U.S. agency mortgage-backed securities	1,851	1,903
Non-U.S. agency mortgage-backed securities	439	465
Total debt securities — available-for-sale	$ 15,622	$16,060

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2010, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 66	$ 66
Due after one year through five years	105	108
Due after five years through ten years	22	23
Due after ten years	10	11
Total debt securities — held-to-maturity	$ 203	$208

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The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2010						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 548	$ (8)	$ 0	$ 0	$ 548	$ (8)
State and municipal obligations	1,383	(40)	18	(2)	1,401	(42)
Corporate obligations	949	(11)	14	0	963	(11)
U.S. agency mortgage-backed securities	355	(6)	0	0	355	(6)
Total debt securities — available-for-sale	$3,235	$ (65)	$ 32	$ (2)	$3,267	$ (67)
Equity securities — available-for-sale	$ 206	$ (14)	$ 11	$ 0	$ 217	$ (14)
December 31, 2009						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 437	$ (11)	$ 4	$ 0	$ 441	$ (11)
State and municipal obligations	392	(6)	100	(5)	492	(11)
Corporate obligations	304	(3)	69	(3)	373	(6)
U.S. agency mortgage-backed securities	355	(3)	2	0	357	(3)
Non-U.S. agency mortgage-backed securities	134	(1)	86	(4)	220	(5)
Total debt securities — available-for-sale	$1,622	$ (24)	$ 261	$ (12)	$1,883	$ (36)
Equity securities — available-for-sale	$ 169	$ (13)	$ 1	$ (1)	$ 170	$ (14)

The Company's mortgage-backed securities in an unrealized loss position by credit rating distribution were as follows:

	December 31, 2010		December 31, 2009	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
AAA	$ 355	$ (6)	$ 543	$ (6)
AA	0	0	31	(2)
A	0	0	0	0
BBB	0	0	1	0
Non-investment grade	0	0	2	0
Total	$ 355	$ (6)	$ 577	$ (8)

The unrealized losses from all securities as of December 31, 2010 were generated from approximately 2,600 positions out of a total of approximately 14,000 positions. The Company believes that it will collect the principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses on investments in state and municipal obligations and corporate obligations as of December 31, 2010 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for securities where the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality of the issuers and the credit ratings of the state and municipal obligations and the corporate obligations, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). The unrealized losses on mortgage-backed securities as of December 31, 2010 were primarily caused by higher

interest rates in the marketplace, reflecting the higher perceived risk assigned by fixed-income investors to commercial mortgage-backed securities. These unrealized losses represented less than 1% of the total amortized cost of the Company's mortgage-backed security holdings as of December 31, 2010. The Company believes these losses to be temporary. All of the Company's mortgage-backed securities in an unrealized loss position as of December 31, 2010 were rated "AAA" with no known deterioration or other factors leading to an OTTI. As of December 31, 2010, the Company did not have the intent to sell any of the securities in an unrealized loss position.

As of December 31, 2010, the Company's holdings of non-U.S. agency mortgage-backed securities included $8 million of commercial mortgage loans in default. These investments were acquired in the first quarter of 2008 pursuant to an acquisition and were recorded at fair value. They represented less than 1% of the Company's total mortgage-backed security holdings as of December 31, 2010.

A portion of the Company's investments in equity securities and venture capital funds consists of investments held in various public and nonpublic companies concentrated in the areas of health care services and related information technologies. Market conditions that affect the value of health care and related technology stocks will likewise impact the value of the Company's equity portfolio. The equity securities and venture capital funds were evaluated for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains (losses), before taxes, were from the following sources:

	Year Ended December 31,		
(in millions)	2010	2009	2008
Total OTTI	$ (23)	$ (64)	$ (121)
Portion of loss recognized in other comprehensive income	0	0	n/a
Net OTTI recognized in earnings	(23)	(64)	(121)
Gross realized losses from sales	(6)	(41)	(50)
Gross realized gains from sales	100	116	165
Net realized gains (losses)	$ 71	$ 11	$ (6)

For the years ended December 31, 2010 and 2009, all of the recorded OTTI charges resulted from the Company's intent to sell certain impaired securities.

4. Fair Value

Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services, the Company has not historically adjusted the prices obtained from the pricing service.

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In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, volatilities, default rates); and
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

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The following table presents information about the Company's financial assets and liabilities, excluding AARP Program-related assets and liabilities, which are measured at fair value on a recurring basis, according to the valuation techniques the Company used to determine their fair values. See Note 12 of Notes to the Consolidated Financial Statements for further detail on AARP.

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2010				
Cash and cash equivalents	$ 8,069	$ 1,054	$ 0	$ 9,123
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,515	719	0	2,234
State and municipal obligations	0	6,148	0	6,148
Corporate obligations	31	5,146	133	5,310
U.S. agency mortgage-backed securities	0	1,903	0	1,903
Non-U.S. agency mortgage-backed securities	0	457	8	465
Total debt securities — available-for-sale	1,546	14,373	141	16,060
Equity securities — available-for-sale	306	2	208	516
Total cash, cash equivalents and investments at fair value	9,921	15,429	349	25,699
Interest rate swap assets	0	46	0	46
Total assets at fair value	$ 9,921	$ 15,475	$ 349	$ 25,745
Percentage of total assets at fair value	39%	60%	1%	100%
Interest rate swap liabilities	$ 0	$ 104	$ 0	$ 104
December 31, 2009				
Cash and cash equivalents	$ 9,135	$ 665	$ 0	$ 9,800
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,024	543	0	1,567
State and municipal obligations	0	6,317	0	6,317
Corporate obligations	18	3,293	110	3,421
U.S. agency mortgage-backed securities	0	1,931	0	1,931
Non-U.S. agency mortgage-backed securities	0	528	10	538
Total debt securities — available-for-sale	1,042	12,612	120	13,774
Equity securities — available-for-sale	262	3	312	577
Total cash, cash equivalents and investments at fair value	$ 10,439	$ 13,280	$ 432	$ 24,151
Percentage of total cash, cash equivalents and investments at fair value	43%	55%	2%	100%

There were no transfers between Levels 1 and 2 during the year ended December 31, 2010.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

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Debt Securities. The estimated fair values of debt securities held as available-for-sale are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. Fair values of debt securities that do not trade on a regular basis in active markets are classified as Level 2.

Equity Securities. Equity securities are held as available-for-sale investments. Fair value estimates for Level 1 and Level 2 publicly traded equity securities are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. The fair values of Level 3 investments in venture capital portfolios are estimated using market modeling approaches that rely heavily on management assumptions and qualitative observations. These investments totaled $166 million and $282 million as of December 31, 2010 and 2009, respectively. The fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The key inputs utilized in the Company's market modeling include, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; similar preferences in the capital structure; discounted cash flows; liquidation values and milestones established at initial funding; and the assumption that the values of the Company's venture capital investments can be inferred from these inputs. The Company's remaining Level 3 equity securities holdings of $42 million and $30 million as of December 31, 2010 and 2009, respectively, consist of preferred stock and other items for which there are no active markets.

Interest Rate Swaps. Fair values of the Company's interest rate swaps are estimated using the terms of the swaps and publicly available market yield curves. Because the swaps are unique and not actively traded, the fair values are classified as Level 2.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2010			December 31, 2009			December 31, 2008		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 120	$ 312	$ 432	$ 62	$ 304	$366	$ 0	$ 133	$133
Purchases (sales), net	19	(122)	(103)	64	22	86	14	202	216
Net unrealized gains in accumulated other comprehensive income	0	9	9	0	7	7	0	2	2
Net realized gains (losses) in investment and other income	2	9	11	(6)	(21)	(27)	0	(54)	(54)
Transfers into Level 3	0	0	0	0	0	0	48	21	69
Balance at end of period	$ 141	$ 208	$ 349	$ 120	$ 312	$432	$ 62	$ 304	$366

With the exception of the goodwill impairment related to the Ingenix business, as discussed in Note 6 of Notes to the Consolidated Financial Statements, there were no significant fair value adjustments recorded during the years ended December 31, 2010 and 2009 for non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis. These assets and liabilities are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment and are classified as Level 3.

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The table below includes fair values for certain financial instruments for which it is practicable to estimate fair value. The carrying values and fair values of these financial instruments were as follows:

	December 31, 2010		December 31, 2009	
(in millions)	Carrying Value	Fair Value	Carrying Value	Fair Value
Assets				
Debt securities — available-for-sale	$16,060	$16,060	$13,774	$13,774
Equity securities — available-for-sale	516	516	577	577
Debt securities — held-to-maturity	203	208	199	203
AARP Program-related investments	2,435	2,435	2,114	2,114
Interest rate swap assets	46	46	0	0
Liabilities				
Senior unsecured notes	10,212	10,903	11,173	11,043
Interest rate swap liabilities	104	104	0	0

In addition to the previously described methods and assumptions for debt and equity securities and interest rate swaps, the following are the methods and assumptions used to estimate the fair value of the other financial instruments:

AARP Program-related Investments. AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program (see Note 12 of Notes to the Consolidated Financial Statements). The Company elected to measure the AARP assets under management at fair value pursuant to the fair value option. See the preceding discussion regarding the methods and assumptions used to estimate the fair value of investments in debt and equity securities.

Senior Unsecured Notes. The fair values of the senior unsecured notes are estimated based on third-party quoted market prices for the same or similar issues.

The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, accounts and other current receivables, unearned revenues, commercial paper, accounts payable and accrued liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2010	December 31, 2009
Land	$ 38	$ 32
Buildings and improvements	764	662
Computer equipment	1,418	1,504
Furniture and fixtures	224	235
Less accumulated depreciation	(1,417)	(1,487)
Property and equipment, net	1,027	946
Capitalized software	2,535	2,445
Less accumulated amortization	(1,362)	(1,251)
Capitalized software, net	1,173	1,194
Total property, equipment and capitalized software, net	$ 2,200	$ 2,140

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Depreciation expense for property and equipment for 2010, 2009 and 2008 was $398 million, $436 million and $439 million, respectively. Amortization expense for capitalized software for 2010, 2009 and 2008 was $349 million, $314 million and $290 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reporting segment, were as follows:

(in millions)	Health Benefits	OptumHealth	Ingenix	Prescription Solutions	Consolidated
Balance at January 1, 2009	$17,044	$ 1,152	$1,052	$ 840	$ 20,088
Acquisitions	161	40	415	0	616
Subsequent payments and adjustments, net	61	(34)	(4)	0	23
Balance at December 31, 2009	17,266	1,158	1,463	840	20,727
Acquisitions	0	187	2,022	0	2,209
Impairment	0	0	(172)	0	(172)
Subsequent payments and adjustments, net	(14)	0	(5)	0	(19)
Balance at December 31, 2010	$17,252	$ 1,345	$3,308	$ 840	$ 22,745

In 2010, there was a decline in the economic environment and competitive landscape for the clinical trial support businesses within one of the Ingenix reporting units. These businesses experienced unexpected declines in new business authorizations from historical levels including continued delays in and lengthening of the selling cycle. During this time the Company began evaluating strategic options with respect to the clinical trial support businesses. In December 2010, as part of the annual goodwill impairment analysis, the Company considered the aforementioned market conditions and operating results as well as indications of interest the Company began to receive on the clinical trial support businesses as the fair value of the reporting unit was evaluated. As a result of that analysis, the Company determined that the implied fair value of the reporting unit was less than its carrying value and an impairment charge of $172 million was recorded. The implied fair value of the reporting unit was determined by a combination of valuation techniques, including discounting future expected cash flows and expected sale proceeds.

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2010			December 31, 2009		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer contracts and membership lists	$ 3,623	$ (1,038)	$ 2,585	$ 2,864	$ (796)	$ 2,068
Patents, trademarks and technology	505	(246)	259	437	(187)	250
Other	132	(66)	66	118	(55)	63
Total	$ 4,260	$ (1,350)	$ 2,910	$ 3,419	$ (1,038)	$ 2,381

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

	2010		2009	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer contracts and membership lists	$786	14 years	$239	12 years
Patents, trademarks, and technology	94	8 years	41	9 years
Other	14	9 years	1	2 years
Total acquired finite-lived intangible assets	$894	13 years	$281	12 years

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Estimated full year amortization expense relating to intangible assets for each of the next five years is as follows:

(in millions)	Estimated Amortization Expense
2011	$ 316
2012	312
2013	304
2014	294
2015	280

Amortization expense relating to intangible assets for 2010, 2009 and 2008 was $317 million, $241 million and $252 million, respectively.

7. Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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, care provider contract rate changes, medical care consumption and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified.

For the year ended December 31, 2010, there was $800 million of net favorable medical cost development related to prior fiscal years. The favorable development in 2010 was primarily driven by lower than expected health system utilization levels; more efficient claims handling and processing, which results in higher completion factors; a reduction in reserves needed for disputed claims from care providers; and favorable resolution of certain state-based assessments.

None of the factors discussed above were individually material to the net favorable medical cost development for the years ended 2009 and 2008.

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2010	2009	2008
Medical costs payable, beginning of period	$ 9,362	$ 8,664	$ 8,331
Acquisitions	0	252	331
Reported medical costs:			
Current year	69,641	65,599	60,589
Prior years	(800)	(310)	(230)
Total reported medical costs	68,841	65,289	60,359
Claim payments:			
Payments for current year	(60,949)	(57,109)	(52,872)
Payments for prior year	(8,034)	(7,734)	(7,485)
Total claim payments	(68,983)	(64,843)	(60,357)
Medical costs payable, end of period	$ 9,220	$ 9,362	$ 8,664

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8. Commercial Paper and Long-Term Debt

Commercial paper and long-term debt consisted of the following:

(in millions)	December 31, 2010 Par Value	December 31, 2010 Carrying Value	December 31, 2010 Fair Value	December 31, 2009 Par Value	December 31, 2009 Carrying Value	December 31, 2009 Fair Value
Commercial paper	$ 930	$ 930	$ 930	$ 0	$ 0	$ 0
Senior unsecured floating-rate notes due June 2010	0	0	0	500	500	499
5.1% senior unsecured notes due November 2010	0	0	0	250	257	259
Senior unsecured floating-rate notes due February 2011	250	250	250	250	250	251
5.3% senior unsecured notes due March 2011	705	712	711	750	781	777
5.5% senior unsecured notes due November 2012	352	372	377	450	480	481
4.9% senior unsecured notes due February 2013	534	541	568	550	549	575
4.9% senior unsecured notes due April 2013	409	425	437	450	464	472
4.8% senior unsecured notes due February 2014	172	186	184	250	268	256
5.0% senior unsecured notes due August 2014	389	425	423	500	540	518
4.9% senior unsecured notes due March 2015	416	456	444	500	544	513
5.4% senior unsecured notes due March 2016	601	666	661	750	847	772
5.4% senior unsecured notes due November 2016	95	95	105	95	95	98
6.0% senior unsecured notes due June 2017	441	484	491	500	587	523
6.0% senior unsecured notes due November 2017	156	167	174	250	285	258
6.0% senior unsecured notes due February 2018	1,100	1,065	1,249	1,100	1,099	1,136
3.9% senior unsecured notes due October 2020	450	413	429	0	0	0
Zero coupon senior unsecured notes due November 2022	1,095	588	677	1,095	558	611
5.8% senior unsecured notes due March 2036	850	844	862	850	844	762
6.5% senior unsecured notes due June 2037	500	495	552	500	495	493
6.6% senior unsecured notes due November 2037	650	645	729	650	645	651
6.9% senior unsecured notes due February 2038	1,100	1,085	1,281	1,100	1,085	1,138
5.7% senior unsecured notes due October 2040	300	298	299	0	0	0
Total commercial paper and long-term debt	$11,495	$11,142	$11,833	$11,340	$11,173	$11,043

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	Maturities of Long-Term Debt
2011	$ 1,892
2012	372
2013	966
2014	611
2015	456
Thereafter	6,257
$1,095 million par, zero coupon senior unsecured notes due November 2022 (a)	588

(a) These notes have been included in current maturities of long-term debt in the Consolidated Balance Sheets as of December 31, 2010 and 2009 due to a current note holder option to "put" the note to the Company which began on November 15, 2010, and recurs each November 15 thereafter until 2022 (except 2014), at accreted value.

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Commercial Paper and Bank Credit Facility

Commercial paper consists of senior unsecured debt sold on a discount basis with maturities up to 270 days. As of December 31, 2010, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.4%.

The Company has a $2.5 billion five-year revolving bank credit facility with 23 banks, which matures in May 2012. This facility supports the Company's commercial paper program and is available for general corporate purposes. There were no amounts outstanding under this facility as of December 31, 2010. The interest rate is variable based on term and amount and is calculated based on the London Interbank Offered Rate (LIBOR) plus a spread. As of December 31, 2010, the annual interest rate on this facility, had it been drawn, would have ranged from 0.5% to 0.7%.

Debt Covenants

The Company's bank credit facility contains various covenants including requiring the Company to maintain a debt-to-total-capital ratio, calculated as debt divided by the sum of debt and shareholders' equity, below 50%. The Company was in compliance with its debt covenants as of December 31, 2010.

Long-Term Debt

In October 2010, the Company issued $750 million in senior unsecured notes under its February 2008 S-3 shelf registration statement. The issuance included $450 million of 3.875% fixed-rate notes due October 2020 and $300 million of 5.700% fixed-rate notes due October 2040.

In February 2010, the Company completed cash tender offers for $775 million in aggregate principal of certain of its outstanding fixed-rate notes to improve the matching of interest rate exposure related to its floating rate assets and liabilities on its balance sheet.

In February 2008, the Company issued a total of $3.0 billion in senior unsecured debt, which included: $250 million of floating-rate notes due February 2011, $550 million of 4.9% fixed-rate notes due February 2013, $1.1 billion of 6.0% fixed-rate notes due February 2018 and $1.1 billion of 6.9% fixed-rate notes due February 2038.

Interest Rate Swap Contracts

During 2010, the Company entered into interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and investment balances. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on fixed-rate debt issues maturing between March 2011 through March 2016 and June 2017 through October 2020. Since the specific terms and notional amounts of the swaps match those of the debt being hedged, they were assumed to be highly effective hedges and all changes in fair value of the swaps were recorded on the Consolidated Balance Sheets with no net impact recorded in the Consolidated Statements of Operations.

The following table summarizes the location and fair value of fair value hedges on the Company's Consolidated Balance Sheet as of December 31, 2010:

Notional Amount (in millions)	Balance Sheet Location	Fair Value (in millions)
$ 5,725	Other assets	$46
	Other liabilities	104

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The following table provides a summary of the effect of changes in fair value of fair value hedges on the Company's Consolidated Statement of Operations:

(in millions)	Year Ended December 31, 2010
Hedge loss recognized in interest expense	$ (58)
Hedged item gain recognized in interest expense	58
Net impact on the Company's Consolidated Statement of Operations	$ 0

9. Income Taxes

The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2010	2009	2008
Current Provision:			
Federal	$2,524	$1,924	$1,564
State and local	180	78	145
Total current provision	2,704	2,002	1,709
Deferred provision	45	(16)	(62)
Total provision for income taxes	$2,749	$1,986	$1,647

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows:

(in millions, except percentages)	2010		2009		2008	
Tax provision at the U.S. federal statutory rate	$2,584	35.0%	$2,033	35.0%	$1,618	35.0%
State income taxes, net of federal benefit	129	1.7	66	1.1	106	2.2
Settlement of state exams, net of federal benefit	(3)	0	(40)	(0.7)	(12)	(0.2)
Tax-exempt investment income	(65)	(0.9)	(70)	(1.2)	(69)	(1.5)
Non-deductible compensation	64	0.9	0	0	0	0
Other, net	40	0.5	(3)	0	4	0.1
Provision for income taxes	$2,749	37.2%	$1,986	34.2%	$1,647	35.6%

The increase in the effective income tax rate in 2010 resulted primarily from a benefit in the 2009 tax rate from the resolution of various historical state income tax matters, as well as from the limitations on the future deductibility of certain compensation related to the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010 (Health Reform Legislation), which was signed into law during the first quarter of 2010.

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The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2010	2009
Deferred income tax assets:		
Share-based compensation	$ 385	$ 419
Net operating loss carryforwards	285	206
Accrued expenses and allowances	233	201
Long term liabilities	147	164
Medical costs payable and other policy liabilities	102	218
Unearned revenues	78	58
Unrecognized tax benefits	62	55
Other	215	190
Subtotal	1,507	1,511
Less: valuation allowances	(247)	(198)
Total deferred income tax assets	$ 1,260	$ 1,313
Deferred income tax liabilities:		
Intangible assets	$(1,104)	$ (890)
Capitalized software development	(450)	(449)
Net unrealized gains on investments	(161)	(163)
Depreciation and amortization	(140)	(80)
Prepaid expenses	(92)	(90)
Total deferred income tax liabilities	(1,947)	(1,672)
Net deferred income tax liabilities	$ (687)	$ (359)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $149 million expire beginning in 2011 through 2030, and state net operating loss carryforwards expire beginning in 2011 through 2029.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2010	2009
Gross unrecognized tax benefits, beginning of period	$220	$340
Gross increases:		
Current year tax positions	13	10
Prior year tax positions	30	11
Gross decreases:		
Prior year tax positions	0	(62)
Settlements	0	(61)
Statute of limitations lapses	(43)	(18)
Gross unrecognized tax benefits, end of period	$220	$220

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During the year ended December 31, 2010, the Company recognized $15 million of interest expense and penalties. During the year ended December 31, 2009, the Company recognized a net tax benefit of $7 million generated from the reduction in interest accrued from the release of previously accrued tax matters. As of December 31, 2010, the Company had $63 million of accrued interest and penalties for uncertain tax positions and, as of December 31, 2009, the Company had $44 million of

accrued interest. These amounts are not included in the reconciliation above. As of December 31, 2010, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate, was $128 million.

The Company currently files income tax returns in the U.S. federal jurisdiction, various states and foreign jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2009 and prior. The Company's 2010 tax returns are under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to 2004. The Company does not believe any adjustments that may result from these examinations will be significant.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $118 million as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the National Association of Insurance Commissioners. 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. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2010, based on the 2009 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could be paid was $3.2 billion. For the year ended December 31, 2010, the Company's regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $686 million of extraordinary dividends. For the year ended December 31, 2009, the Company's regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $2.5 billion of extraordinary dividends. The total dividends received in both 2010 and 2009 included all of the ordinary dividend capacity of $3.2 billion and $3.1 billion, respectively. In some cases, ordinary dividends were classified as extraordinary dividends due to their increased size and/or accelerated timing. As of December 31, 2010, $974 million of the Company's $25.9 billion of cash and investments was held by non-regulated entities.

The Company's regulated subsidiaries had aggregate statutory capital and surplus of approximately $11 billion as of December 31, 2010; regulated entity statutory capital exceeded state minimum capital requirements.

OptumHealth Bank must meet minimum requirements for Tier 1 leverage capital, Tier 1 risk-based capital, and Total risk-based capital of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2010, the Company believes that OptumHealth Bank met the FDIC requirements to be considered "Well Capitalized".

Dividends

In May 2010, the Company's Board of Directors increased the Company's cash dividend to shareholders and moved the Company to a quarterly dividend payment cycle. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change. Prior to May 2010, the Company's policy had been to pay an annual dividend.

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The following table provides details of the Company's dividend payments:

Year	Aggregate Amount per Share	Total Amount Paid (in millions)
2008	$ 0.030	$ 37
2009	0.030	36
2010	0.405	449

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time at prevailing prices in the open market, subject to certain Board restrictions. In February 2010, the Board renewed and increased the Company's share repurchase program, and authorized the Company to repurchase up to 120 million shares of its common stock. During the year ended December 31, 2010, the Company repurchased 76 million shares at an average price of approximately $33 per share and an aggregate cost of $2.5 billion. As of December 31, 2010, the Company had Board authorization to purchase up to an additional 48 million shares of its common stock.

11. Share-Based Compensation

The Company's 2002 Stock Incentive Plan (Plan), as amended and restated May 15, 2002, is intended to attract and retain employees and non-employee directors, offer them incentives to put forth maximum efforts for the success of the Company's business and afford them an opportunity to acquire a proprietary interest in the Company. The Plan allows the Company to grant stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards or other stock-based awards to eligible employees and non-employee directors. The Plan incorporates the following prior plans: 1991 Stock and Incentive Plan, 1998 Broad-Based Stock Incentive Plan and Non-employee Director Stock Option Plan. All outstanding stock options, restricted stock and other awards issued under the prior plans shall remain subject to the terms and conditions of these plans under which they were issued.

As of December 31, 2010, the Company had 63.4 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, stock-settled stock appreciation rights (SARs), and up to 12.5 million of awards in restricted stock and restricted stock units (collectively, restricted shares). The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares.

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Stock Options and SARs

Stock options and SARs generally vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Stock option and SAR activity for the year ended December 31, 2010 is summarized in the table below:

	Shares (in millions)	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in millions)
Outstanding at beginning of period	124	$ 39		
Granted	10	33		
Exercised	(12)	19		
Forfeited	(10)	39		
Outstanding at end of period	112	$ 40	5.3	$ 395
Exercisable at end of period	82	$ 42	4.4	$ 283
Vested and expected to vest end of period	110	$ 40	5.3	$ 388

To determine compensation expense related to the Company's stock options and SARs, the fair value of each award is estimated on the date of grant using an option-pricing model. For purposes of estimating the fair value of the Company's employee stock option and SAR grants, the Company uses a binomial model. The principal assumptions the Company used in applying the option-pricing models were as follows:

	2010	2009	2008
Risk free interest rate	1.0% - 2.1%	1.7% - 2.4%	2.2% - 3.4%
Expected volatility	45.4% - 46.2%	41.3% - 46.8%	29.5%
Expected dividend yield	0.1% - 1.7%	0.1%	0.1%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.6 - 5.1	4.4 - 5.1	4.3

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Beginning in 2009, the Company changed the weighting of historical and implied volatilities used in the calculation of expected volatility to 90% and 10%, respectively. Before the change, the Company had weighted historical and implied volatility equally. Due to the significant economic turbulence and resulting instability of the exchange-traded options throughout 2008, the Company concluded that they were no longer as representative of the fair value of its common stock over the expected life of its options and SARs. The change had no impact on the Company's reported Net Earnings nor Earnings per Share. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

The weighted-average grant date fair value of stock options and SARs granted for 2010, 2009 and 2008 was approximately $13 per share, $10 per share and $9 per share. The total intrinsic value of stock options and SARs exercised during 2010, 2009 and 2008 was $164 million, $282 million and $244 million, respectively.

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Restricted Shares

Restricted shares generally vest ratably over three to five years. Compensation expense related to restricted shares is based on the share price on date of grant. Restricted share activity for the year ended December 31, 2010 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value
Nonvested at beginning of period	11	$ 32
Granted	6	32
Vested	(3)	33
Forfeited	(1)	32
Nonvested at end of period	13	$ 31

The weighted-average grant date fair value of restricted shares granted during 2010, 2009 and 2008 was approximately $32 per share, $29 per share and $34 per share, respectively. The total fair value of restricted shares vested during 2010, 2009 and 2008 was $99 million, $56 million and $17 million, respectively.

Employee Stock Purchase Plan

The Company's Employee Stock Purchase Plan (ESPP) is intended to enhance employee commitment to the goals of the Company, by providing a means of achieving stock ownership at advantageous terms to eligible employees of the Company. Eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. During 2010, 2009 and 2008, 3.8 million shares, 3.7 million shares and 2.9 million shares of common stock, respectively, were purchased under the ESPP. The compensation expense is included in the compensation expense amounts recognized and discussed below. As of December 31, 2010, there were 5.6 million shares of common stock available for issuance under the ESPP.

Share-Based Compensation Recognition

The Company recognizes compensation expense for share-based awards, including stock options, SARs and restricted shares, on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Beginning with share-based awards granted in 2009, the Company's equity award program includes a retirement provision that treats all employees who are age 55 or older with at least ten years of recognized employment with the Company as retirement-eligible. For 2010, 2009 and 2008, the Company recognized compensation expense related to its share-based compensation plans of $326 million ($278 million net of tax effects), $334 million ($220 million net of tax effects) and $305 million ($202 million net of tax effects), respectively. Share-based compensation expense is recognized in Operating Costs in the Company's Consolidated Statements of Operations. As of December 31, 2010, there was $449 million of total unrecognized compensation cost related to share awards that is expected to be recognized over a weighted-average period of 1.2 years. For 2010, 2009 and 2008, the income tax benefit realized from share-based award exercises was $78 million, $94 million and $106 million, respectively.

As further discussed in Note 10 of Notes to the Consolidated Financial Statements, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure, cost of capital and return to shareholders, as well as to offset the dilutive impact of shares issued for share-based award exercises.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for all employees. Compensation expense related to this plan was not significant for the years 2010, 2009 and 2008.

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In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within Long-Term Investments with an approximately equal amount in Other Liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $258 million and $216 million as of December 31, 2010 and 2009, respectively.

12. AARP

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the Program), and separate Medicare Advantage and Medicare Part D arrangements. The products and services under the Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

In October 2007, the Company entered into four agreements with AARP, effective January 1, 2008, that amended its existing AARP arrangements. These agreements extended the Company's arrangements with AARP on the Program to December 31, 2017, extended the Company's arrangement with AARP on the Medicare Part D business to December 31, 2014, and gave the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage offerings until December 31, 2014, subject to certain limited exclusions.

Under the Program, the Company is compensated for transaction processing and other services, as well as for assuming underwriting risk. The Company is also engaged in product development activities to complement the insurance offerings. Premium revenues from the Company's portion of the Program for 2010, 2009 and 2008 were $6.3 billion, $6.0 billion and $5.7 billion, respectively.

The Company's agreement with AARP on the Program provides for the maintenance of the RSF that is held by the Company on behalf of policyholders. Underwriting gains or losses related to the AARP Medicare Supplement Insurance business are directly 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. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. To the extent underwriting losses exceed the balance in the RSF, losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the Consolidated Balance Sheets and changes in the RSF are reported in Medical Costs in the Consolidated Statement of Operations. The Company believes the RSF balance as of December 31, 2010 is sufficient to cover potential future underwriting and other risks and liabilities associated with the contract.

The effects of changes in balance sheet amounts associated with the Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Under the Company's agreement with AARP, the Company separately manages the assets that support the Program. These assets are held at fair value in the Consolidated Balance Sheets as Assets Under Management. These assets are invested at the Company's discretion, within investment guidelines approved by the Program and are used to pay costs associated with the Program. The Company does not guarantee any rates of investment return on these investments and upon any transfer of the Program to another entity, the Company would transfer cash in an amount equal to the fair value of these investments at the date of transfer. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF and, thus, are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the AARP RSF and were $107 million, $99 million and $82 million in 2010, 2009 and 2008, respectively.

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The Company elected to measure the entirety of the AARP Assets Under Management at fair value, pursuant to the fair value option.

The following AARP Program-related assets and liabilities were included in the Company's Consolidated Balance Sheets:

(in millions)	December 31, 2010	December 31, 2009
Accounts receivable	$ 526	$ 509
Assets under management	2,550	2,383
Medical costs payable	1,150	1,182
Accounts payable and accrued liabilities	48	40
Other policy liabilities	1,286	1,145
Future policy benefits	533	482
Other liabilities	59	43

The fair value of cash, cash equivalents and investments associated with the Program, reflected as assets under management, and the fair value of other assets and other liabilities were classified in accordance with the fair value hierarchy as discussed in Note 4 of Notes to the Consolidated Financial Statements and were as follows:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2010				
Cash and cash equivalents	$ 115	$ 0	$ 0	$ 115
Debt securities:				
U.S. government and agency obligations	515	244	0	759
State and municipal obligations	0	15	0	15
Corporate obligations	0	1,129	0	1,129
U.S. agency mortgage-backed securities	0	393	0	393
Non-U.S. agency mortgage-backed securities	0	137	0	137
Total debt securities	515	1,918	0	2,433
Equity securities — available-for-sale	0	2	0	2
Total cash, cash equivalents and investments at fair value	$ 630	$ 1,920	$ 0	$ 2,550
Other liabilities	$ 0	$ 0	$ 59	$ 59
Total liabilities at fair value	$ 0	$ 0	$ 59	$ 59
December 31, 2009				
Cash and cash equivalents	$ 269	$ 0	$ 0	$ 269
Debt securities:				
U.S. government and agency obligations	358	298	0	656
State and municipal obligations	0	9	0	9
Corporate obligations	0	955	0	955
U.S. agency mortgage-backed securities	0	343	0	343
Non-U.S. agency mortgage-backed securities	0	149	0	149
Total debt securities	358	1,754	0	2,112
Equity securities — available-for-sale	0	2	0	2
Total cash, cash equivalents and investments at fair value	$ 627	$ 1,756	$ 0	$ 2,383
Other liabilities	$ 0	$ 0	$ 43	$ 43
Total liabilities at fair value	$ 0	$ 0	$ 43	$ 43

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13. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are noncancelable and expire on various dates through 2028. Rent expense under all operating leases for 2010, 2009 and 2008 was $297 million, $303 million and $264 million, respectively.

As of December 31, 2010, future minimum annual lease payments, net of sublease income, under all noncancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2011	$ 259
2012	240
2013	191
2014	156
2015	129
Thereafter	579

The Company contracts on an administrative services only (ASO) basis with customers who fund their own claims. The Company charges these customers administrative fees based on the expected cost of administering their self-funded programs. In some cases, the Company provides performance guarantees related to its administrative function. If these standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. Amounts accrued for performance guarantees were not material as of December 31, 2010 and 2009.

As of December 31, 2010, the Company has outstanding, undrawn letters of credit with financial institutions of $66 million and surety bonds outstanding with insurance companies of $288 million, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, providers, customers and regulators, relating to the Company's management and administration of health benefit plans. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices. The adverse resolution of any specific lawsuit or any potential regulatory proceeding or action could have a material adverse effect on the Company's business, financial condition and results of operations.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of probable costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, except as otherwise noted below, the Company is unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

MDL Litigation. Beginning in 1999, a series of class action lawsuits were filed against the Company by health care providers alleging various claims relating to the Company's reimbursement practices, including alleged violations of the Racketeer Influenced Corrupt Organization Act (RICO) and state prompt payment laws and breach of contract claims. Many of these lawsuits were consolidated in a multi-district litigation in the United States District Court for the Southern District Court of Florida (MDL). In the lead MDL lawsuit, the court

certified a class of health care providers for certain of the RICO claims. In 2006, the trial court dismissed all of the claims against the Company in the lead MDL lawsuit, and the Eleventh Circuit Court of Appeals later affirmed that dismissal, leaving eleven related lawsuits that had been stayed during the litigation of the lead MDL lawsuit. In August 2008, the trial court, applying its rulings in the lead MDL lawsuit, dismissed seven of these lawsuits (the seven lawsuits). The trial court also dismissed all but one claim in an eighth lawsuit, and ordered the final claim to arbitration. In December 2008, at the plaintiffs' request, the trial court dismissed without prejudice one of the three remaining lawsuits. The court also denied the plaintiffs' request to remand the remaining two lawsuits to state court and a federal magistrate judge recommended dismissal of those suits. In April 2009, the plaintiffs in these last two suits filed amended class action complaints alleging breach of contract, but those amended complaints were subsequently dismissed without prejudice. In July 2010, the Eleventh Circuit reversed the trial court's dismissal of the seven lawsuits and remanded those cases to the trial court for further proceedings. In addition, the Company is party to a number of arbitrations in various jurisdictions involving claims similar to those alleged in the seven lawsuits. The Company is vigorously defending against the remaining claims in these cases.

AMA Litigation. On March 15, 2000, a group of plaintiffs including the American Medical Association (AMA) filed a lawsuit against the Company in state court in New York, which was removed to federal court. The complaint and subsequent amended complaints asserted antitrust claims and claims based on the Employee Retirement Income Security Act of 1974, as amended (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 health care providers by the Company's affiliates. On January 14, 2009, the parties announced an agreement to settle the lawsuit, along with a similar case filed in 2008 in federal court in New Jersey. Under the terms of the settlement, the Company and its affiliated entities will be released from claims relating to their out-of-network reimbursement policies from March 15, 1994 through the date of final court approval of the settlement and the Company agreed to pay $350 million (the settlement amount) to a fund for health plan members and out-of-network providers in connection with out-of-network procedures performed since March 15, 1994. The agreement contains no admission of wrongdoing. The court granted preliminary approval of the settlement over the objections of certain plaintiffs' counsel on December 1, 2009, and granted final approval of the settlement on September 20, 2010. On October 18, 2010, the Company paid the settlement amount, plus interest, to an escrow account established by the plaintiffs. Several members of the plaintiff class have filed appeals challenging approval of the settlement. Other lawsuits in various jurisdictions relating to the calculation of reasonable and customary reimbursement rates for non-network health care providers remain pending against a number of health insurers, including the Company.

California Claims Processing Matter. In 2007, the California Department of Insurance (CDI) examined the Company's PacifiCare health insurance plan in California. The examination findings related to the timeliness and accuracy of claims processing, interest payments, provider contract implementation, provider dispute resolution and other related matters. On January 25, 2008, the CDI issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations in connection with the CDI's examination findings. On June 3, 2009, the Company filed a Notice of Defense to the Order to Show Cause denying all material allegations and asserting certain defenses. The matter has been the subject of an administrative hearing before a California administrative law judge (ALJ) since December 2009. CDI amended its Order to Show Cause three times in 2010 to allege a total of 992,936 violations, the large majority of which relate to an alleged failure to include certain language in standard claims correspondence during a four month period in 2007. Although we believe that CDI has never issued an aggregate penalty in excess of $8 million, CDI alleges in press reports and releases that the Company could theoretically be subject to penalties of up to $10,000 per violation. The Company is vigorously defending against these claims. After the ALJ issues a ruling at the conclusion of the administrative proceeding, the California Insurance Commissioner may accept, reject or modify the ALJ's ruling, issue his own decision, and impose a fine or penalty. The Commissioner's decision is subject to challenge in court.

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Historical Stock Option Practices. In 2006, a consolidated shareholder derivative action, captioned In re UnitedHealth Group Incorporated Shareholder Derivative Litigation was filed against certain of the Company's current and former officers and directors in the United States District Court for the District of Minnesota. The consolidated amended complaint was brought on behalf of the Company by several pension funds and other shareholders and named certain of the Company's current and former officers and directors as defendants, as well as the Company as a nominal defendant. The consolidated amended complaint generally alleged that the defendants breached their fiduciary duties to the Company, were unjustly enriched and violated the securities laws in connection with the Company's historical stock option practices. On June 26, 2006, the Company's Board of Directors created a Special Litigation Committee under Minnesota Statute 302A.241, consisting of two former Minnesota Supreme Court Justices, with the power to investigate the claims raised in the derivative actions and shareholder demands and determine whether the Company's rights and remedies should be pursued.

A consolidated derivative action, captioned In re UnitedHealth Group Incorporated Derivative Litigation, was also filed in Hennepin County District Court, State of Minnesota. The action was brought by two individual shareholders and named certain of the Company's current and former officers and directors as defendants, as well as the Company as a nominal defendant.

On December 6, 2007, the Special Litigation Committee concluded its review of claims relating to the Company's historical stock option practices and published a report. The Special Litigation Committee reached settlement agreements on behalf of the Company with its former Chairman and Chief Executive Officer William W. McGuire, M.D., former General Counsel David J. Lubben and former director William G. Spears. In addition, the Special Litigation Committee concluded that all claims against all named defendants in the derivative actions, including current and former Company officers and directors, should be dismissed. Each settlement agreement is conditioned upon dismissal of claims in the derivative actions and resolution of any appeals. Following notice to shareholders, the federal court granted the parties' motion for final approval of the proposed settlements on July 1, 2009, and entered final judgment dismissing the federal case with prejudice on July 2, 2009. The state court granted the parties' motion for final approval of the proposed settlements and dismissed the state case with prejudice on May 14, 2009, and entered final judgment on July 17, 2009. The federal and state courts also awarded plaintiffs' counsel fees and expenses of $30 million and $6 million, respectively, which have been paid by the Company. A shareholder filed an appeal challenging only the federal plaintiffs' counsel's fee award, which was dismissed by the U.S. Court of Appeals for the Eighth Circuit on January 26, 2011.

As previously disclosed, the Company also received inquiries from a number of federal and state regulators from 2006 through 2008 regarding its historical stock option practices. Many of those inquiries have been closed, resolved or inactive since 2008.

Government Regulation

The Company's business is regulated at federal, state, local and international levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been and is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor, the Federal Deposit Insurance Corporation and other governmental authorities. Examples of audits include the risk adjustment data validation (RADV) audits discussed below and a review by the U.S. Department of Labor of the Company's administration of applicable customer employee benefit plans with respect to ERISA compliance.

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Government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs and could have a material adverse effect on the Company's financial results.

Risk Adjustment Data Validation Audits. CMS adjusts capitation payments to Medicare Advantage and Medicare Part D plans according to the predicted health status of each beneficiary, as supported by data provided by health care providers. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

As previously disclosed, in 2008, CMS announced that it would perform RADV audits of selected Medicare Advantage health plans each year to validate the coding practices of and supporting documentation maintained by health care providers. These audits involve a review of medical records maintained by providers and may result in retrospective adjustments to payments made to health plans. Certain of the Company's health plans have been selected for audit. These audits are focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. Although these audits are ongoing, the Company does not believe they will have a material impact on the Company's results of operations, financial position or cash flows.

In December 2010, CMS published for public comment a new proposed RADV audit and payment adjustment methodology. The proposed methodology contains provisions allowing retroactive contract level payment adjustments for the year audited using an extrapolation of the "error rate" identified in audit samples. The Company has submitted comments to CMS regarding concerns the Company has with CMS's proposed methodology. These concerns include, among others, the fact that the proposed methodology does not take into account the "error rate" in the original Medicare fee-for-service data that was used to develop the risk adjustment system. Additionally, payments received from CMS, as well as benefits offered and premiums charged to members, are based on actuarially certified bids that did not include any assumption of retroactive audit payment adjustments. The Company believes that applying retroactive audit and payment adjustments after CMS acceptance of bids undermines the actuarial soundness of the bids. On February 3, 2011, CMS notified the Company that CMS was evaluating all comments received on the proposed methodology and that it anticipated making changes to the draft, based on input CMS had received. CMS also indicated that it anticipated the final methodology would be issued in the near future. Depending on the methodology utilized, potential payment adjustments could have a material adverse effect on the Company's results of operations, financial position and cash flows.

The Company is also in discussions with the OIG for Health and Human Services regarding audits of the Company's risk adjustment data for two plans. While the Company does not believe OIG has governing authority to directly impose payment adjustments for risk adjustment audits of Medicare health plans operated under the regulatory authority of CMS, the OIG can recommend to CMS a proposed payment adjustment, and the Company is unable to predict the outcome of these discussions and audits.

Guaranty Fund Assessments. The Pennsylvania Insurance Commissioner has placed Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. If Penn Treaty is liquidated, the Company's insurance entities and other insurers may be required to pay a portion of Penn Treaty's policyholder claims through guaranty association assessments in future periods. The Company is unable to estimate losses or ranges of losses because the Company cannot predict when the state court will render a decision, the amount of the insolvency, if any, the amount and timing of any associated guaranty fund assessments or the availability and amount of any potential offsets, such as an offset of any premium taxes otherwise payable by the Company. An assessment could have a material adverse effect on the on the Company's results of operations, financial position and cash flows.

See Item 1, "Business — Government Regulation," and Item 1A, "Risk Factors," for additional regulatory information and related risks.

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14. Segment Financial Information

Factors used in determining the Company's reporting segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision-maker to evaluate its results of operations.

The Company's accounting policies for reporting segment operations are the same as those described in the Summary of Significant Accounting Policies (see Note 2 of Notes to the Consolidated Financial Statements). Transactions between reporting segments principally consist of sales of pharmacy benefit products and services to Health Benefits customers by Prescription Solutions, certain product offerings sold to Health Benefits customers by OptumHealth, and medical benefits cost, quality and utilization data and predictive modeling sold to Health Benefits by Ingenix. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reporting segment using estimates of pro-rata usage. Cash and investments are assigned such that each reporting segment has at least minimum specified levels of regulatory capital or working capital for non-regulated businesses.

Substantially all of the Company's assets are held and operations are conducted in the United States. In accordance with accounting principles generally accepted in the United States, reporting segments with similar economic characteristics may be combined. The financial results of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State have been aggregated in the Health Benefits segment column in the following tables 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. These businesses also share significant common assets, including the Company's contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 27% for both years ended December 31, 2010 and 2009, and 25% for the year ended December 31, 2008 most of which were generated by UnitedHealthcare Medicare & Retirement and included in the Health Benefits segment.

On January 1, 2011, the Company realigned certain of its businesses to respond to changes in the markets the Company serves and the opportunities that are emerging as the health system evolves. For example, in 2011 OptumHealth's results of operations will include the Company's clinical services assets, including Southwest Medical multi-specialty clinics in Nevada and the Evercare nurse practitioners serving the frail and elderly, which had historically been reported in UnitedHealthcare Employer & Individual and UnitedHealthcare Medicare & Retirement, respectively. UnitedHealthcare Employer & Individual's results of operations will include OptumHealth Specialty Benefits, including dental, vision, life and disability. There were no changes to the Company's reportable segments as a result of these changes. The Company's periodic filings beginning with the first quarter 2011 Form 10-Q will include historical segment results restated to reflect the effect of this realignment.

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The following table presents reporting segment financial information as of and for the years ended December 31:

(in millions)	Health Benefits	OptumHealth	Ingenix	Prescription Solutions	Corporate and Intersegment Eliminations	Consolidated
2010						
Revenues — external customers:						
Premiums	$ 82,890	$ 2,515	$ 0	$ 0	$ 0	$ 85,405
Services	4,015	337	1,403	64	0	5,819
Products	0	0	93	2,229	0	2,322
Total revenues — external customers	86,905	2,852	1,496	2,293	0	93,546
Total revenues — intersegment	0	2,930	845	14,478	(18,253)	0
Investment and other income	537	67	0	5	0	609
Total revenues	$ 87,442	$ 5,849	$ 2,341	$ 16,776	$ (18,253)	$ 94,155
Earnings from operations	$ 6,636	$ 610	$ 84	$ 534	$ 0	$ 7,864
Interest expense	0	0	0	0	(481)	(481)
Earnings before income taxes	$ 6,636	$ 610	$ 84	$ 534	$ (481)	$ 7,383
Total assets	$ 50,178	$ 4,763	$ 5,131	$ 3,138	$ (147)	$ 63,063
Purchases of property, equipment and capitalized software	$ 495	$ 131	$ 155	$ 80	$ 17	$ 878
Depreciation and amortization	$ 709	$ 115	$ 158	$ 82	$ 0	$ 1,064
Goodwill impairment	$ 0	$ 0	$ 172	$ 0	$ 0	$ 172
2009						
Revenues — external customers:						
Premiums	$ 76,882	$ 2,433	$ 0	$ 0	$ 0	$ 79,315
Services	3,937	277	1,042	50	0	5,306
Products	0	0	90	1,835	0	1,925
Total revenues — external customers	80,819	2,710	1,132	1,885	0	86,546
Total revenues — intersegment	0	2,753	691	12,562	(16,006)	0
Investment and other income	522	65	0	5	0	592
Total revenues	$ 81,341	$ 5,528	$ 1,823	$ 14,452	$ (16,006)	$ 87,138
Earnings from operations	$ 4,788	$ 636	$ 246	$ 689	$ 0	$ 6,359
Interest expense	0	0	0	0	(551)	(551)
Earnings before income taxes	$ 4,788	$ 636	$ 246	$ 689	$ (551)	$ 5,808
Total assets	$ 49,068	$ 4,395	$ 2,415	$ 3,061	$ 106	$ 59,045
Purchases of property, equipment and capitalized software	$ 452	$ 78	$ 142	$ 67	$ 0	$ 739
Depreciation and amortization	$ 668	$ 116	$ 129	$ 78	$ 0	$ 991
2008						
Revenues — external customers:						
Premiums	$ 71,298	$ 2,310	$ 0	$ 0	$ 0	$ 73,608
Services	3,871	311	925	45	0	5,152
Products	0	0	95	1,560	0	1,655
Total Revenues — external customers	75,169	2,621	1,020	1,605	0	80,415
Total Revenues — intersegment	0	2,529	532	10,960	(14,021)	0
Investment and other income	688	75	0	8	0	771
Total revenues	$ 75,857	$ 5,225	$ 1,552	$ 12,573	$ (14,021)	$ 81,186
Earnings from operations	$ 5,068	$ 718	$ 229	$ 363	$ (1,115)	$ 5,263
Interest expense	0	0	0	0	(639)	(639)
Earnings before income taxes	$ 5,068	$ 718	$ 229	$ 363	$ (1,754)	$ 4,624
Total Assets	$ 46,459	$ 4,195	$ 1,755	$ 2,603	$ 803	$ 55,815
Purchases of property, equipment and capitalized software	$ 522	$ 100	$ 112	$ 57	$ 0	$ 791
Depreciation and amortization	$ 691	$ 120	$ 105	$ 65	$ 0	$ 981

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15. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2010 and 2009 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2010				
Revenues	$23,193	$23,264	$ 23,668	$ 24,030
Operating costs	21,177	21,363	21,523	22,228
Earnings from operations	2,016	1,901	2,145	1,802
Net earnings	1,191	1,123	1,277	1,043
Basic net earnings per common share	1.04	1.00	1.15	0.95
Diluted net earnings per common share	1.03	0.99	1.14	0.94
2009				
Revenues	$22,004	$21,655	$ 21,695	$ 21,784
Operating costs	20,336	20,215	20,019	20,209
Earnings from operations	1,668	1,440	1,676	1,575
Net earnings	984	859	1,035	944
Basic net earnings per common share	0.82	0.73	0.90	0.82
Diluted net earnings per common share	0.81	0.73	0.89	0.81

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

The Company maintains disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by the Company in reports that it files or submits under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to the Company's management, including its principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-K, management evaluated, under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of the Company's disclosure controls and procedures as of December 31, 2010. Based upon that evaluation, the Company's Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2010.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2010 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

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Report of Management on Internal Control over Financial Reporting as of December 31, 2010

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2010. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control — Integrated Framework*. Based on our assessment and those criteria, we believe that, as of December 31, 2010, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2010, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal controls over financial reporting as of December 31, 2010.

/s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Executive Officer

/s/ DAVID S. WICHMANN

David S. Wichmann
Executive Vice President and
Chief Financial Officer of UnitedHealth Group and
President of UnitedHealth Group Operations

/s/ ERIC S. RANGEN

Eric S. Rangen
Senior Vice President and Chief Accounting Officer

February 10, 2011

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2010, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2010. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on the criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2010 of the Company and our reports dated February 10, 2011 expressed an unqualified opinion on those consolidated financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2011

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ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by Item 201(d) of Regulation S-K will be included under the heading "Equity Compensation Plan Information" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2011 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

Reports of Independent Registered Public Accounting Firm.

Consolidated Balance Sheets as of December 31, 2010 and 2009.

Consolidated Statements of Operations for the years ended December 31, 2010, 2009 and 2008.

Consolidated Statements of Changes in Shareholders' Equity for the year ended December 31, 2010, 2009 and 2008.

Consolidated Statements of Cash Flows for the year ended December 31, 2010, 2009 and 2008.

Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

3. *Exhibits***

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

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4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10.2	Amendment to the UnitedHealth Group Incorporated 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.3	Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.4	Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.5	Form of Agreement for Initial Restricted Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.6	Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(e) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.7	Form of Agreement for Stock Option Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.8	Form of Agreement for Restricted Stock Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.9	Form of Agreement for Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.10	Form of Agreement for Stock Appreciation Rights Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.11	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.12	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, effective as of February 9, 2011
*10.13	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, effective as of February 9, 2011
*10.14	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)

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*10.15	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.16	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.17	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 31, 2006)
*10.18	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.19	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.21	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
*10.22	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.23	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to the Company's Annual Report on Form 10K for the year ended December 31, 2009)
*10.24	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)

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*10.30	Amendment to Employment Agreement, dated as of December 14, 2010, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 15, 2010)
*10.31	Employment Agreement, effective as of November 7, 2006, by and between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 30, 2007)
*10.32	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.33	Amended and Restated Employment Agreement, dated as of June 2, 2010, between United HealthCare Services, Inc. and Gail K. Boudreaux
*10.34	Employment Agreement, effective as of April 12, 2007, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.35	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.36	Employment Agreement, effective as of January 29, 2009, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.37	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.38	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
12.1	Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of the Company
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2010, filed on February 10, 2011, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Changes in Shareholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements, tagged as blocks of text.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request(c) Financial Statement Schedule

(c) Financial Statement Schedule

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

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Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2010 and 2009, and for each of the three years in the period ended December 31, 2010, and the Company's internal control over financial reporting as of December 31, 2010, and have issued our reports thereon dated February 10, 2011; such consolidated financial statements and reports are included elsewhere in this Form 10-K. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2011

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2010	2009
Assets		
Current assets:		
Cash and cash equivalents	$ 916	$ 2,309
Deferred income taxes	57	163
Prepaid expenses and other current assets	207	61
Total current assets	1,180	2,533
Equity in net assets of subsidiaries	36,246	32,812
Other assets	110	60
Total assets	$37,536	$35,405
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 301	$ 522
Note payable to subsidiary	130	100
Commercial paper and current maturities of long-term debt	2,480	2,164
Total current liabilities	2,911	2,786
Long-term debt, less current maturities	8,662	9,009
Deferred income taxes and other liabilities	138	4
Total liabilities	11,711	11,799
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value —10 shares authorized; no shares issued or outstanding	0	0
Common stock, $0.01 par value — 3,000 shares authorized; 1,086 and 1,147 issued and outstanding	11	11
Retained earnings	25,562	23,342
Accumulated other comprehensive income (loss):		
Net unrealized gains (losses) on investments, net of tax effects	280	277
Foreign currency translation loss	(28)	(24)
Total shareholders' equity	25,825	23,606
Total liabilities and shareholders' equity	$37,536	$35,405

See Notes to the Condensed Financial Statements of Registrant

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Operations

(in millions)	For the Year Ended December 31, 2010	2009	2008
Revenues:			
Investment and other income	$ 2	$ 10	$ 20
Total revenues	2	10	20
Operating costs:			
Operating costs	54	5	1,256
Interest expense	433	509	565
Total operating costs	487	514	1,821
Loss before income taxes	(485)	(504)	(1,801)
Benefit for income taxes	180	172	641
Loss of parent company	(305)	(332)	(1,160)
Equity in undistributed income of subsidiaries	4,939	4,154	4,137
Net earnings	$ 4,634	$ 3,822	$ 2,977

See Notes to the Condensed Financial Statements of Registrant

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2010	2009	2008
Operating activities			
Cash flows from operating activities	$ 3,731	$ 5,065	$ 3,962
Investing activities			
Capital contributions to subsidiaries	(104)	(90)	(7)
Cash paid for acquisitions	(2,470)	(1,045)	(4,419)
Cash received from dispositions	0	0	185
Cash flows used for investing activities	(2,574)	(1,135)	(4,241)
Financing activities			
Proceeds from (repayments of) commercial paper, net	930	(99)	(1,346)
Proceeds from issuance of long-term debt	747	0	2,981
Payments for retirement of long-term debt	(1,583)	(1,350)	(500)
Proceeds from interest rate swap termination	0	513	0
Proceeds from issuance of note to subsidiary	30	0	100
Common stock repurchases	(2,517)	(1,801)	(2,684)
Proceeds from common stock issuances	272	282	299
Share-based compensation excess tax benefits	27	38	62
Dividends paid	(449)	(36)	(37)
Other	(7)	(48)	(143)
Cash flows used for financing activities	(2,550)	(2,501)	(1,268)
(Decrease) increase in cash and cash equivalents	(1,393)	1,429	(1,547)
Cash and cash equivalents, beginning of period	2,309	880	2,427
Cash and cash equivalents, end of period	$ 916	$ 2,309	$ 880
Supplemental cash flow disclosures			
Cash paid for interest	$ 459	$ 485	$ 547
Cash paid for income taxes	$ 2,725	$ 2,048	$ 1,882

See Notes to the Condensed Financial Statements of Registrant.

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements
For the Years Ended December 31, 2010, 2009 and 2008

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in the Summary of Significant Accounting Policies in Note 2 of Notes to the Consolidated Financial Statements.

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $4.3 billion, $5.4 billion and $1.8 billion in 2010, 2009 and 2008, respectively.

3. Commercial Paper and Long-Term Debt

Further discussion of maturities of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements.

4. Commitments and Contingencies

Operating costs for 2008 included $350 million for the settlement of class action litigation related to reimbursement for out-of-network medical services. For a summary of the proposed settlement and other commitments and contingencies, see Note 13 of Notes to the Consolidated Financial Statements.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 10, 2011

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY
Stephen J. Hemsley
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director, President and Chief Executive Officer (principal executive officer)	February 10, 2011
/S/ DAVID S. WICHMANN **David S. Wichmann**	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations (principal financial officer)	February 10, 2011
/S/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 10, 2011
* **William C. Ballard, Jr.**	Director	February 10, 2011
* **Richard T. Burke**	Director	February 10, 2011
* **Robert J. Darretta**	Director	February 10, 2011
* **Michele J. Hooper**	Director	February 10, 2011
* **Rodger A. Lawson**	Director	February 10, 2011
* **Douglas W. Leatherdale**	Director	February 10, 2011
* **Glenn M. Renwick**	Director	February 10, 2011
* **Kenneth I. Shine**	Director	February 10, 2011
* **Gail R. Wilensky**	Director	February 10, 2011

*By /S/ CHRISTOPHER J. WALSH
Christopher J. Walsh,
As Attorney-in-Fact

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EXHIBIT INDEX[**]

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10.2	Amendment to the UnitedHealth Group Incorporated 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.3	Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.4	Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.5	Form of Agreement for Initial Restricted Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.6	Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(e) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.7	Form of Agreement for Stock Option Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.8	Form of Agreement for Restricted Stock Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated October 23, 2009)

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*10.9	Form of Agreement for Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.10	Form of Agreement for Stock Appreciation Rights Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.11	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.12	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, effective as of February 9, 2011
*10.13	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, effective as of February 9, 2011
*10.14	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.16	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.17	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 31, 2006)
*10.18	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.19	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 of the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.21	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
*10.22	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.23	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to the Company's Annual Report on Form 10K for the year ended December 31, 2009)
*10.24	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.25	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)

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*10.26	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.27	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.28	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.29	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.30	Amendment to Employment Agreement, dated as of December 14, 2010, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 15, 2010)
*10.31	Employment Agreement, effective as of November 7, 2006, by and between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 30, 2007)
*10.32	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.33	Amended and Restated Employment Agreement, dated as of June 2, 2010, between United HealthCare Services, Inc. and Gail K. Boudreaux
*10.34	Employment Agreement, effective as of April 12, 2007, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.35	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.36	Employment Agreement, effective as of January 29, 2009, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.37	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008)
*10.38	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10.37 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
12.1	Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of the Company
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney

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31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2010, filed on February 10, 2011, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Changes in Shareholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements, tagged as blocks of text.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request(c) Financial Statement Schedule

(c) Financial Statement Schedule

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

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

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2009**

OR

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

Commission file number: 1-10864

UNITEDHEALTH GROUP INCORPORATED
(Exact name of registrant as specified in its charter)

MINNESOTA	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UNITEDHEALTH GROUP CENTER 9900 BREN ROAD EAST MINNETONKA, MINNESOTA	**55343**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (952) 936-1300

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
(Do not check if a smaller reporting company)	

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2009 was $28,599,603,374 (based on the last reported sale price of $24.98 per share on June 30, 2009, on the New York Stock Exchange).*

As of February 3, 2010, there were 1,157,533,379 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we incorporate by reference certain information from our Definitive Proxy Statement for the Annual Meeting of Shareholders to be held on May 25, 2010. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

*Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the Company have been excluded in determining this number.

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group Incorporated is a diversified health and well-being company, serving more than 70 million Americans (the terms "we," "our," "us" "UnitedHealth Group" or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries). Our focus is on improving the overall health and well-being of the people we serve and their communities and enhancing the performance of the health system. We work with physicians and other health care professionals, hospitals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost, support the physician/patient relationship, and empower people with the information, guidance and tools they need to make personal health choices and decisions.

During 2009, we managed approximately $120 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our primary focus is on improving the 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 professionals, 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 information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable. These core competencies are focused in two market areas – health benefits and health services. Health benefits are offered in the individual and employer markets and the public and senior markets through our UnitedHealthcare, Ovations and AmeriChoice businesses. Health services are provided to the participants in the health system itself, ranging from employers and health plans to physicians and life sciences companies through our OptumHealth, Ingenix and Prescription Solutions businesses.

Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. We have four reporting segments:

- Health Benefits (formerly Health Care Services), which includes UnitedHealthcare, Ovations and AmeriChoice;
- OptumHealth;
- Ingenix; and
- Prescription Solutions

For a discussion of our financial results by reporting segment, see Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly

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reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

Our transfer agent, Wells Fargo Shareowner Services, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

DESCRIPTION OF REPORTING SEGMENTS

Health Benefits

Our Health Benefits reporting segment consists of the following businesses: UnitedHealthcare, Ovations and AmeriChoice. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been aggregated in the Health Benefits reporting segment due to their similar economic characteristics, products and services, types of customers, distribution methods, operational processes and regulatory environment. These businesses also share significant common assets, including our contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources. Health Benefits arranges for discounted access to care through a network of approximately 700,000 physicians and other health care professionals and 5,200 hospitals across the United States.

UnitedHealthcare

UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare facilitated access to health care services on behalf of approximately 25 million Americans as of December 31, 2009. With its risk-based product offerings, UnitedHealthcare assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate for a one-year period. UnitedHealthcare also provides administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependants, for which UnitedHealthcare receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependants, while UnitedHealthcare provides coordination and facilitation of medical services, customer and health care professional services and access to a contracted network of physicians, hospitals and other health care professionals. Large employer groups, such as those serviced by UnitedHealthcare National Accounts, typically use self-funded arrangements. As of December 31, 2009, UnitedHealthcare National Accounts served approximately 380 large employer groups under these arrangements, including 150 of the *Fortune 500* companies. Small employer groups are more likely to purchase risk-based products because they are less willing to bear a greater potential liability for health care expenditures. UnitedHealthcare also offers a variety of non-employer based insurance options for purchase by individuals, which are designed to meet the health coverage needs of these consumers and their families.

UnitedHealthcare offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs). UnitedHealthcare's product strategy centers on several principles: consumer choice, broad access to health professionals, and use of data and science to promote better outcomes, quality service, transparency and affordability. Integrated wellness programs and services help individuals make informed decisions, maintain healthy lifestyles and optimize health outcomes by coordinating access to care services and providing personalized, targeted education and information services.

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Individuals served by UnitedHealthcare have access to approximately 88% of the physicians and other health care professionals and 96% of the hospitals in the Health Benefits network. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare to contract for cost-effective access to a large number of conveniently located care professionals. Directly or through UnitedHealth Group's family of companies, UnitedHealthcare offers:

- A comprehensive range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;
- Affordability across a broad set of price points and a wide product line, from offerings covering essential needs to comprehensive benefit plans, all of which offer access to our broad-based proprietary network of contracted physicians, hospitals and other health care professionals with economic benefits reflective of the aggregate purchasing capacity of our organization;
- Innovative clinical programs that are built around an extensive clinical data set and principles of evidence-based medicine;
- Consumer access to information about physician and hospital performance against quality and cost efficiency criteria based on claims data assessment through the UnitedHealth Premium Designation Program and the UnitedHealth Hospital Comparison Program;
- Physician and facility access to performance feedback information to support continuous quality improvement;
- Care facilitation services that use several identification tools, including proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risks for potential health problems, and then facilitate appropriate interventions;
- Disease and condition management programs to help individuals address significant, complex disease states; and
- Convenient self-service tools for health transactions and information.

UnitedHealthcare's regional and national access to broad, affordable and quality networks of health care professionals has advanced over the past several years, with significant increases in access to services throughout the United States. UnitedHealthcare has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

UnitedHealthcare's innovation distinguishes its product offerings from its competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. To provide consumers with the necessary resources and information to make more informed choices when managing their health, data-driven networks and clinical management are organized through clinical lines of service such as cardiology, oncology, neuroscience, orthopedics, women's health, primary care and emergency services. UnitedHealthcare also offers comprehensive and integrated pharmaceutical management services that promote lower costs by using formulary programs that drive better unit costs for drugs, benefit designs that encourage consumers to use drugs that offer better value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare provides innovative programs that enable consumers to take ownership and control of their health care benefits. These products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs), or health savings accounts (HSAs), and are offered on a self-funded and fully-insured basis. UnitedHealthcare provided these products to approximately 24,000 employer-sponsored benefit plans during 2009, including approximately 150 employers in the large group self-funded market serviced by UnitedHealthcare National Accounts.

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UnitedHealthcare's distribution system consists primarily of brokers and direct and internet sales in the individual market, brokers in the small employer group market, and brokers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare's direct distribution efforts are generally limited to the individual market, portions of the large employer group and public sector markets, and cross-selling of specialty products to existing customers.

Ovations

Ovations provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations is fully dedicated to this market segment, as it provides products and services in all 50 states, the District of Columbia, and most U.S. territories. Ovations participates nationally in the Medicare program, offering a wide-ranging spectrum of Medicare products, including Medigap products that supplement traditional fee-for-service coverage, more traditional health-plan-type programs under Medicare Advantage, Medicare Part D prescription drug coverage, and special offerings for beneficiaries who are chronically ill and/or Medicaid and Medicare dual-eligible.

Ovations has extensive capabilities and experience with distribution, including direct marketing to consumers on behalf of its key clients – AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, state and U.S. government agencies and employer groups. Ovations also has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to risk-based health products and services in the senior and geriatric markets.

Ovations currently has a number of contracts with Centers for Medicare & Medicaid Services (CMS), which primarily relate to the Medicare health benefit programs authorized under the 2003 Medicare Modernization Act. Premium revenues from CMS were 27% of our total consolidated revenues for the year ended December 31, 2009, most of which were generated by Ovations.

Ovations provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS. Ovations also offers Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Special Needs Plans, Point-of-Service (POS) plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, Ovations provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside, demographic factors such as age, gender, and institutionalized status, and the health status of the individual. Ovations offers Medicare Advantage products in all 50 states and the District of Columbia. As of December 31, 2009, Ovations had approximately 1.8 million enrolled individuals in its Medicare Advantage products.

Additionally, Ovations provides the Medicare prescription drug benefit (Part D) to beneficiaries throughout the United States and its territories. Among the several Part D plans it offers, Ovations provides Medicare Part D coverage plans with the AARP brand. Ovations provides Part D drug coverage through its Medicare Advantage program, Special Needs Plans (covering individuals who live in an institutional long-term care setting, individuals dual-eligible for Medicaid and Medicare services or individuals with severe or disabling chronic conditions) and stand-alone Part D plans. As of December 31, 2009, Ovations had enrolled approximately 5.9 million members in the Part D program, including approximately 4.3 million members in the stand-alone Part D plans and approximately 1.6 million members in Medicare Advantage plans incorporating Part D coverage.

In association with AARP, Ovations provides a range of standardized Medicare supplement and hospital indemnity insurance offerings from its insurance company affiliates to approximately 3.8 million AARP members. Additional Ovations services include a nurse healthline service, a lower cost standardized Medicare supplement offering that provides consumers with a national hospital network, 24-hour access to health care information, and access to discounted health services from a network of physicians.

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Ovations also provides complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. Ovations serves approximately 365,000 individuals (including approximately 255,000 individuals in the Medicare Advantage products) across the nation in long-term care settings including nursing homes, community-based settings and private homes, as well as through hospice and palliative care. Ovations offers services through innovative care management and clinical programs, integrating federal, state and personal funding through a continuum of products from Special Needs Plans and long-term care Medicaid programs to hospice care, and serves people in 35 states and in the District of Columbia in home, community and nursing home settings. These services are provided primarily through nurse practitioners, nurses and care managers.

Ovations also offers a comprehensive eldercare service program providing service coordination, consultation, claim management and information resources nationwide. Proprietary, automated medical record software enables the Ovations clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of coherent care information that bridges across home, hospital and nursing home care settings for high-risk populations. Ovations also operates hospice and palliative care programs in 16 local markets in 11 states.

AmeriChoice

AmeriChoice provides network-based health and well-being services to beneficiaries of State Medicaid Children's Health Insurance Programs (SCHIP), and other government-sponsored health care programs. AmeriChoice provides health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state. AmeriChoice also offers government agencies a number of diverse management service programs, including a clinical care consulting program, disease and conditions management, pharmacy benefit services and administrative and technology services, to help them effectively administer their distinct health care delivery systems and benefits for individuals in their programs. AmeriChoice also contracts with CMS for the provision of Special Needs Plans serving individuals dual-eligible for Medicaid and Medicare services. These programs are primarily organized toward enrolling individuals who are dual-eligible for Medicaid and Medicare coverage in states where AmeriChoice operates its Medicaid health plans. As of December 31, 2009, AmeriChoice covered 2.8 million beneficiaries through all of its programs in 22 states and District of Columbia.

AmeriChoice's approach is grounded in its belief that health care cannot be provided effectively without considering all of the factors (social, behavioral, economic, environmental, and physical) that affect a person's life. AmeriChoice coordinates resources among family members, physicians, other health care professionals and government and community-based agencies and organizations to provide continuous and effective care. For members, this means that the AmeriChoice Personal Care Model offers them a holistic approach to health care, emphasizing practical programs to improve their living circumstances as well as quality medical care and treatment in accessible, culturally sensitive, community-oriented settings. For example, AmeriChoice's disease management and outreach programs focus on high-prevalence and debilitating illnesses such as hypertension and cardiovascular disease, asthma, sickle cell disease, diabetes, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), cancer and high-risk pregnancy. AmeriChoice has developed several of these programs with the help of leading researchers and clinicians at academic medical centers and medical schools.

For physicians, the AmeriChoice Personal Care Model means assistance with coordination of their patients' care. AmeriChoice utilizes sophisticated technology to monitor preventive care interventions and evidence-based treatment protocols to support care management. AmeriChoice operates advanced and unique pharmacy administrative services, including benefit design, generic drug incentive programs, drug utilization review and preferred drug list development to help optimize the use of appropriate quality pharmaceuticals and concurrently manage pharmacy expenditures to levels appropriate to the specific clinical situations.

For state customers, the AmeriChoice Personal Care Model means increased access to care and improved quality for their beneficiaries, in a measurable system that reduces their administrative burden and lowers their costs. AmeriChoice considers a variety of factors when determining in which state programs to participate and on what

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basis. They include a state's consistency of support for service innovation and funding of its Medicaid program, the population base, the commitment of the physician/provider community to the AmeriChoice Personal Care Model, and the presence of community-based organizations that can partner with AmeriChoice to meet member needs.

OptumHealth

OptumHealth serves nearly 58 million unique individuals with its diversified offering of health, financial and ancillary benefit services and products that assist consumers in navigating the health care system, accessing health services based on their needs, supporting their emotional health and well-being, providing ancillary insurance benefits and helping people finance their health care needs through account-based programs. OptumHealth seeks to simplify the consumer health care experience and facilitate the efficient and effective delivery of care. Its capabilities can be deployed individually or integrated to provide a comprehensive solution oriented around a broad base of consumer needs within the health care system.

OptumHealth's simple, modular service designs can be easily integrated to meet varying employer, payer, public sector and consumer needs at a wide range of price points. OptumHealth offers its products on an administrative fee basis where it manages and administers benefit claims for self-insured customers in exchange for a fixed fee per individual served, and on a risk basis, where OptumHealth assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth distributes its products through three strategic markets: employer (which includes the sub-markets of large, mid and small employers), payer (which includes the sub-markets of health plans, third party administrators, underwriter/stop-loss carriers and individual market intermediaries) and public sector (which includes Medicaid, Medicare and Federal procurement).

OptumHealth is one brand, organized into four major operating groups: OptumHealth Care Solutions, OptumHealth Financial Services, OptumHealth Behavioral Solutions and OptumHealth Specialty Benefits.

Care Solutions. Care Solutions serves more than 40 million individuals through personalized health management solutions that improve people's health and well-being, improve clinical outcomes and workforce productivity and reduce health care costs. Programs include wellness and prevention, disease management, case management, physical health programs, complex condition management, specialized provider networks, personalized health portals and consumer marketing services.

Care Solutions also provides benefit administration and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services through its national network consisting of approximately 24,000 chiropractors, 16,000 physical and occupational therapists and 8,000 complementary and alternative health professionals.

Financial Services. Financial Services provides health-based financial services for consumers, employers, payers and health care professionals. These financial services include HSAs, HRAs and Flexible Spending Accounts offered through OptumHealth Bank, a Utah-chartered industrial bank. As of December 31, 2009, Financial Services had approximately $860 million in assets under management. Financial Services' health benefit card programs include electronic systems for verification of benefit coverage and eligibility. Financial Services also provides electronic payment and statement services for health care professionals and payers. In 2009, Financial Services electronically transmitted $36 billion in medical payments to physicians and other health care providers.

Behavioral Solutions. Behavioral Solutions serves 43 million individuals with its employee assistance programs, work/life offerings, and clinically driven behavioral health, substance abuse and psychiatric disability management programs. Its consumer-focused programs incorporate state-of-the-art predictive modeling,

outcomes management and evidence-based best practices, which result in better care and a reduction in overall health care costs. Behavioral Solutions customers have access to a national network of approximately 87,000 clinicians and counselors and approximately 2,900 facilities in 5,000 locations.

Specialty Benefits. Specialty Benefits includes dental, vision, life, critical illness, short-term disability and stop-loss product offerings delivered through an integrated platform that enhances efficiency and effectiveness. Specialty Benefits covers nearly 23 million individuals and includes a network of approximately 32,000 vision professionals in private and retail settings, and approximately 119,000 dental providers. Stop-loss insurance is marketed throughout the United States through a network of TPAs, brokers and consultants.

Ingenix

Ingenix offers database and data management services, software products, publications, consulting and actuarial services, business process outsourcing services and pharmaceutical data consulting and research services in conjunction with the development of pharmaceutical products on a nationwide and international basis. As of December 31, 2009, Ingenix's customers include approximately 6,000 hospitals, 245,000 physicians, 2,000 payers and intermediaries, 200 *Fortune 500* companies, 655 life sciences companies, 350 government entities, and 135 United Kingdom Government Payers, as well as other UnitedHealth Group businesses.

Ingenix is engaged in the simplification of health care administration with information and technology. Ingenix helps customers accurately and efficiently manage the information flowing through the health care system. Ingenix uses data to help advance transparency on cost and quality and help customers streamline their processes to make health care more efficient. Ingenix is a leader in contract research services, and pharmacoeconomics, epidemiology and safety and outcomes (including comparative effectiveness) research through its i3 businesses.

Ingenix's products and services are sold primarily through a direct sales force focused on specific customers and market segments across the pharmaceutical, biotechnology, employer, government, hospital, physician, payer and property and casualty insurance market segments. Ingenix's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

Many of Ingenix's contract research services, consulting arrangements and software and related information services are performed over an extended period, often several years. Ingenix maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts or other legally binding agreements that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. Ingenix's aggregate backlog at December 31, 2009 was $2.2 billion, of which $1.6 billion is expected to be realized within the next 12 months. This includes $0.7 billion related to intersegment agreements all of which are included in the current portion. Ingenix cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services and the potential for cancellation or early termination of certain service arrangements.

The Ingenix companies are divided into two groups: Information Services and i3.

Information Services. Information Services' diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trend management, physician practice revenue cycle management, including integrated electronic medical record systems, revenue and payment cycle management for payer and health care professional organizations, payment accuracy solutions, decision-support portals for evaluation of health benefits and treatment options, risk management solutions, connectivity solutions and claims management tools to reduce administrative errors and support fraud recovery services. Information Services uses proprietary software

applications that manage clinical and administrative data across diverse information technology environments. Information Services also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets. Information Services offers comprehensive Electronic Data Interchange (EDI) services helping health care professionals and payers decrease costs of claims transmission, payment and reimbursement through both networked and direct connection services. Information Services publishes print and electronic media products that provide customers with information regarding medical claims coding, reimbursement, billing and compliance issues.

Information Services provides other services, such as verification of physician credentials, health care professional directories, Healthcare Effectiveness Data and Information Set (HEDIS) reporting, and fraud and abuse detection and prevention services. Information Services also offers consulting services, including actuarial and financial advisory work through its Ingenix Consulting division and health care policy research, implementation, strategy and management consulting through its subsidiary, The Lewin Group, as well as product development, health care professional contracting and medical policy management.

i3. i3 uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical and biotechnology development. i3 provides services on a nationwide and international basis, helping customers effectively and efficiently get drug data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. i3's capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services – pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology and safety and outcomes (including comparative effectiveness) research. i3's global contract research services include regulatory assistance, project management, data management, biostatistical analysis, quality assurance, medical writing and staffing resource services. i3's contract research services are therapeutically focused on oncology, the central nervous system, respiratory, infectious and pulmonary diseases and endocrinology.

Prescription Solutions

Prescription Solutions offers a comprehensive suite of integrated pharmacy benefit management (PBM) services to approximately 11 million people, delivering drug benefits through approximately 66,000 retail network pharmacies and two mail service facilities as of December 31, 2009. Prescription Solutions processed approximately 320 million adjusted scripts in 2009 by servicing internal customers in our Health Benefits segment, as well as external employer groups, union trusts, managed care organizations, Medicare-contracted plans, Medicaid plans and TPAs, including mail service only and carve-out accounts.

Prescription Solutions' integrated PBM services include retail network pharmacy management, mail order pharmacy services, specialty pharmacy services, benefit design consultation, drug utilization review, formulary management programs, disease therapy management and adherence programs. Prescription Solutions' products and services are designed to enhance clinical outcomes with reduced costs for those served. The fulfillment capabilities of Prescription Solutions are an important strategic component in serving commercial health plans and Medicare-contracted businesses, including Part D prescription drug plans.

Prescription Solutions' distribution system consists primarily of health insurance brokers and other health care consultant-based or direct sales. In addition to PBM services, Prescription Solutions' Consumer Health Products division delivers diabetic testing and other specialized medical supplies, over the counter items, vitamins and supplements directly to members' homes.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated by federal and state regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. This regulation can vary significantly from jurisdiction to jurisdiction. Federal and state governments continue to enact and consider

various legislative and regulatory proposals that could materially impact certain aspects of the health care system, including proposals to address the affordability and availability of health insurance and to reduce the number of uninsured individuals. The interpretation of existing laws and rules also may change periodically. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, could negatively affect our business. We believe we are in compliance in all material respects with applicable laws, regulations and rules. In the event we fail to comply with federal and state regulations, or fail to respond quickly and appropriately to health care reforms and frequent changes in federal and state regulations, our business, financial condition and results of operations could be materially adversely affected. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with federal and state government regulations.

Federal Laws and Regulation

We are subject to various levels of federal regulation. CMS regulates Ovations and AmeriChoice Medicare and Medicaid businesses. CMS has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care given to Medicare beneficiaries. Our Health Benefits reporting segment, through AmeriChoice and Ovations, also has Medicaid and SCHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services, and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance. When we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. Government contracts. In addition, the portion of Ingenix's business that includes clinical research is subject to regulation by the U.S. Food and Drug Administration. Laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, anti-money laundering, securities and antitrust also affect us.

HIPAA, GLBA and Other Privacy and Security Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. HIPAA requires guaranteed health care coverage for small employers and certain eligible individuals. It also requires guaranteed renewability for employers and individuals and limits exclusions based on preexisting conditions. Federal regulations promulgated pursuant to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may also apply to us.

Federal privacy and security requirements change frequently because of legislation, regulations and judicial or administrative interpretation. For example, the U.S. Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA) which significantly amends, and adds new, privacy and security provisions to HIPAA and imposes additional requirements on uses and disclosures of health information. AARA includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to the Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personal identifiable information. The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with HIPAA, GLBA and other privacy-related regulations.

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ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the DOL provide additional rules for claims payment and member appeals under health care plans governed by ERISA. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

FDIC. The Federal Deposit Insurance Corporation (FDIC) has federal regulatory and supervisory authority over OptumHealth Bank and performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements. In addition to such annual examinations, the FDIC performs periodic examinations of the bank's compliance with applicable federal banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subject to increased operational expenses, governmental oversight and monetary penalties.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners to adopt elements substantially similar to the Sarbanes-Oxley Act of 2002, we expect that these states will continue to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies.

Health plans and insurance companies are also regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends.

In addition, some of our business and related activities may be subject to other health care-related regulations and requirements, including PPO, managed care organization (MCO), utilization review (UR) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices, and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing unnecessary medical services, and improper marketing. Our AmeriChoice and Ovations Medicaid businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits by AmeriChoice to its Medicaid and SCHIP beneficiaries and by Ovations to its Medicaid beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Pharmacy Regulation. Prescription Solutions' mail order pharmacies must be licensed to do business as a pharmacy in the state in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals there are laws and

regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, "Risk Factors" for a discussion of the risks related to our PBM businesses.

Privacy and Security Laws. States have adopted regulations to implement provisions of the GLBA. Like HIPAA, GLBA allows states to adopt more stringent requirements governing privacy protection. A number of states have also adopted other laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure and protection of social security numbers. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines. See Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy-related regulations.

UDFI. In addition, the Utah State Department of Financial Institutions (UDFI) has state regulatory and supervisory authority over OptumHealth Bank and in conjunction with federal regulators performs annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements. In addition to such annual examinations, the UDFI in conjunction with federal regulators performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subjected to increased operational expenses, governmental oversight and monetary penalties.

Commitments. In connection with the PacifiCare Health Systems, Inc. (PacifiCare) and Sierra Health Services, Inc. (Sierra) acquisitions, which closed in December 2005 and February 2008, respectively, certain of our subsidiaries entered into various commitments with state regulatory departments, principally in California and Nevada. Many of the PacifiCare commitments in California expired on December 19, 2009. We believe that none of the remaining commitments in any of the affected states will materially affect our operations.

Audits and Investigations

We have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the Internal Revenue Service, the U.S. Department of Labor and other governmental authorities. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. See Note 14 of Notes to the Consolidated Financial Statements for details. In addition, disclosure of any adverse investigation, audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services and retain our current business.

International Regulation

Some of our business units, including Ingenix's i3 business, have international operations. These international operations are subject to different legal and regulatory requirements in different jurisdictions, including various tax, tariff and trade regulations, as well as employment, intellectual property, privacy, and investment rules and laws.

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COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to directly contract with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our Health Benefits businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas. For our Prescription Solutions businesses, competitors include Medco Health Solutions, Inc., CVS Caremark Corporation and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a broad and diverse set of other businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales, marketing and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected. See Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

EMPLOYEES

As of December 31, 2009, we employed approximately 80,000 individuals. We believe our employee relations are generally positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 3, 2010, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	57	President and Chief Executive Officer
George L. Mikan III	38	Executive Vice President and Chief Financial Officer
Gail K. Boudreaux	49	Executive Vice President of UnitedHealth Group and President of UnitedHealthcare
William A. Munsell	57	Executive Vice President of UnitedHealth Group and President of Enterprise Services Group
Eric S. Rangen	53	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	56	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Public and Senior Markets Group
Lori K. Sweere	51	Executive Vice President of Human Capital
Christopher J. Walsh	44	Executive Vice President, General Counsel and Assistant Secretary
Anthony Welters	54	Executive Vice President of UnitedHealth Group and President of Public and Senior Markets Group
David S. Wichmann	47	Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations
Mitchell E. Zamoff	42	Executive Vice President, General Counsel and Assistant Secretary

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Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. Mr. Hemsley served as President and Chief Operating Officer from 2004 to November 2006. He joined UnitedHealth Group in 1997 and held various executive positions with the Company from 1997 to 2004.

Mr. Mikan is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since November 2006. Mr. Mikan served as Senior Vice President of Finance of UnitedHealth Group from February 2006 to November 2006. From June 2004 to February 2006, Mr. Mikan served as Chief Financial Officer of UnitedHealthcare and as President of UnitedHealth Networks. Mr. Mikan was Chief Financial Officer of Specialized Care Services (now OptumHealth) in 2004. Mr. Mikan joined UnitedHealth Group in 1998 and held various executive positions with the Company from 1998 to 2004.

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and President of UnitedHealthcare and has served in that capacity since May 2008. Prior to joining UnitedHealth Group, Ms. Boudreaux served as Executive Vice President of Health Care Services Corporation (HCSC) from December 2005 to May 2008 and as President of Blue Cross and Blue Shield of Illinois, a division of HCSC, from 2002 to December 2005.

Mr. Munsell is Executive Vice President of UnitedHealth Group and President of the Health Services Group and has served in that capacity since September 2007. From December 2006 to August 2007, Mr. Munsell served as Executive Vice President of UnitedHealth Group. From November 2004 to December 2006, Mr. Munsell served as Chief Executive Officer of Specialized Care Services (now OptumHealth). In 2004, Mr. Munsell served as the Chief Administrative Officer and Chief Operating Officer of UnitedHealthcare. Mr. Munsell joined UnitedHealth Group in 1997 and held various executive positions with the Company from 1997 to 2004.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006. From November 2006 to December 2006, Mr. Rangen was Senior Vice President of UnitedHealth Group. Mr. Rangen joined UnitedHealth Group in November 2006. Prior to joining UnitedHealth Group, Mr. Rangen served as Executive Vice President and Chief Financial Officer of Alliant Techsystems Inc. from April 2004 to March 2006 and as Vice President and Chief Financial Officer of Alliant Techsystems, Inc. from 2001 to April 2004.

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group and has served in that capacity since October 2009. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations. Prior to joining UnitedHealth Group, Mr. Renfro served as President of Fidelity Developing Businesses at Fidelity Investments and as a member of the Fidelity Executive Committee from June 2008 to January 2009. From November 2005 to May 2008, Mr. Renfro held several senior positions at AARP Services Inc., including President and Chief Executive Officer of AARP Services Inc., Chief Operating Officer of AARP Services Inc., President and Chief Executive Officer of AARP Financial and President of the AARP Funds. From November 2004 to October 2005, Mr. Renfro served as Managing Director of Devonshire Financial Group. Mr. Renfro served as Chairman and Chief Executive Officer of New River Inc. from 1998 to October 2004.

Ms. Sweere is Executive Vice President of Human Capital of UnitedHealth Group and has served in that capacity since June 2007. Prior to joining UnitedHealth Group, Ms. Sweere served as Executive Vice President of Human Resources of CNA Corporation from October 2004 to April 2007 and held various leadership positions with CNA Corporation from 2003 to October 2004.

Mr. Walsh is Executive Vice President, General Counsel and Assistant Secretary of UnitedHealth Group and has served in that capacity since October 2009. From August 2007 to October 2009, Mr. Walsh served as Senior Vice President and Deputy General Counsel of UnitedHealth Group, and from January 2009 to October 2009,

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Mr. Walsh served also as interim Co-Chief Legal Officer of UnitedHealth Group. Mr. Walsh joined UnitedHealth Group in August 2007. Prior to joining UnitedHealth Group, Mr. Walsh was a partner at Hogan and Hartson from July 2000 to August 2007.

Mr. Welters is Executive Vice President of UnitedHealth Group and President of the Public and Senior Market Group and has served in that capacity since September 2007. Mr. Welters was named Executive Vice President of UnitedHealth Group in November 2006. From 2004 to November 2006, Mr. Welters was President and Chief Executive Officer of AmeriChoice. Mr. Welters joined UnitedHealth Group in 2002 and held various executive positions with the Company from 2002 to 2004.

Mr. Wichmann is Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since April 2008. From December 2006 to April 2008, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of the Commercial Markets Group (now UnitedHealthcare). From July 2004 to December 2006, Mr. Wichmann served as President and Chief Operating Officer of UnitedHealthcare. In 2004, Mr. Wichmann served as Chief Executive Officer of Specialized Care Services (now OptumHealth). Mr. Wichmann joined UnitedHealth Group in 1998 and held various executive positions with the Company from 1998 to 2004.

Mr. Zamoff is Executive Vice President, General Counsel and Assistant Secretary of UnitedHealth Group and has served in that capacity since October 2009. From March 2008 to October 2009, Mr. Zamoff served as General Counsel of UnitedHealthcare, and from January 2009 to October 2009, Mr. Zamoff served also as interim Co-Chief Legal Officer of UnitedHealth Group. Mr. Zamoff joined UnitedHealth Group in March 2008. Prior to joining UnitedHealth Group, Mr. Zamoff was a partner at Hogan and Hartson from January 2001 to March 2008, and from December 1996 to December 2000 Mr. Zamoff served as Assistant U.S. Attorney for the U.S. Department of Justice.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news 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 “believe,” “expect,” “intend,” “estimate,” “anticipate,” “plan,” project,” “should” or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. 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. We do not undertake to address or update forward-looking statements in future filings or communications regarding our business or results of operations, 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 past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or 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. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in this report or any of our prior communications.

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Proposed health care reforms could materially adversely affect our revenues, financial position and our results of operations.

Both houses of Congress have recently passed bills relating to health care reform, which have not yet been reconciled with each other and signed into law. Examples of health care reform proposals include policy changes that would change the dynamics of the health care industry, including having the federal or one or more state governments assume a larger role in the health care system such as competing with private health insurers, imposing new and potentially significant taxes on health insurers and health care benefits, guaranteed coverage requirements, elimination of pre-existing condition exclusions or annual lifetime maximum limits, restrictions on our ability to price products based on our underwriting standards, or restructuring the Medicare or Medicaid programs, including reducing payments to private plans offering Medicare Advantage over the intermediate term. In addition, from time to time, Congress has considered various forms of managed care reform legislation, which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. Additionally, there is legislative interest in modifying ERISA's preemptive effect on state laws. If adopted, such limitations could increase our liability exposure and could permit greater state regulation of our operations.

A number of state legislatures, including California, Colorado, New York, Ohio and Pennsylvania, have contemplated but have not enacted significant reform of their health insurance markets. Other states are expected to consider significant reform of their health insurance markets as well as more modest reforms aimed at expanding Medicaid and/or SCHIP eligibility and new coverage options for those not eligible for government programs. These proposals include provisions affecting both public programs and privately financed health insurance arrangements. States also are considering proposals that would reform the underwriting and marketing practices of individual and group health insurance products by, for example, placing restrictions on rating and pricing and mandating minimum medical benefit cost ratios.

The enactment of health care reforms at the federal or state level may affect certain aspects of our business, including contracting with physicians, hospitals and/or other health care professionals; medical, administrative, technology or other costs; physician reimbursement methods and payment rates; premium rates; coverage determinations; mandated benefits; minimum medical expenditures; claim payments and processing; drug utilization and patient safety efforts; collection, use, disclosure, maintenance and disposal of individually identifiable health information; personal health records; consumer-driven health plans and health savings accounts and insurance market reforms; and government-sponsored programs.

We cannot predict if any of these proposals will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be. Any health care reforms enacted may be phased in over a number of years but, if enacted, could reduce our revenues, increase our costs, expose us to expanded liability and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our results of operations, our financial position, including our ability to maintain the value of our goodwill, and cash flows could be materially adversely affected by such changes.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products could decline and could materially adversely affect our future financial results.

Under our risk-based product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our risk-based products depends in large part on our ability to predict, price for, and effectively manage medical costs.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue on commercial policies is typically fixed for a

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12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. We base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period; however, medical cost inflation, regulation and other factors may cause actual costs to exceed what was estimated and reflected in premiums or bids. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical costs on our financial results, relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for commercial insured products, our annual net earnings for 2009 would have been reduced by approximately $200 million.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, they will have a negative impact on our future results.

Our business activities are highly regulated; new laws or regulations or changes in existing laws or regulations or their enforcement could materially adversely affect our results of operations, financial position and cash flows.

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. For example, in 2009, CMS implemented a reduction in Medicare Advantage reimbursements of approximately 5% for 2010. Although we have adjusted members' benefits and premiums on a selective basis, terminated benefit plans in certain counties, and intensified both our medical and operating cost management in response to these rate reductions, there can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage program. Our results of operations, financial position and cash flows could be materially adversely affected by such reductions.

The broad latitude that is given to the agencies administering regulations governing our business, as well as 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. For example, in October 2008 Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires insurers to provide mental health and substance use disorder benefits under terms that are no more restrictive than those applied to medical and surgical benefits. The MHPAEA specifically directed the Secretaries of Labor, Health and Human Services and the Treasury to issue regulations to effectuate the legislation. Although regulations regarding how the MHPAEA will be implemented were issued on February 2, 2010 in the form of an interim final rule, final regulations have not yet been published. Because of the broad range of treatment limitations to which parity is expected to apply under the regulations, the regulations will likely lead to an increase in the costs associated with both insured and self-insured plans for behavioral health benefits and services and impact our market for carve-out health benefit administration, which could have an adverse effect on our earnings from operations.

We must also obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions, including integration of certain acquisitions. Delays in obtaining approvals or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

In August 2007, we entered into a multi-state national agreement with regulatory offices in 39 states and the District of Columbia relating to UnitedHealthcare's fully insured commercial business administered on the

organization's main processing platforms. The agreement covers several key areas of review of our business operations, including claims payment accuracy and timeliness, appeals and grievances resolution timeliness, health care professional network/service, utilization review, explanation of benefits accuracy, and oversight and due diligence of contracted entities and vendor performance. The agreement addressed and resolved past regulatory matters related to the areas of review prior to August 2007 and establishes a transparent framework for evaluating and regulating performance through December 2010. The agreement is similar to a customer performance guarantee, whereby we self report quarterly and annually our current operational performance on a set of national performance standards agreed to by the participating states. We must perform to the standards set forth in the agreement, or be subject to fines and penalties.

We are also involved in various governmental investigations, audits and reviews. These regulatory activities include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor and other governmental authorities. For example, in 2007, the California Department of Insurance examined our PacifiCare health insurance plan in California. The examination findings related to claims processing accuracy and timeliness, accurate and timely interest payments, timely implementation of provider contracts, timely, accurate provider dispute resolution, and other related matters. The matter is now the subject of an administrative proceeding before an administrative law judge. In addition, the U.S. Department of Labor is conducting an investigation of our administration of our employee benefit plans with respect to ERISA compliance. Reviews and investigations of this sort can lead to government actions, which can result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, and could have a material adverse effect on our business and results of operations.

In addition, the health care industry is subject to negative publicity. Negative publicity, including negative publicity surrounding routine governmental investigations, may adversely affect our stock price, damage our reputation in various markets and result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by adversely affecting our ability to market our products and services, requiring us to change our products and services, or increasing the regulatory burdens under which we operate.

For a discussion of various federal and state laws and regulations governing our businesses, see Item 1, "Business – Government Regulation."

Adverse economic conditions could adversely affect our revenues and our results of operations.

The current recessionary U.S. economic environment may continue to impact demand for certain of our products and services. For example, higher unemployment rates and significant employment layoffs and downsizings have caused and could continue to lead to lower enrollment in our employer group plans, lower enrollment in our non-employer individual plans and a higher number of employees opting out of our employer group plans. Adverse economic conditions have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, the economic downturn could continue to negatively impact our employer group renewal prospects and our ability to increase premiums and could result in cancellation of products and services by our customers. All of these could lead to a decrease in our membership levels and premium and fee revenues and could adversely affect our results of operations. In addition, a prolonged economic downturn could negatively impact the financial position of hospitals and other care providers and therefore could adversely affect our contracted rates with these parties and increase our medical costs.

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During a prolonged economic downturn, state and federal budgets could be adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and SCHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to payments already negotiated and/or received from the government and could adversely affect our revenues and results of operations. In addition, the state and federal budgetary pressures could cause the government to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on insurance companies and health maintenance organizations and surcharges on select fee-for-service and capitated medical claims, and could adversely affect our results of operations.

Our businesses providing PBM services face regulatory and other risks and uncertainties associated with the PBM industry that may differ from the risks of our business of providing managed care and health insurance products.

We provide PBM services through our Prescription Solutions and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry that could adversely affect current industry practices, including the receipt or required disclosure of rebates from pharmaceutical companies. See Item 1, “Business – Government Regulation” for a discussion of various federal and state laws and regulations governing our PBM businesses.

Our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or entering into certain prohibited transactions.

Prescription Solutions also conducts business as a mail order pharmacy, which subjects it to extensive federal, state and local laws and regulations. The failure to adhere to these laws and regulations could expose Prescription Solutions to civil and criminal penalties. Further, Prescription Solutions is subject to the Payment Card Industry Data Security Standards, which is a multifaceted security standard that includes requirements for security management, policies, procedures, network architecture, software design and other critical protective measures to protect customer account data as mandated by the credit card brands. The failure to adhere to such standards could expose Prescription Solutions to liability or impact their ability to process credit card transactions.

In addition, our PBM businesses would be adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and could face potential claims in connection with purported errors by our mail order pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order pharmacies due to failure of technology or any other failure or disruption to these systems or to the infrastructure due to fire, electrical outage, natural disaster, acts of terrorism or some other catastrophic event could reduce our ability to process and dispense prescriptions and provide products and services to customers.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which we operate. We compete with other companies on the basis of many factors, including price of benefits offered and cost and risk of alternatives, location and choice of health care providers, quality of customer service,

comprehensiveness of coverage offered, reputation for quality care, financial stability and diversity of product offerings. For our Health Benefits reporting segment, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas or market segments such as Medicare specialty services. For our Prescription Solutions business, competitors include Medco Health Solutions, Inc., CVS/Caremark Corporation and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a broad and diverse set of other businesses.

We believe that barriers to entry in many markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. In particular markets, competitors may have capabilities or resources that give them a competitive advantage. Greater market share, established reputation, superior supplier or health care professional arrangements, existing business relationships, and other factors all can provide a competitive advantage to our businesses or to their competitors.

In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers (including hospitals, physician groups and other care professionals) in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or advance profitability. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect, if membership or demand for other services declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products, our business and results of operations could be materially adversely affected.

As a payer in various government health care programs, we are exposed to additional risks associated with program funding, enrollments, payment adjustments and audits that could adversely affect our revenues, cash flows and results of operations.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and SCHIP, and receive revenues from these programs. These programs generally are subject to frequent changes, 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 medical costs under such programs. For example, CMS recently implemented a reduction in Medicare Advantage reimbursements of approximately 5% for 2010. Such changes have adversely affected our results of operations and willingness to participate in such programs in certain geographic areas in the past, and may do so in the future.

Our participation in the Medicare Advantage, Medicare Part D, and various Medicaid programs and SCHIP occurs through bids that are submitted periodically. Revenues for these programs are dependent upon periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs is dependent upon many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level, and general political issues and priorities. A reduction or less than expected increase in government funding for these programs or change in allocation methodologies may adversely affect our revenues and results of operations.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including determining payments by considering the risk status of our Medicare members as supported by provider medical record documentation. Federal regulators audit the supporting documents and can revise payments based on the audit findings. CMS announced in 2008 that it will perform audits of selected Medicare health plans each year to

validate the coding practices of and supporting documentation maintained by care providers. These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in prospective and retrospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. The Office of Inspector General for HHS is conducting an audit of our risk adjustment data for two plans. We are unable to predict the outcome of the audits. However, any material adjustments could have a material effect on our results of operations.

Our ability to retain and acquire Medicare, Medicaid and SCHIP enrollees is impacted by bids and plan designs submitted by our competitors and us. Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a threshold, which is set by the government after our bids are submitted. If the enrollee premium is not below the government threshold, we risk losing the members who were auto-assigned to us and we will not have additional members auto-assigned to us. For example, we lost approximately 650,000 of our auto-enrolled low-income subsidy members in 2008 because certain of our bids exceeded thresholds set by the government. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect or our competitors' bids and positioning are different than anticipated, either as a result of unforeseen changes to the Medicare program or otherwise, our results of operations could be materially affected.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices and services. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices and services. Failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could adversely affect our business and results of operations.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical 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. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be adversely affected.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the health care provider receives a fixed percentage of premium to cover all or a defined portion of the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the professional. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with

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whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. There can be no assurance that health care providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have an adverse effect on the provision of services to our members and our operations.

In addition, some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with the provider about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances, it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example, we are involved in litigation with out-of-network providers that is described in more detail in "Legal Matters" in Note 14 of Notes to the Consolidated Financial Statements. Failure to maintain satisfactory relationships with out-of-network health care providers could adversely affect our business and results of operations.

Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of independent third party brokers, consultants and agents.

Our products are sold in part through independent brokers, consultants and agents who assist in the production and servicing of business. We typically do not have long-term contracts with our independent brokers, consultants and agents, who generally are not exclusive to us and who typically also recommend and/or market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be adversely affected if we are unable to attract or retain independent brokers, consultants and agents or if we do not adequately provide support, training and education to them regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling these companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practice, which could adversely impact our ability to market our products.

If we fail to comply with restrictions on patient privacy and data security regulations, including taking steps to ensure that our business associates who obtain access to sensitive patient information maintain its confidentiality and security, our reputation and business operations could be materially adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of individually identifiable data by our businesses are regulated at the international, federal and state levels. These laws and rules are subject to change by legislation or administrative or judicial interpretation. Various state laws address the use and disclosure of individually identifiable health information to the extent they are more restrictive than those contained in the privacy and security provisions in the federal GLBA and in HIPAA. HIPAA now requires business associates as well as covered entities to comply with certain privacy and security requirements. See Item 1, "Business – Government Regulation" for a discussion of various federal and state privacy laws and regulations governing our businesses.

Even though we provide for appropriate protections through our contracts with our business associates and in certain cases assess our business associates' security controls, we still have limited control over their actions and

practices. Privacy and security requirements regarding personally identifiable information are also imposed on us through controls with our customers. In addition, despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems and those of our third party service providers may be vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with new privacy and security laws, requirements, and new regulations, such as ARRA, will result in cost increases due to necessary systems changes (including further implementation of encryption and other data protection standards), new limitations or constraints on our business models, the development of new administrative processes, the effects of potential noncompliance by our business associates, and increased enforcement actions and fines and penalties. They also may impose further restrictions on our collection, disclosure and use of patient identifiable data that is housed in one or more of our administrative databases.

Noncompliance with any privacy or security laws and regulations or any security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive or confidential member information, whether by us or by one of our business associates, could have a material adverse effect on our business, reputation and results of operations, including mandatory disclosure to the media, significant increase in the number and cost of managing and remediating data security incidents, increased enforcement actions, material fines and penalties, compensatory, special, punitive, and statutory damages, litigation, consent orders regarding our privacy and security practices, adverse actions against our licenses to do business, and injunctive relief.

Our relationship with AARP is important and the loss of such relationship could have an adverse effect on our business and results of operations.

Under our agreements with AARP, we provide AARP-branded Medicare Supplement insurance, hospital indemnity insurance and other products to AARP members and Medicare Part D prescription drug plans to AARP members and non-members. One of our agreements with AARP expands the relationship to include AARP-branded Medicare Advantage plans for AARP members and non-members. Our agreements with AARP contain commitments regarding corporate governance, corporate social responsibility, diversity and measures intended to improve and simplify the health care experience for consumers. The AARP agreements may be terminated early under certain circumstances, including, depending on the agreement, a material breach by either party, insolvency of either party, a material adverse change in the financial condition of the Company, material changes in the Medicare programs, material harm to AARP caused by the Company, and by mutual agreement. The success of our AARP arrangements depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, meet our corporate governance, corporate social responsibility, and diversity commitments, and respond effectively to federal and state regulatory changes. The loss of our AARP relationship could have an adverse effect on our business and results of operations.

Because of the nature of our business, we are routinely subject to various litigation actions, which, if resolved unfavorably, could result in substantial penalties and/or monetary damages and adversely affect our financial position, results of operations and cash flows.

Periodically, 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 business, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. These matters include, among others, claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), tort, contract disputes and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups.

We are largely self-insured with regard to litigation risks. Although we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive

damages in some circumstances, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters; however, it is possible that the level of actual losses will exceed the liabilities recorded.

A description of significant legal actions in which we are currently involved is included in Note 14 of Notes to the Consolidated Financial Statements. We cannot predict the outcome of these actions with certainty, and we are incurring expenses in resolving these matters. Therefore, these legal actions could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

Our investment portfolio may suffer losses, which could materially adversely affect our results of operations.

Fluctuations in the fixed income or equity markets could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2009. In addition, defaults by issuers, primarily from investments in liquid corporate and municipal bonds, who fail to pay or perform on their obligations, could reduce our investment income and net realized investment gains or result in net realized investment losses as we may be required to write down the value of our investments, which would adversely affect our profitability and shareholders' equity.

We also invest a small proportion of our investments in equity investments, which are subject to greater volatility than fixed income investments. General economic conditions, stock market conditions, and many other factors beyond our control can adversely affect the value of our equity investments and may result in investment losses.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than the carrying value of these investments. Changes in the value of our investment assets, as a result of interest rate fluctuations, illiquidity or otherwise, could have a negative effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have an adverse effect on our results of operations.

If the value of our intangible assets is materially impaired, our results of operations, shareholders' equity and debt ratings could be materially adversely affected.

Goodwill and other intangible assets were $23.1 billion as of December 31, 2009, representing 39% of our total assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the enactment of health care reforms may impact our ability to maintain the value of our goodwill and other intangible assets in some of our businesses, as any passed legislation may significantly change the growth rate assumptions for some of our businesses. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Large-scale medical emergencies may result in significant medical costs and may have a material adverse effect on our business, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. Such emergencies could materially and adversely affect the U.S. economy in general and the health care industry specifically. For example, in the event of a natural disaster, bioterrorism attack, pandemic or other extreme events, we could face, among other things, significant medical costs and increased use of health care services. Any such disaster or similar event could have a material adverse effect on our business, financial condition and results of operations.

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If we fail to properly maintain the integrity or availability of our data or to strategically implement new or upgrade or consolidate existing information systems, our business could be materially adversely affected.

Our ability to adequately price our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to accurately report our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we have been taking steps to consolidate and integrate the number of systems we operate and have upgraded and expanded our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, and changing customer patterns. If the information we rely upon to run our businesses were found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, have regulatory sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, protecting and enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially impact our business, financial condition and results of operations.

If we are not able to protect our proprietary rights to our databases and related products, our ability to market our knowledge and information-related businesses could be hindered and our business could be adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, 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 and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our revenues and results of operations could be adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. These subsidiaries generally are regulated by states' departments of insurance. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts. In addition, we normally notify the state departments of insurance prior to making payments that do not require approval. An inability of our regulated subsidiaries to pay dividends to their parent companies could impact the scale to which we could reinvest in our business through capital expenditures, business acquisitions and the repurchase of shares of our common stock and our ability to repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

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Any failure by us to manage and complete acquisitions and other significant transactions successfully could harm our results of operations, business and prospects.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our results of operations could be adversely affected.

Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by recognized rating organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. Downgrades in our credit ratings, should they occur, may adversely affect our business, financial condition and results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2009, we owned and/or leased real properties totaling approximately 15.2 million square feet to support our business operations in the United States and other countries. Our facilities are primarily located in the United States. Of this total, we owned approximately 1 million aggregate square feet of space and leased the remainder. Our leases expire at various dates through September 30, 2028. Our various reporting segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Note 14 of Notes to the Consolidated Financial Statements in this Form 10-K, which is incorporated by reference herein.

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

None.

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PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET PRICES

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On February 3, 2010, there were 18,145 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE were as follows:

	High	Low
2010		
First quarter (through February 3, 2010)	$36.07	$30.97
2009		
First quarter	$30.25	$16.18
Second quarter	$29.69	$19.85
Third quarter	$30.00	$23.69
Fourth quarter	$33.25	$23.50
2008		
First quarter	$57.86	$33.57
Second quarter	$38.33	$25.50
Third quarter	$33.49	$21.00
Fourth quarter	$27.31	$14.51

DIVIDEND POLICY

Our Board of Directors established our dividend policy in August 1990. Pursuant to our dividend policy, our Board of Directors reviews our consolidated financial statements following the end of each fiscal year and decides whether to declare a dividend on the outstanding shares of common stock. On February 9, 2010, our Board of Directors approved an annual dividend of $0.03 per share, which will be paid on April 20, 2010 to shareholders of record on April 6, 2010. Shareholders of record on April 2, 2009 received an annual dividend for 2009 of $0.03 per share and shareholders of record on April 2, 2008 received an annual dividend for 2008 of $0.03 per share.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2009

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs(a)
October 31, 2009	880,797(b)	$ 25.04	878,313	35,583,125
November 30, 2009	709,550	$ 28.18	709,550	34,873,575
December 31, 2009	6,274,229(c)	$ 30.76	6,216,220	28,657,355
TOTAL	7,864,576	$ 29.88	7,804,083	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In February 2010, the Board renewed and increased our share repurchase program, and authorized us to repurchase up to 120 million shares of our common stock at prevailing market prices. There is no established expiration date for the program. The maximum number of shares that may be purchased under the plans or programs as of December 31, 2009 does not reflect this increase.

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(b) Represents 878,313 shares of our common stock repurchased during the period, and 2,484 shares of our common stock withheld by us, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

(c) Represents 6,216,220 shares of our common stock repurchased during the period, and 58,009 shares of our common stock withheld by us, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

PERFORMANCE GRAPHS

The following two performance graphs compare the Company's total return to shareholders with indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on UnitedHealth Group's common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group (the "*Fortune 50* Group"), an index of certain *Fortune 50* companies for the five-year period ended December 31, 2009. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2009. The Company is not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2004 in Company common stock and in each index, and that dividends were reinvested when paid.

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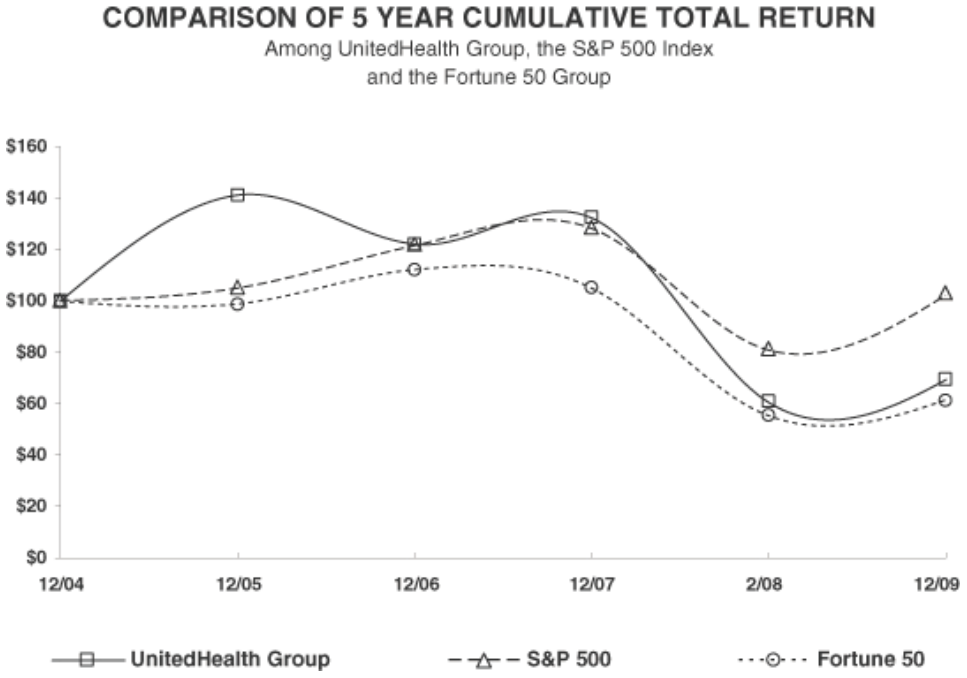
Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.



	12/04	12/05	12/06	12/07	12/08	12/09
UnitedHealth Group	**$100.00**	**$141.22**	**$122.18**	**$132.41**	**$60.57**	**$ 69.51**
S&P 500	**100.00**	**104.91**	**121.48**	**128.16**	**80.74**	**102.11**
Fortune 50 Group	**100.00**	**99.04**	**112.31**	**105.03**	**55.31**	**61.84**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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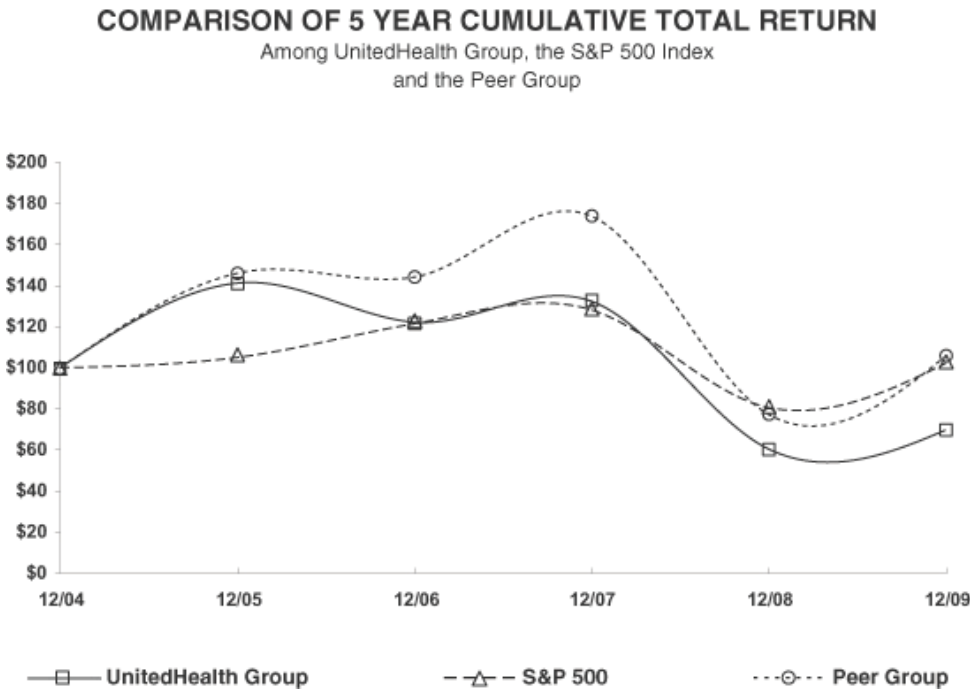
Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc. and WellPoint, Inc. We believe that this peer group reflects our peers in the health care industry.



	12/04	12/05	12/06	12/07	12/08	12/09
UnitedHealth Group	**$100.00**	**$141.22**	**$122.18**	**$132.41**	**$60.57**	**$ 69.51**
S&P 500	**100.00**	**104.91**	**121.48**	**128.16**	**80.74**	**102.11**
Peer Group	**100.00**	**146.00**	**144.14**	**173.91**	**77.52**	**105.61**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(in millions, except percentages and per share data)	For the Year Ended December 31, 2009 (a,b)	2008 (a,b)	2007 (a,b)	2006 (a,b)	2005 (b)
Consolidated Operating Results					
Revenues	$ 87,138	$ 81,186	$ 75,431	$ 71,542	$46,425
Earnings from operations	6,359	5,263	7,849	6,984	5,080
Net earnings	3,822	2,977	4,654	4,159	3,083
Return on shareholders' equity	17.3%	14.9%	22.4%	22.2%	25.2%
Basic net earnings per common share	$ 3.27	$ 2.45	$ 3.55	$ 3.09	$ 2.44
Diluted net earnings per common share	3.24	2.40	3.42	2.97	2.31
Common stock dividends per share	0.030	0.030	0.030	0.030	0.015
Consolidated Cash Flows From (Used For)					
Operating activities	$ 5,625	$ 4,238	$ 5,877	$ 6,526	$ 4,083
Investing activities	(976)	(5,072)	(4,147)	(2,101)	(3,489)
Financing activities	(2,275)	(605)	(3,185)	474	836
Consolidated Financial Condition					
(As of December 31)					
Cash and investments	$ 24,350	$ 21,575	$ 22,286	$ 20,582	$14,982
Total assets	59,045	55,815	50,899	48,320	41,288
Total commercial paper and long-term debt	11,173	12,794	11,009	7,456	7,095
Shareholders' equity	23,606	20,780	20,063	20,810	17,815
Debt-to-total-capital ratio	32.1%	38.1%	35.4%	26.4%	28.5%

Financial Highlights should be read with the accompanying Management's Discussion and Analysis of Financial Condition and Results of Operations and Consolidated Financial Statements and Notes to the Consolidated Financial Statements.

(a) On January 1, 2006, we began serving as a plan sponsor offering Medicare Part D drug insurance coverage under a contract with CMS. Total revenues generated under this program were $6.4 billion, $5.8 billion, $5.9 billion and $5.7 billion for the years ended December 31, 2009, 2008, 2007 and 2006, respectively. See Note 2 of Notes to the Consolidated Financial Statements for a detailed discussion of this program.

(b) We acquired Unison Health Plans in May 2008 for total consideration of approximately $930 million, Sierra Health Services, Inc. in February 2008 for total consideration of approximately $2.6 billion, Fiserv Health, Inc. in January 2008 for total consideration of approximately $740 million and PacifiCare Health Systems, Inc. in December 2005 for total consideration of approximately $8.8 billion. The results of operations and financial condition of these acquisitions have been included in our Consolidated Financial Statements since the respective acquisition dates.

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers should be cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or PSLRA. 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. A description of some of the risks and uncertainties can be found in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company, serving more than 70 million Americans. Our focus is on improving the overall health and well-being of the people we serve and their communities and enhancing the performance of the health system. We work with health care professionals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost, support the physician/patient relationship, and empower people with the information, guidance and tools they need to make personal health choices and decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to make health care work better. These core competencies are focused in two market areas, health benefits and health services. Health benefits are offered in the individual and employer markets and the public and senior markets through our UnitedHealthcare, Ovations and AmeriChoice businesses. Health services are provided to the participants in the health system itself, ranging from employers and health plans to physicians and life sciences companies through our OptumHealth, Ingenix and Prescription Solutions businesses. In aggregate, these businesses have more than two dozen distinct business units that address specific end markets. Each of these business units focuses on the key goals in health and well-being: access, affordability, quality and simplicity as they apply to their specific market.

Revenues

Our revenues are primarily comprised of premiums 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 benefits and related administrative costs. We also generate revenues from services performed for customers that self-insure the health care costs of their employees and employees' dependants. For both risk-based and fee-based health care benefit arrangements, we provide coordination and facilitation of medical services; transaction processing; health care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. We also generate service revenues from Ingenix health intelligence and contract research businesses. Product revenues are mainly comprised of products sold by our Prescription Solutions pharmacy benefit management business and sales of Ingenix publishing and software products. We derive investment income primarily from interest earned on our investments in debt securities. Our investment income also includes gains or losses when the securities are sold, or other-than-temporarily impaired.

Operating Costs

Medical Costs. Our operating results depend in large part on our ability to effectively estimate, price for and manage our medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. Controlling medical costs requires a comprehensive and integrated approach to organize and advance the full range of interrelationships among patients/consumers, health professionals, hospitals, pharmaceutical/technology manufacturers and other key stakeholders.

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Medical costs include estimates of our obligations for medical care services rendered on behalf of insured consumers for which we neither have received nor processed claims, and for liabilities for physician, hospital and other medical cost disputes. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Our medical care ratio, calculated as medical costs as a percentage of premium revenues, reflects the combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts. We seek to sustain a stable medical care ratio for an equivalent mix of business, however, changes in business mix, such as expanding participation in comparatively higher medical care ratio government-sponsored public sector programs, will change the dynamics of our results.

Operating Costs. Operating costs are primarily comprised of costs related to employee compensation and benefits, agent and broker commissions, premium taxes and assessments, professional fees, advertising and occupancy costs.

Cash Flows

We generate cash primarily from premiums, service revenues and investment income, as well as proceeds from the sale or maturity of our investments. Our primary uses of cash are for payments of medical claims, purchases of investments, common stock repurchases and payments on long-term debt. For more information on our cash flows, see “Liquidity” below.

Business Trends

Our businesses participate in the U.S. health economy, which comprises approximately 17% of U.S. gross domestic product and which has grown consistently for many years. We expect overall spending on health care in the U.S. to continue to rise in the future, based on inflation, demographic trends in the U.S. population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and proposed health care reforms, which could also impact our results of operations.

Adverse Economic Conditions. The current U.S. recessionary economic environment has impacted demand for some of our products and services. For example, decreases in employment have reduced the number of workers and dependants offered health care benefits by our employer customers, putting pressure on top line growth for our UnitedHealthcare and OptumHealth businesses. This workplace attrition contributed more than half of the 7% decrease in UnitedHealthcare’s commercial membership during 2009, and this attrition trend is expected to continue at a generally elevated level until national employment stabilizes. In contrast, our AmeriChoice business is experiencing growth in its state Medicaid offerings as employment rates fall. If the recessionary economic environment continues for a prolonged period, federal and state governments may decrease funding for various health care government programs in which we participate and/or impose new or higher levels of taxes or assessments. Our revenues are also impacted by U.S. monetary and fiscal policy. In response to recessionary conditions, the U.S. Federal Reserve has maintained the target federal funds rate at a range of zero to 25 basis points. Changes in federal monetary policy have reduced the level of investment income received on our portfolio on a year-over-year basis.

In total, we believe that economic recessions will slow our revenue growth rate and could impact our operating profitability. We also believe that government funding pressure, coupled with recessionary economic conditions, will impact the financial positions of hospitals, physicians and other care providers and could therefore increase medical cost trends experienced by our businesses. For additional discussions regarding how the adverse economic conditions could affect our business, see Item 1A, “Risk Factors.”

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American Recovery and Reinvestment Act. Our businesses may benefit from elements of the federal economic stimulus package that was enacted in response to the current recession. These elements include expansion of funding to state programs, which could mitigate funding pressure for AmeriChoice Medicaid offerings at the state level, and funding for health care information technology, which could expand market opportunities for Ingenix.

Proposed Health Care Reforms and Reimbursement Changes. Both houses of Congress have recently passed bills relating to health care reform, which have not yet been reconciled with each other and signed into law. Examples of health care reform proposals include policy changes that would change the dynamics of the health care industry, including having the federal or one or more state governments assume a larger role in the health care system such as competing with private health insurers, imposing new and potentially significant taxes on health insurers and health care benefits, guaranteed coverage requirements, elimination of pre-existing condition exclusions or annual lifetime maximum limits, restrictions on our ability to price products based on our underwriting standards, or restructuring the Medicare or Medicaid programs, including reducing payments over the intermediate term to private plans offering Medicare Advantage. We cannot predict if any of these proposals will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be. Any health care reforms enacted may be phased in over a number of years, but, if enacted, could reduce our revenues, increase our costs, expose us to expanded liability and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our operating results, our financial position, including our ability to maintain the value of our goodwill, and cash flows could be materially adversely affected by such changes.

The administration and various congressional leaders have advanced proposals to reduce payments over the intermediate term to private plans offering Medicare Advantage. Further, Centers for Medicare and Medicaid Services (CMS) implemented a reduction in Medicare Advantage reimbursements of approximately 5% for 2010. Although we have adjusted members' benefits and premiums on a selective basis, terminated benefit plans in certain counties, and intensified both our medical and operating cost management in response to these rate reductions, there can be no assurance that we will be able to execute successfully on these or other strategies to address changes in the Medicare Advantage program. Our operating results, financial position and cash flows could be materially adversely affected by these reductions. If industry-wide Medicare Advantage membership declines, there is likely to be increased demand for Medicare Supplemental insurance and Part D prescription drug coverage, and in both categories Ovations is a market leader.

We operate a diversified set of health care focused businesses; this business model has been intentionally designed to address a multitude of market sectors. Therefore, we could see simultaneous increases and decreases in demand for our various products and services, depending on the scope, shape and timing of health care reforms. It is difficult to predict the outcome of reform discussions with precision over the mid- to long-term time horizon. For discussions regarding our risks related to health care reforms, see Item 1A, "Risk Factors."

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RESULTS SUMMARY

The following summarizes the consolidated financial results for the years ended December 31:

(in millions, except percentages and per share data)	2009		2008		2007		Increase (Decrease) 2009 vs. 2008			Increase (Decrease) 2008 vs. 2007		
REVENUES:												
Premiums	$79,315		$73,608		$68,781		$5,707	8	%	$ 4,827	7	%
Services	5,306		5,152		4,608		154	3		544	12	
Products	1,925		1,655		898		270	16		757	84	
Investment and other income	592		771		1,144		(179)	(23)		(373)	(33)	
Total revenues	87,138		81,186		75,431		5,952	7		5,755	8	
OPERATING COSTS:												
Medical costs	65,289		60,359		55,435		4,930	8		4,924	9	
Medical care ratio	82.3	%	82.0	%	80.6	%		0.3			1.4	
Operating costs	12,734		13,103		10,583		(369)	(3)		2,520	24	
Operating cost ratio	14.6	%	16.1	%	14.0	%		(1.5)			2.1	
Cost of products sold	1,765		1,480		768		285	19		712	93	
Depreciation and amortization	991		981		796		10	1		185	23	
Total operating costs	80,779		75,923		67,582		4,856	6		8,341	12	
EARNINGS FROM OPERATIONS	6,359		5,263		7,849		1,096	21		(2,586)	(33)	
Operating margin	7.3	%	6.5	%	10.4	%		0.8			(3.9)	
Interest expense	(551)		(639)		(544)		(88)	(14)		95	17	
EARNINGS BEFORE INCOME TAXES	5,808		4,624		7,305		1,184	26		(2,681)	(37)	
Provision for income taxes	(1,986)		(1,647)		(2,651)		339	21		(1,004)	(38)	
Tax rate	34.2	%	35.6	%	36.3	%		(1.4)			(0.7)	
NET EARNINGS	$ 3,822		$ 2,977		$ 4,654		$ 845	28	%	$(1,677)	(36)	%
DILUTED NET EARNINGS PER COMMON SHARE	$ 3.24		$ 2.40		$ 3.42		$ 0.84	35	%	$ (1.02)	(30)	%
RETURN ON EQUITY	17.3	%	14.9	%	22.4	%		2.4	%		(7.5)	%
TOTAL PEOPLE SERVED	70		73		71		(3)	(4)	%	2	3	%

ACQUISITIONS

AIM Healthcare Services, Inc. On June 1, 2009, we acquired all of the outstanding shares of AIM Healthcare Services, Inc. (AIM) for approximately $440 million in cash. AIM is a leading provider of payment accuracy solutions for health care payer and hospital clients in all 50 states. This acquisition strengthened our capabilities to simplify and improve administration in the health care industry. The results of operations and financial condition of AIM have been included in our consolidated results and the results of the Ingenix reporting segment since the acquisition date.

Unison Health Plans. On May 30, 2008, we acquired all of the outstanding shares of Unison Health Plans (Unison) for approximately $930 million in cash. Unison provides government-sponsored health plan coverage to people in Pennsylvania, Ohio, Tennessee, Delaware, South Carolina and Washington, D.C. through a network of independent health care professionals. This acquisition strengthened our resources and capabilities in these areas. The results of operations and financial condition of Unison have been included in our consolidated results and the results of our Health Benefits reporting segment since the acquisition date.

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Sierra Health Services, Inc. On February 25, 2008, we acquired all of the outstanding shares of Sierra Health Services, Inc. (Sierra), a diversified health care services company based in Las Vegas, Nevada, for approximately $2.6 billion in cash, representing a price of $43.50 per share of Sierra common stock. This acquisition strengthened our position in the southwest region of the United States. The U.S. Department of Justice approved the acquisition conditioned upon the divestiture of our individual Medicare Advantage HMO plans in Clark and Nye Counties, Nevada, which represented approximately 30,000 members. The divestiture was completed on April 30, 2008. We received proceeds of $185 million for this transaction, which were recorded as a reduction to Operating Costs. Group Medicare Advantage plans offered through commercial contracts were excluded from the divestiture. Also, we retained Sierra's Medicare Advantage HMO plans in Nevada. The results of operations and financial condition of Sierra have been included in our consolidated results and the results of the Health Benefits, OptumHealth and Prescription Solutions reporting segments since the acquisition date.

Fiserv Health, Inc. On January 10, 2008, we acquired all of the outstanding shares of Fiserv Health, Inc. (Fiserv Health), a subsidiary of Fiserv, Inc., for approximately $740 million in cash. Fiserv Health is a leading administrator of medical benefits and also provides care facilitation services, specialty health solutions and pharmacy benefit management (PBM) services. This transaction allows us to expand the capacity of our existing benefits administration businesses and enables existing and new customers to leverage our full range of assets, including ancillary services, our national network and technology tools. The results of operations and financial condition of Fiserv Health have been included in our consolidated results and the results of the Health Benefits, OptumHealth, Ingenix and Prescription Solutions reporting segments since the acquisition date.

For the years ended December 31, 2009, 2008 and 2007, aggregate consideration paid, net of cash assumed for smaller acquisitions was $95 million, $94 million and $262 million, respectively. These acquisitions were not material to our results of operations.

2009 RESULTS OF OPERATIONS COMPARED TO 2008 RESULTS

Consolidated Financial Results

Revenues

Consolidated revenues for 2009 increased primarily due to the increase in premium revenues in the Health Benefits reporting segment. The increase in premium revenues was primarily due to strong organic growth in risk-based offerings in our public and senior markets businesses and premium rate increases in response to growth in underlying medical costs, partially offset by a decline in the number of people served in the commercial market. The effect of 2008 Health Benefits acquisitions also contributed to the increase in premium revenues during 2009.

Medical Costs

Medical costs for 2009 increased primarily due to growth in public and senior markets risk-based businesses, elevated medical costs due to the H1N1 influenza virus, unemployment-related benefit continuation programs due to an increased level of national unemployment, medical cost inflation and increased utilization of medical services.

For 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 periods, resulting from more complete claim information identified in the current period, are included in total medical costs reported for the current period. For 2009 and 2008, medical costs included $310 million and $230 million, respectively, of net favorable medical cost development related to prior fiscal years.

Operating Costs

Operating costs for 2009 decreased due to certain expenses incurred in 2008 as discussed below and disciplined operating cost management, which were partially offset by increased costs due to acquired and organic business growth and from an increase in state insurance assessments levied against premiums, a portion of which was in lieu of state income taxes in one of the states in which we operate.

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Operating costs for 2008 included $882 million for settlement of two class action lawsuits related to our historical stock option practices and related legal costs, $350 million for the settlement of class action litigation related to reimbursement for out-of-network medical services, $50 million related to estimated costs to conclude a legal matter and $46 million for employee severance related to operating cost reduction initiatives and other items, partially offset by a $185 million reduction in operating costs for proceeds from the sale of certain assets and membership in the individual Medicare Advantage business in Nevada in May 2008.

Income Tax Rate

Our income tax rate for 2009 decreased primarily due to the favorable resolution of various historical state income tax matters and the change to a premium tax in lieu of an income tax in one of the states in which we operate, which increased operating costs and decreased income taxes.

Reporting Segments

We have four reporting segments:

- Health Benefits, which includes UnitedHealthcare, Ovations and AmeriChoice;
- OptumHealth;
- Ingenix; and
- Prescription Solutions.

Transactions between reporting segments principally consist of sales of pharmacy benefit products and services to Health Benefits customers by Prescription Solutions, certain product offerings sold to Health Benefits customers by OptumHealth, and consulting and other services sold to Health Benefits by Ingenix. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation.

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The following summarizes the operating results of our reporting segments:

(in millions, except percentages)	2009	2008	2007	Increase (Decrease) 2009 vs. 2008		Increase (Decrease) 2008 vs. 2007	
Revenues							
Health Benefits	$ 81,341	$ 75,857	$ 71,199	$ 5,484	7 %	$ 4,658	7 %
OptumHealth	5,528	5,225	4,921	303	6	304	6
Ingenix	1,823	1,552	1,304	271	17	248	19
Prescription Solutions	14,452	12,573	13,249	1,879	15	(676)	(5)
Eliminations	(16,006)	(14,021)	(15,242)	(1,985)	nm	1,221	nm
Consolidated revenues	$ 87,138	$ 81,186	$ 75,431	$ 5,952	7 %	$ 5,755	8 %
Earnings from Operations							
Health Benefits	$ 4,788	$ 5,068	$ 6,595	$ (280)	(6)%	$(1,527)	(23)%
OptumHealth	636	718	895	(82)	(11)	(177)	(20)
Ingenix	246	229	266	17	7	(37)	(14)
Prescription Solutions	689	363	269	326	90	94	35
Corporate	—	(1,115)	(176)	1,115	nm	(939)	nm
Consolidated earnings from operations	$ 6,359	$ 5,263	$ 7,849	$ 1,096	21 %	$(2,586)	(33)%
Operating Margin							
Health Benefits	5.9 %	6.7 %	9.3 %		(0.8)%		(2.6)%
OptumHealth	11.5	13.7	18.2		(2.2)		(4.5)
Ingenix	13.5	14.8	20.4		(1.3)		(5.6)
Prescription Solutions	4.8	2.9	2.0		1.9		0.9
Consolidated operating margin	7.3 %	6.5 %	10.4 %		0.8 %		(3.9)%

nm = not meaningful

The following summarizes the number of individuals served by our Health Benefits segment, by major market segment and funding arrangement, at December 31:

(in thousands, except percentages)	2009	2008	2007	Increase (Decrease) 2009 vs. 2008		Increase (Decrease) 2008 vs. 2007	
Commercial risk-based	9,415	10,360	10,805	(945)	(9)%	(445)	(4)%
Commercial fee-based	15,210	15,985	14,720	(775)	(5)	1,265	9
Total commercial	24,625	26,345	25,525	(1,720)	(7)	820	3
Medicare Advantage	1,790	1,495	1,370	295	20	125	9
Medicaid	2,900	2,515	1,710	385	15	805	47
Standardized Medicare supplement	2,680	2,540	2,400	140	6	140	6
Total public and senior	7,370	6,550	5,480	820	13	1,070	20
Total people served by Health Benefits	31,995	32,895	31,005	(900)	(3)%	1,890	6 %

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Health Benefits

Revenue growth in Health Benefits for 2009 was primarily due to growth in the number of individuals served by our public and senior markets businesses and premium rate increases, partially offset by a decline in individuals served through commercial products and a decrease in investment and other income driven by lower short-term investment yields. UnitedHealthcare revenues of $40.8 billion for 2009 decreased by $1.0 billion, or 2%, compared to 2008, as the reduction in individuals served was partially offset by premium rate increases. Ovations revenues of $32.1 billion for 2009 increased by $4.1 billion, or 15%, over 2008, primarily due to an increase in individuals served through Medicare Part D, Medicare Advantage and standardized Medicare Supplement offerings, as well as premium rate increases. AmeriChoice generated revenues of $8.4 billion for 2009, an increase of $2.4 billion, or 40%, over the comparable 2008 period, primarily due to an increase in the number of individuals served by Medicaid plans and premium rate increases as well as the full year impact from the mid-2008 Unison acquisition.

The decrease in Health Benefits earnings from operations for 2009 was primarily due to a $166 million reduction in investment and other income and a decrease in commercial business, partially offset by the growth in lower margin public and senior markets businesses. The 2009 UnitedHealthcare medical care ratio increased to 84.0% from 83.5% in 2008, largely due to elevated medical costs related to the H1N1 influenza virus and a higher proportion of participants receiving care under unemployment-related benefit continuation programs. Health Benefits' operating margins decreased due to the factors that decreased earnings from operations.

OptumHealth

Increased OptumHealth revenues for 2009 were primarily driven by new business development in large-scale public sector care and behavioral health programs for state clients, which were partially offset by a decline in individuals served through commercial products. As of December 31, 2009 and 2008, OptumHealth provided services to approximately 58 million and 60 million consumers, respectively.

Earnings from operations and operating margins for 2009 decreased due to the decrease in commercial membership described above, start-up costs for new large contracts and lower investment income, partially offset by earnings growth from expanding services in the public sector and disciplined operating cost management.

Ingenix

Improvements in Ingenix revenues and earnings from operations for 2009 were primarily due to the impact of improved performance in the payer business, new internal service offerings and the effect of 2009 acquisitions. The decreases in operating margins for 2009 were primarily due to investments in services offerings, including outsourcing services for pharmaceutical customers and costs for international expansion, hospital revenue cycle management and data privacy and security.

Prescription Solutions

The increased Prescription Solutions revenues for 2009 were primarily due to growth in customers served through Medicare Part D prescription drug plans by our Ovations business, which is the largest customer of this reporting segment. Intersegment revenues eliminated in consolidation were $12.6 billion and $11.0 billion for 2009 and 2008, respectively.

Prescription Solutions earnings from operations for 2009 increased primarily due to prescription volume growth, strong success under performance-based purchasing arrangements, gains in mail service drug fulfillment and a continuing favorable mix shift to generic pharmaceuticals.

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2008 RESULTS COMPARED TO 2007 RESULTS

Consolidated Financial Results

Revenues

Consolidated revenues for 2008 increased from 2007 primarily due to the increase in premium revenue in the Health Benefits reporting segment. The premium revenue growth generated by our Health Benefits reporting segment was the primary driver in the consolidated premium revenues increase. This increase was due to the growth in individuals served by public and senior markets businesses, premium rate increases for medical cost inflation and acquisitions completed in 2008, partially offset by a decline in individuals served through both UnitedHealthcare risk-based products and Medicare Part D prescription drug plans.

Investment and Other Income. The decrease in investment and other income in 2008 was primarily due to lower investment yields primarily because of the decrease in interest rates on our cash equivalents, decreased average investment balances related to lower operating cash flows, decreased deposits held for certain government-sponsored programs and increased other-than-temporary impairment charges related to the disruption in the financial markets.

Medical Costs

Medical costs for 2008 increased primarily due to medical cost inflation, acquisitions completed in 2008 and growth in Ovations Medicare Advantage and Medicare Supplement products, partially offset by a decrease in the number of individuals served through both UnitedHealthcare risk-based products and Medicare Part D prescription drug plans. For 2008 and 2007, medical costs included $230 million and $420 million, respectively, of net favorable medical cost development related to prior fiscal years.

Operating Costs

The operating cost ratio increased in 2008 primarily due to certain expenses as described in "2009 Results of Operations Compared to 2008 Results" above, acquisitions completed in 2008, costs for anticipated revenue growth that did not fully materialize and a change in business mix towards service revenues from fee-based businesses.

Operating costs for 2007 include $176 million of expenses recorded in the first quarter of 2007 related to application of deferred compensation rules under Section 409A of the Internal Revenue Code (Section 409A) to our historical stock option practices. The $176 million Section 409A charge includes $87 million of expenses for the payment of certain optionholders' tax obligations for stock options exercised in 2006 and early 2007 and $89 million of expenses for the modification related to increasing the exercise price of unexercised stock options granted to nonexecutive officer employees and the related cash payments. For an expanded discussion of our Section 409A charges, see Note 12 of Notes to the Consolidated Financial Statements.

Depreciation and Amortization

The increase in depreciation and amortization was primarily related to higher levels of computer equipment and capitalized software as a result of technology development and enhancements, as well as additional depreciation and amortization related to business acquisitions.

Income Tax Rate

The decrease in our effective income tax rate was primarily due to lower earnings resulting in an increased proportion of tax-free investment income to total earnings.

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Reporting Segments

Health Benefits

The revenue growth in Health Benefits for 2008 was primarily due to growth in the number of individuals served by our Public and Senior Markets Group, premium rate increases for medical cost inflation and the 2008 acquisitions of Sierra, Fiserv Health, and Unison, partially offset by an organic decline in individuals served through commercial risk-based products and Medicare Part D products and a decrease in investment income. UnitedHealthcare revenues of $41.8 billion in 2008 increased over the comparable 2007 period by $1.6 billion, or 4%. The UnitedHealthcare increase was primarily driven by the same factors as discussed for Health Benefits in 2008. Ovations revenues of $28.1 billion in 2008 increased over the comparable 2007 period by $1.6 billion, or 6%. The increase was primarily due to an increase in individuals served with the standardized Medicare Supplement and Medicare Advantage products gained through both organic growth and the Sierra acquisition and premium rate increases, which were partially offset by a net organic decrease of 675,000 stand-alone Medicare Part D members primarily due to the reassignment by CMS of certain dual-eligible low income beneficiaries based on annual price bids. AmeriChoice generated revenues of $6.0 billion in 2008, an increase of $1.5 billion, or 34%, over the comparable 2007 period, primarily due to an increase in the number of individuals served by Medicaid plans, premium rate increases and the acquisition of Unison in the second quarter of 2008.

The decrease in Health Benefits earnings from operations was primarily due to pressure on enrollment and gross margins in the UnitedHealthcare risk-based business and pressure on gross margins in Medicare Part D prescription drug plans, partially offset by acquisitions. The UnitedHealthcare medical care ratio increased to 83.5% in 2008 from 82.6% in 2007. This increase was primarily driven by the effects of a competitive pricing environment where price increases, net of customer benefit package changes, did not fully match the rise in medical costs, and an increased mix of national account pharmaceutical benefit business, which typically carries a higher medical care ratio. Health Benefits' operating margin was 6.7% for the year ended December 31, 2008, a decrease from 9.3% in 2007 primarily driven by the factors discussed above.

The number of individuals served with commercial products increased due to acquisitions, which included the addition of 1,315,000 fee-based members from Fiserv Health and the addition of 310,000 risk-based individuals gained through the Sierra acquisition. These additions were partially offset by a net decline in individuals served with commercial products of 805,000, or 3%, from December 31, 2007, primarily due to a decline in individuals served with commercial risk-based products and the impact of a competitive commercial risk-based pricing environment. The number of individuals served by Medicare Advantage products at December 31, 2008 increased through the addition of 60,000 seniors from our acquisition of Sierra and organic growth of 95,000 seniors, partially offset by the divestiture of 30,000 individuals in Nevada related to the Sierra acquisition. Medicaid enrollment grew due to the addition of 320,000 and 60,000 individuals from our Unison and Sierra acquisitions, respectively, and strong organic growth of 425,000 individuals.

OptumHealth

Increased revenues in OptumHealth were driven by rate increases for medical cost inflation and an increased number of consumers served by this segment. OptumHealth provided services to approximately 60 million consumers at December 31, 2008, an increase of approximately 1 million individuals year-over-year.

Earnings from operations and operating margin decreased due to the increased costs for risk-based behavioral and specialty benefits businesses and the mix of continued growth in lower margin business.

Ingenix

The improvement in Ingenix revenues was due to continued growth in its health intelligence and contract research businesses as well as from business acquisitions. The decrease in earnings from operations and operating margin was primarily due to excess staffing costs during 2008 for certain research projects, which were cancelled, as well as lower demand for certain consulting services due to the current economic environment.

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Prescription Solutions

The decreased Prescription Solutions revenues were primarily due to the reduction in the number of individuals served related to the reassignment of dual-eligible beneficiaries described above through Medicare Part D prescription drug plans by our Ovations business, and a shift from name brand pharmaceuticals towards generic utilization, partially offset by revenues related to the Fiserv Health acquisition and growth in business with unaffiliated clients. Intersegment revenues eliminated in consolidation were $11.0 billion and $12.4 billion for 2008 and 2007, respectively.

Prescription Solutions earnings from operations increased primarily due to the Fiserv Health acquisition, gains in mail service drug fulfillment, and a continuing favorable mix shift to generic pharmaceuticals.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before depreciation, amortization and other non-cash expenses. As a result, any future decline in our profitability may have a negative impact on our liquidity. The diversity of our businesses, our geographic and customer diversity and our disciplined underwriting and pricing processes for our risk-based businesses, which seek to match premium rate increases with future expected medical costs, partially mitigates the risk of rising medical and operating costs.

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 exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. We make these investments pursuant to our Board of Directors' approved investment policy, which focuses on preservation of capital, credit quality, diversification, income and duration. The policy also generally governs return objectives, regulatory limitations, tax implications and risk tolerances.

Our regulated subsidiaries are subject to regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the National Association of Insurance Commissioners. 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. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2009, based on the 2008 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could be paid was $3.1 billion. For the year ended December 31, 2009, our regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $2.5 billion of extraordinary dividends. For the year ended December 31, 2008, our regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $1.2 billion of extraordinary dividends. The increase in the proportion of extraordinary dividends to total dividends in 2009 primarily reflects the acceleration of dividend timing, as well as the size of specific dividends beyond ordinary levels. Given expected statutory capital levels, we anticipate lower overall regulated subsidiary dividends in 2010.

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Our non-regulated businesses also generate cash flows from operations for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of commercial paper and long-term debt, as well as the availability of our committed credit facility, further strengthen our operating and financial flexibility. We generally use these cash flows to reinvest in our businesses through capital expenditures, expanding our services through business acquisitions, repaying debt and/or repurchasing shares of our common stock, depending on market conditions.

Results

A summary of our major sources and uses of cash is reflected in the table below:

	Year Ended December 31,		
(in millions)	2009	2008	2007
Sources of Cash:			
Cash provided by operating activities	$ 5,625	$ 4,238	$ 5,877
Sales of investments	4,040	5,568	1,271
Maturities of investments	2,675	3,030	2,094
Issuance of long-term debt	—	2,981	3,582
Interest rate swap termination	513	—	—
Other	546	1,770	1,962
Total sources of cash	13,399	17,587	14,786
Uses of Cash:			
Purchases of investments	(6,466)	(9,251)	(6,379)
Cash paid for acquisitions, net of cash assumed and disposition	(486)	(3,813)	(262)
Retirement of long-term debt	(1,350)	(500)	(950)
Common stock repurchases	(1,801)	(2,684)	(6,599)
Repayments of commercial paper, net	(99)	(1,346)	—
Other	(823)	(1,432)	(2,051)
Total uses of cash	(11,025)	(19,026)	(16,241)
Net increase (decrease) in cash	$ 2,374	$ (1,439)	$ (1,455)

2009 Cash Flows Compared To 2008 Cash Flows

Cash flows from operating activities increased $1.4 billion, or 33%, primarily due to the payment in 2008 of $573 million, net of taxes, for the settlement of two class action lawsuits related to our historical stock option practices, the 2009 increase in medical costs payable driven by membership growth in risk-based products in the public and senior markets businesses, and the effect of changes to our receivable and payable balances with CMS related to Medicare Part D. Additionally, we paid less taxes in 2009 due to tax law changes that took effect in 2008. Operating cash flows in 2008 included payment of 2007 taxes due under the prior tax law, while the 2009 payment did not include prior year amounts. We anticipate lower cash flows from operations in 2010 as compared to 2009 as a result of an anticipated decrease in net earnings, the timing of certain CMS payments and the impact of a legislated change to the timing of payments for Medicare Part D claims.

Cash flows used for investing activities decreased $4.1 billion, or 81%, primarily due to acquisitions completed in 2008 and decreases in the usage of cash in 2009 for purchases of investments, which more than offset the 2009 decreases in sales and maturities of investments.

Cash flows used for financing activities increased $1.7 billion due to the issuance of long-term debt in 2008 and the effect of our change in intent with respect to offsetting cash balances in excess of bank deposits in 2008. See Note 2 of Notes to the Consolidated Financial Statements for further detail of our policy on offsetting cash balances. These items were partially offset by decreases in common stock repurchases in 2009 and the 2009 proceeds from our terminated interest rate swap contracts.

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2008 Cash Flows Compared To 2007 Cash Flows

Cash flows from operating activities decreased $1.6 billion, or 28%, primarily due to the decrease in net earnings, which included payments for the settlement of two class action lawsuits described above.

Cash flows used for investing activities increased $925 million, or 22%, primarily due to acquisitions completed in 2008 and increases in the usage of cash in 2008 for purchases of investments offset by the 2008 decreases in sales and maturities of investments.

Cash flows used for financing activities decreased $2.6 billion, or 81%, primarily due to decreases in common stock repurchases in 2008 offset by the effect of our change in intent with respect to offsetting cash balances in excess of bank deposits in 2008.

Financial Condition

As of December 31, 2009, our cash, cash equivalent and available-for-sale investment balances of $24.2 billion included $9.8 billion of cash and cash equivalents (which included $2.3 billion held by non-regulated entities), $13.8 billion of debt securities and $577 million of equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity. The use of different market assumptions or valuation methodologies, primarily used in valuing our Level 3 equity securities, may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows, reduce the need to sell investments in adverse markets. See Note 5 of Notes to the Consolidated Financial Statements for further detail of our fair value measurements.

Our investment portfolio has a weighted average duration of 2.1 years and a weighted average credit rating of "AA" as of December 31, 2009. Included in the debt securities balance were $3.0 billion of state and municipal obligations that are guaranteed by third parties. A number of different guarantors guarantee the securities, and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted average credit rating of these securities both with and without the guarantee is "AA" as of December 31, 2009.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and significant cash and cash equivalent balances at our regulated and unregulated entities, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a commercial paper program, which facilitates the issuance of senior unsecured debt sold on a discount basis with maturities of up to 270 days through third-party broker-dealers. The commercial paper program is supported by the $2.5 billion bank credit facility described below. We did not have any commercial paper outstanding as of December 31, 2009.

Bank Credit Facility. We have a five-year revolving bank credit facility with 23 banks, which matures in May 2012. This facility supports our commercial paper program and is available for general corporate purposes. We had no amounts outstanding under this facility as of December 31, 2009. The interest rate is variable based on term and amount and is calculated based on the London Interbank Offered Rate (LIBOR) plus a spread. As of December 31, 2009, the interest rate on this facility, had it been drawn, would have ranged from 0.4% to 0.7%.

Our bank credit facility contains various covenants, the most restrictive of which requires us to maintain a debt-to-total-capital ratio below 50%. 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, was 32.1% and 38.1% as of December 31, 2009 and December 31, 2008, respectively. We complied with the requirements of all debt covenants as of December 31, 2009.

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Shelf Registration. In February 2008, we filed a universal S-3 shelf registration statement with the SEC registering an unspecified amount of debt securities.

Credit Ratings. Our credit ratings at December 31, 2009 were as follows:

	Moody's		Standard & Poor's		Fitch	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	Baa1	Stable	A-	Negative	A-	Negative
Commercial paper	P-2	n/a	A-2	n/a	F1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have therefore adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Debt Tender. In February 2010, we completed cash tender offers for $775 million aggregate principal amount of certain of our outstanding notes. We believe this debt repurchase will improve the matching of floating rate assets and liabilities on our balance sheet and reduce our debt service cost. We used cash on hand to fund the purchase of the notes.

Share Repurchases. Under our Board of Directors' authorization, we maintain a common share repurchase program. Repurchases may be made from time to time at prevailing prices in the open market. In 2009, we repurchased 74.3 million shares at an average price of approximately $24 per share and an aggregate cost of $1.8 billion. As of December 31, 2009, we had Board of Directors' authorization to purchase up to an additional 28.7 million shares of our common stock. In February 2010, the Board renewed and increased our share repurchase program, and authorized us to repurchase up to 120 million shares of our common stock.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2009, under our various contractual obligations and commitments:

(in millions)	2010	2011 to 2012	2013 to 2014	Thereafter	Total
Debt (a)	$2,164	$ 1,361	$ 1,559	$ 6,089	$11,173
Interest on debt (b)	545	659	406	3,549	5,159
Operating leases	255	420	272	644	1,591
Purchase obligations (c)	115	31	—	—	146
Future policy benefits (d)	139	353	337	1,152	1,981
Unrecognized tax benefits (e)	19	—	—	104	123
Unfunded investment commitments (f)	138	42	24	16	220
Other obligations (g)	210	80	—	252	542
Total contractual obligations	$3,585	$ 2,946	$ 2,598	$ 11,806	$20,935

(a) See Note 9 of Notes to the Consolidated Financial Statements for more detail.

(b) Calculated using stated rates from the debt agreements and assuming amounts are outstanding through their contractual term, including the effect of the debt tender described in Note 9 of Notes to the Consolidated Financial Statements. For variable-rate obligations, we used the rates in place as of December 31, 2009 to estimate all remaining contractual payments. Includes unamortized discounts from par values.

(c) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2009.

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(d) Estimated payments required under life and annuity contracts held by a divested entity. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica, but we remain liable to the policyholders if they are unable to pay. We have recorded a corresponding reinsurance receivable from OneAmerica in our Consolidated Financial Statements.
(e) Since the timing of future settlements is uncertain, the long-term portion has been classified as "Thereafter." See Note 10 of Notes to the Consolidated Financial Statements for more detail.
(f) Includes remaining capital commitments for venture capital funds and the investment commitment related to the PacifiCare acquisition.
(g) Includes obligations associated with contingent consideration related to a business acquisition, certain employee benefit programs, and charitable contributions related to the PacifiCare acquisition. Due to uncertainty regarding payment timing, obligations for employee benefit programs and the charitable contributions have been classified as "Thereafter".

We do not have other significant contractual obligations 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.

OFF-BALANCE SHEET ARRANGEMENTS

We do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (SPEs), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2009, we were not involved in any SPE transactions.

RECENTLY ISSUED ACCOUNTING STANDARDS

In October 2009, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2009-13, "Multiple-Deliverable Revenue Arrangements" (ASU 2009-13). This update removes the criterion that entities must use objective and reliable evidence of fair value in separately accounting for deliverables and provides entities with a hierarchy of evidence that must be considered when allocating arrangement consideration. The new guidance also requires entities to allocate arrangement consideration to the separate units of accounting based on the deliverables' relative selling price. The provisions will be effective for revenue arrangements entered into or materially modified in our fiscal year 2011 and must be applied prospectively. We are currently evaluating the impact of the provisions of ASU 2009-13.

We have determined that all other recently issued accounting standards will not have a material impact on our Consolidated Financial Statements, or do not apply to our operations.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make 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 estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

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, health care professional 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 professional and type of service, the typical billing lag for services can be up to 90 days from the 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 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 more complete claim information becomes available, we adjust 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). Medical costs in 2009, 2008 and 2007, included net favorable medical cost development related to prior periods of $310 million, $230 million and $420 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months. For the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. This approach is consistently applied from period to period.

Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2009:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs Payable (in millions)
(0.75)%	$ 171
(0.50)	114
(0.25)	57
0.25	(57)
0.50	(113)
0.75	(169)

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Medical cost PMPM trend factors are the most significant factors we use in developing our medical costs payable estimates for the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2009:

Medical Cost PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs Payable (in millions)
3%	$ 332
2	222
1	111
(1)	(111)
(2)	(222)
(3)	(332)

The analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Our estimate of medical costs payable represents management's best estimate of our liability for unpaid medical costs as of December 31, 2009, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2009; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our December 31, 2009 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance, 2009 net earnings would increase or decrease by $52 million and diluted net earnings per common share would increase or decrease by $0.04 per share.

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 coordinating care with physicians and other health care professionals and rate discounts from physicians and other health care professionals. Through contracts with physicians and other health care professionals, 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 professionals 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.

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 period 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.

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CMS deploys a risk adjustment model, which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. We and other health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows. To determine fair values we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Where available and appropriate, comparative market multiples are used to corroborate the results of our discounted cash flow test.

We completed our annual assessment of goodwill as of January 1, 2010 and determined that no impairment existed as of December 31, 2009. Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, there is uncertainty inherent in those projections. That uncertainty is increased by potential health care reforms as discussed in "Proposed Health Care Reforms and Reimbursement Changes" above, as any passed legislation may significantly change the forecasts and long-term growth rate assumptions for some or all of our reporting units.

Intangible assets. Finite lived intangible assets are acquired in a business combination and are assets that represent future expected benefits but lack physical substance (e.g., customer lists and trademarks). We do not have material holdings of indefinite lived intangible assets. Intangible assets are amortized over their expected useful lives and are subject to impairment tests when events or circumstances indicate that a finite lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. If the carrying value exceeds its estimated fair value, an impairment would be recorded.

We calculate the estimated fair value of finite lived intangible assets using undiscounted cash flows that are expected to result from the use of the intangible asset or group of assets. We consider many factors, including estimated future utility to estimate cash flows. There were no material impairments of finite lived intangible assets during the current year.

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Investments

As of December 31, 2009, we had investments with a carrying value of $14.6 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from earnings and report net unrealized gains or losses, 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, 2009, our investments had gross unrealized gains of $493 million and gross unrealized losses of $50 million. We evaluate investments for impairment considering the length of time and extent to which market value has been less than cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost. For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell a debt security before recovery of the entire amortized cost basis or maturity of the debt security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income. For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in net earnings. New information and the passage of time can change these judgments. We manage our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements. Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes.

We have established a net valuation allowance against certain deferred tax assets for which the ultimate realization of future benefits is uncertain. After application of the valuation allowances, we anticipate that no limitations will apply with respect to utilization of any of the other net deferred income tax assets. We believe that our estimates for the valuation allowances against deferred tax assets and tax contingency reserves are appropriate based on current facts and circumstances.

According to U.S. Generally Accepted Accounting Principles (GAAP), a tax benefit from an uncertain tax position may be recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits.

We have established an estimated liability for federal, state and non-U.S. income tax exposures that arise and meet the criteria for accrual under U.S. GAAP. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax contingencies due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

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The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2009 earnings before income taxes would have caused the provision for income taxes to change by $58 million.

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, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters. It is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions.

LEGAL MATTERS

A description of our legal proceedings is included in Note 14 of Notes to the Consolidated Financial Statements and is incorporated by reference herein.

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us 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, 2009, we had an aggregate $2.0 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as “A.” As of December 31, 2009, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate financial investments and debt and (b) changes in equity prices that impact the value of our equity investments.

As of December 31, 2009, $9.8 billion of our financial investments were classified as cash and cash equivalents on which interest rates received vary with market interest rates, which may materially impact our investment income. Also, $750 million of our debt as of December 31, 2009 was at interest rates that vary with market rates.

The fair value of certain of our fixed-rate financial investments and debt also varies with market interest rates. As of December 31, 2009, $14.0 billion of our investments were fixed-rate debt securities and $10.4 billion of our debt was fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities and interest rate indices, as well as endeavoring to match our floating rate assets and liabilities over time in normal markets, either directly or through the use of interest rate swap

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contracts. As part of our risk management strategy, we may enter into interest rate swap agreements with financial institutions to manage the impact of market interest rates on interest expense. In January 2009, we terminated interest rate swap contracts with $4.9 billion in notional value to lock-in the benefit of low market interest rates. This gain will be realized over the remaining life of the applicable hedged fixed-rate debt as a reduction to interest expense in the Consolidated Statements of Operations.

The following table summarizes the impact of a hypothetical change in market interest rates by 1% or 2% as of December 31, 2009 on our investment income and interest expense per annum, and the fair value of our financial investments and debt (in millions):

Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Investments	Fair Value of Debt
2%	$ 196	$ 15	$ (1,059)	$ (1,187)
1	98	8	(540)	(633)
(1)	(15)	(6)	541	730
(2)	nm	nm	1,075	1,579

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating rate assets and liabilities as of December 31, 2009, the assumed hypothetical change in interest rates has been floored at zero and does not reflect the full 1% point reduction in interest income or interest expense.

As of December 31, 2009, we had $577 million of equity securities and venture capital funds, a portion of which were invested 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 investments.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2009 and 2008, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2009. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2009 and 2008, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2009, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2009, based on the criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 10, 2010 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2010

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UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2009	2008
ASSETS		
Current assets:		
Cash and cash equivalents	$ 9,800	$ 7,426
Short-term investments	1,239	783
Accounts receivable, net of allowances of $220 and $148	1,954	1,929
Assets under management	2,383	2,199
Deferred income taxes	448	424
Other current receivables	1,838	1,715
Prepaid expenses and other current assets	538	514
Total current assets	18,200	14,990
Long-term investments	13,311	13,366
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,738 and $2,363	2,140	2,181
Goodwill	20,727	20,088
Other intangible assets, net of accumulated amortization of $1,038 and $803	2,381	2,329
Other assets	2,286	2,861
TOTAL ASSETS	$59,045	$55,815
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current liabilities:		
Medical costs payable	$ 9,362	$ 8,664
Accounts payable and accrued liabilities	6,283	5,685
Other policy liabilities	3,137	2,823
Commercial paper and current maturities of long-term debt	2,164	1,456
Unearned revenues	1,217	1,133
Total current liabilities	22,163	19,761
Long-term debt, less current maturities	9,009	11,338
Future policy benefits	2,325	2,286
Other liabilities	1,942	1,650
Total liabilities	35,439	35,035
Commitments and contingencies (Note 14)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 1,147 and 1,201 issued and outstanding	11	12
Additional paid-in capital	—	38
Retained earnings	23,342	20,782
Accumulated other comprehensive income (loss):		
Net unrealized gains (losses) on investments, net of tax effects	277	(30)
Foreign currency translation losses	(24)	(22)
Total shareholders' equity	23,606	20,780
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$59,045	$55,815

See Notes to the Consolidated Financial Statements.

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UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Year Ended December 31, 2009	2008	2007
REVENUES:			
Premiums	$79,315	$73,608	$68,781
Services	5,306	5,152	4,608
Products	1,925	1,655	898
Investment and other income	592	771	1,144
Total revenues	87,138	81,186	75,431
OPERATING COSTS:			
Medical costs	65,289	60,359	55,435
Operating costs	12,734	13,103	10,583
Cost of products sold	1,765	1,480	768
Depreciation and amortization	991	981	796
Total operating costs	80,779	75,923	67,582
EARNINGS FROM OPERATIONS	6,359	5,263	7,849
Interest expense	(551)	(639)	(544)
EARNINGS BEFORE INCOME TAXES	5,808	4,624	7,305
Provision for income taxes	(1,986)	(1,647)	(2,651)
NET EARNINGS	$ 3,822	$ 2,977	$ 4,654
BASIC NET EARNINGS PER COMMON SHARE	$ 3.27	$ 2.45	$ 3.55
DILUTED NET EARNINGS PER COMMON SHARE	$ 3.24	$ 2.40	$ 3.42
BASIC WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	1,168	1,214	1,312
DILUTIVE EFFECT OF COMMON STOCK EQUIVALENTS	11	27	49
DILUTED WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	1,179	1,241	1,361
ANTI-DILUTIVE SHARES EXCLUDED FROM THE CALCULATION OF DILUTIVE EFFECT OF COMMON STOCK EQUIVALENTS	107	90	38

See Notes to the Consolidated Financial Statements.

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UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
Balance at January 1, 2007	**1,345**	**$ 13**	**$ 6,406**	**$ 14,376**	**$ 15**	**$ 20,810**
Net earnings	—	—	—	4,654	—	4,654
Unrealized holding gains on investment securities during the period, net of tax expense of $60	—	—	—	—	107	107
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $14	—	—	—	—	(24)	(24)
Comprehensive income						4,737
Issuances of common stock, and related tax benefits	33	1	590	—	—	591
Common stock repurchases	(125)	(1)	(6,598)	—	—	(6,599)
Conversion of convertible debt	—	—	24	—	—	24
Share-based compensation, and related tax benefits	—	—	602	—	—	602
Adjustment to adopt FIN 48	—	—	(1)	(61)	—	(62)
Common stock dividend ($0.03 per share)	—	—	—	(40)	—	(40)
Balance at December 31, 2007	**1,253**	**$ 13**	**$ 1,023**	**$ 18,929**	**$ 98**	**$ 20,063**
Net earnings	—	—	—	2,977	—	2,977
Unrealized holding losses on investment securities during the period, net of tax benefit of $76	—	—	—	—	(132)	(132)
Reclassification adjustment for net realized losses included in net earnings, net of tax benefit of $2	—	—	—	—	4	4
Foreign currency translation loss	—	—	—	—	(22)	(22)
Comprehensive income						2,827
Issuances of common stock, and related tax benefits	20	—	272	—	—	272
Common stock repurchases	(72)	(1)	(1,596)	(1,087)	—	(2,684)
Share-based compensation, and related tax benefits	—	—	339	—	—	339
Common stock dividend ($0.03 per share)	—	—	—	(37)	—	(37)
Balance at December 31, 2008	**1,201**	**$ 12**	**$ 38**	**$ 20,782**	**$ (52)**	**$ 20,780**
Net earnings	—	—	—	3,822	—	3,822
Unrealized holding gains on investment securities during the period, net of tax expense of $187	—	—	—	—	314	314
Reclassification adjustment for net realized gains included in net earnings, net of tax expense of $4	—	—	—	—	(7)	(7)
Foreign currency translation loss	—	—	—	—	(2)	(2)
Comprehensive income						4,127
Issuances of common stock, and related tax benefits	20	—	221	—	—	221
Common stock repurchases	(74)	(1)	(574)	(1,226)	—	(1,801)
Share-based compensation, and related tax benefits	—	—	315	—	—	315
Common stock dividend ($0.03 per share)	—	—	—	(36)	—	(36)
Balance at December 31, 2009	**1,147**	**$ 11**	**$ —**	**$ 23,342**	**$ 253**	**$ 23,606**

See Notes to the Consolidated Financial Statements.

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UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2009	2008	2007
OPERATING ACTIVITIES			
Net earnings	$ 3,822	$ 2,977	$ 4,654
Noncash items:			
Depreciation and amortization	991	981	796
Deferred income taxes	(16)	(166)	86
Share-based compensation	334	305	505
Other	23	(122)	(213)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	100	(219)	(194)
Other assets	(250)	(48)	(386)
Medical costs payable	424	(41)	149
Accounts payable and other liabilities	99	708	269
Other policy liabilities	104	(170)	188
Unearned revenues	(6)	33	23
Cash flows from operating activities	5,625	4,238	5,877
INVESTING ACTIVITIES			
Cash paid for acquisitions, net of cash assumed	(486)	(4,012)	(270)
Cash received from disposition	—	199	8
Purchases of property, equipment and capitalized software	(739)	(791)	(871)
Proceeds from disposal of property, equipment and capitalized software	—	185	—
Purchases of investments	(6,466)	(9,251)	(6,379)
Sales of investments	4,040	5,568	1,271
Maturities of investments	2,675	3,030	2,094
Cash flows used for investing activities	(976)	(5,072)	(4,147)
FINANCING ACTIVITIES			
(Repayments of) proceeds from commercial paper, net	(99)	(1,346)	947
Proceeds from issuance of long-term debt	—	2,981	3,582
Payments for retirement of long-term debt	(1,350)	(500)	(950)
Proceeds from interest rate swap termination	513	—	—
Common stock repurchases	(1,801)	(2,684)	(6,599)
Proceeds from common stock issuances	282	299	712
Share-based compensation excess tax benefit	38	62	303
Customer funds administered	204	(461)	(1,110)
Dividends paid	(36)	(37)	(40)
Checks outstanding	22	1,224	—
Other	(48)	(143)	(30)
Cash flows used for financing activities	(2,275)	(605)	(3,185)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	2,374	(1,439)	(1,455)
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	7,426	8,865	10,320
CASH AND CASH EQUIVALENTS, END OF PERIOD	$ 9,800	$ 7,426	$ 8,865
Supplemental cash flow disclosures			
Cash paid for interest	$ 527	$ 621	$ 553
Cash paid for income taxes	$ 2,048	$ 1,882	$ 2,277

See Notes to the Consolidated Financial Statements.

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UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Description of Business

UnitedHealth Group Incorporated (also referred to as "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to making health care work better. The Company emphasizes enhancing the performance of the health system and improving the overall health and well-being of the people it serves and their communities. The Company helps people get the care they need at an affordable cost; supports the physician/patient relationship; and empowers people with the information, guidance and tools they need to make personal health choices and decisions.

The Company's primary focus is on improving the 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 professionals, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through its diversified family of businesses, the Company leverages core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

2. Basis of Presentation and Summary of Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The Company has eliminated intercompany balances and transactions.

The Company has evaluated subsequent events through February 10, 2010, the date this Form 10-K was filed with the SEC. Other than the debt tender that is discussed in Note 9 of Notes to the Consolidated Financial Statements and the change to the Company's share repurchase program discussed in Note 11 of Notes to the Consolidated Financial Statements, no material subsequent events have occurred since December 31, 2009 that required recognition or disclosure in these financial statements.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to medical costs, medical costs payable, revenues, goodwill, other intangible assets, investments, income taxes and contingent liabilities. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs. The Company recognizes premium revenues in the period in which eligible individuals are entitled to receive health care benefits. The Company records health care premium payments received from its customers in advance of the service period as unearned revenues.

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UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependants. Under service fee contracts, the Company recognizes revenue in the period the related services are performed based upon the fee charged to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependants, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. Since the Company has neither the obligation for funding the health care costs, nor the responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements.

For both risk-based and fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals.

Through the Company's Prescription Solutions pharmacy benefits management (PBM) business, revenues are derived from products sold through a contracted network of retail pharmacies, and from administrative services, including claims processing and formulary design and management. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized always exclude the member's applicable co-payment. Product revenues are recognized upon sale or shipment based on contract terms. Service revenues are recognized when the prescription claim is adjudicated. The Company has entered into retail service contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless if the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members. As a result, revenues are reported on a gross basis. Product revenues also include sales of Ingenix publishing and software products that are recognized as revenue upon shipment.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers but for which the Company has either not yet received or processed claims, and for liabilities for physician, hospital and other medical cost disputes. The Company develops estimates for medical costs 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, care professional contract rate changes, medical care consumption and other medical cost trends. The Company estimates 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, 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 estimates recorded in prior periods become more exact, the Company adjusts the amount of the estimates, and

UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, the Company's operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

The Company had checks outstanding in excess of bank deposits of $1.2 billion as of both December 31, 2009 and 2008, which were classified as Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets and have been reflected as Checks Outstanding within financing activities in the Consolidated Statements of Cash Flows. During the fourth quarter of 2008, the Company changed its intent with respect to offsetting cash balances, which affected its balances in checks outstanding in excess of bank deposits for certain cash balances. There were no checks outstanding in excess of bank deposits as of December 31, 2007.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings and reports them, net of income tax effects, as a separate component of shareholders' equity. The Company evaluates investments for impairment by considering the length of time and extent to which market value has been less than cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost. For debt securities, if the Company intends to either sell or determines that it will be more likely than not be required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in earnings. If the Company does not intend to sell the debt security and it determines that it will not be more likely than not be required to sell the security but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income. For equity securities, the Company recognizes impairments in other comprehensive income if it expects to hold the security until fair value increases to at least the security's cost basis and it expects that increase in fair value to occur in a reasonably forecasted period. If the Company intends to sell the equity security or if it believes that recovery of fair value to cost will not occur in a reasonably forecasted period, the Company recognizes the impairment in net earnings. New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy. To calculate realized gains and losses on the sale of investments, the Company uses the specific cost or amortized cost of each investment sold.

Assets Under Management

The Company administers certain aspects of AARP's insurance program (see Note 13 of Notes to the Consolidated Financial Statements). Pursuant to the Company's agreement, AARP assets are managed separately

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UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

from its general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon transfer of the AARP contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with the AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. Accordingly, they are not included in the Company's earnings.

Other Current Receivables

Other current receivables include amounts due from pharmacy rebates, CMS for Medicare Part D, reinsurance and other miscellaneous amounts due to the Company.

The Company's PBM businesses contract with pharmaceutical manufacturers, some of whom provide rebates based on use of the manufacturers' products by its PBM businesses' affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The PBM businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms. The PBM businesses record rebates attributable to affiliated clients as a reduction to medical costs. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold with a corresponding payable for the amounts of the rebates to be remitted to non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of Product Revenue. The Company generally receives rebates between two to five months after billing.

For details on the Company's Medicare Part D receivables see "Medicare Part D Pharmacy Benefits Contract" below.

For details on the Company's reinsurance receivable see "Future Policy Benefits and Reinsurance Receivables" below.

Medicare Part D Pharmacy Benefits Contract

The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are six separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy*. CMS pays the Company a cost reimbursement estimate monthly to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS based on actual cost experience, after the end of the plan year.

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- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums it received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including member eligibility status differences with CMS. The Company records risk-share adjustments to Premium Revenues in the Consolidated Statements of Operations and Other Policy Liabilities or Other Current Receivables in the Consolidated Balance Sheets.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and therefore are recorded as Premium Revenues in the Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in Unearned Revenues in the Consolidated Balance Sheets.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are not reflected as premium revenues, but rather are accounted for as deposits. As of December 31, 2009 and 2008, the amounts received for these subsidies were insufficient to cover the costs incurred for these contract elements; therefore, the Company recorded a receivable in Other Current Receivables in the Consolidated Balance Sheets. Related cash flows are presented as Customer Funds Administered within financing activities in the Consolidated Statements of Cash Flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred and are recognized in Medical Costs and Operating Costs, respectively, in the Consolidated Statements of Operations.

The final 2009 risk-share amount is expected to be settled during the second half of 2010, and is subject to the reconciliation process with CMS.

The Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	December 31, 2009		December 31, 2008	
(in millions)	CMS Subsidies (a)	Risk-Share	CMS Subsidies (a)	Risk-Share
Other current receivables	$ 271	$ —	$ 349	$ 19
Other policy liabilities	—	268	—	—

(a) Includes the Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy.

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As of January 1, 2010, certain changes were made to the Medicare Part D coverage by CMS, including:

- The initial coverage limit increased to $2,830 from $2,700 in 2009.
- The catastrophic coverage begins at $6,440 as compared to $6,154 in 2009.
- The annual out-of-pocket maximum increased to $4,550 from $4,350 in 2009.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. The Company reviews property, equipment and capitalized software for events or changes in circumstances that would indicate that we might not recover their carrying value. If the Company determines that an asset may not be recoverable, an impairment charge is recorded.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 7 years
Buildings	35 to 40 years
Leasehold improvements	Shorter of useful life or remaining lease term
Capitalized software	3 to 5 years

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. To determine whether goodwill is impaired, the Company performs a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, the Company would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

The Company calculates the estimated fair value of our reporting units using discounted cash flows. To determine fair values the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (includes significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Where available and appropriate, comparative market multiples are used to corroborate the results of our discounted cash flow test.

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The Company completed its annual assessment of goodwill as of January 1, 2010 and determined that no impairment existed as of December 31, 2009. Although the Company believes that the financial projections used are reasonable and appropriate for all of its reporting units, there is uncertainty inherent in those projections. That uncertainty is increased by potential health care reforms, as any passed legislation may significantly change the forecasts and long-term growth rate assumptions for some or all of its reporting units.

Intangible assets

Finite lived intangible assets are acquired in a business combination and are assets that represent future expected benefits but lack physical substance (e.g., customer lists and trademarks). The Company does not have material holdings of indefinite lived intangible assets. Intangible assets are amortized over their expected useful lives and are subject to impairment tests when events or circumstances indicate that a finite lived intangible asset's (or asset group's) carrying value may exceed its estimated fair value. If the carrying value exceeds its estimated fair value, an impairment would be recorded.

The Company calculates the estimated fair value of finite lived intangible assets using undiscounted cash flows that are expected to result from the use of the intangible asset or group of assets. The Company considers many factors, including estimated future utility to estimate cash flows. There were no material impairments of finite lived intangible assets during the current year.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP program (see Note 13 of Notes to the Consolidated Financial Statements), health savings account deposits, deposits under the Medicare Part D program (see "Medicare Part D Pharmacy Benefits Contract" above), and the current portion of future policy benefits. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits and Reinsurance Receivables

Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. As a result of the 2005 sale of the life and annuity business within the Company's Golden Rule Financial Corporation (Golden Rule) subsidiary under an indemnity reinsurance arrangement, the Company has maintained a liability associated with the reinsured contracts, as it remains primarily liable to the policyholders, and has recorded a corresponding reinsurance receivable due from the purchaser. As of December 31, 2009, the Company had an aggregate $2.0 billion reinsurance receivable, of which $139 million was recorded in Other Current Receivables and $1.9 billion was recorded in Other Assets in the Consolidated Balance Sheets. As of

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

December 31, 2008, the Company had an aggregate $2.0 billion reinsurance receivable, of which $154 million was recorded in Other Current Receivables and $1.9 billion was recorded in Other Assets in the Consolidated Balance Sheets. The Company evaluates the financial condition of the reinsurer and only records the reinsurance receivable to the extent of probable recovery.

Policy Acquisition Costs

The Company's commercial health insurance contracts typically have a one-year term and may be cancelled by the customer with at least 31 days notice. Costs related to the acquisition and renewal of commercial customer contracts are charged to expense as incurred.

Share-Based Compensation

Share-based compensation expense is measured at the grant date based on the fair values of the awards and is recognized as expense over the period in which the share-based compensation vests.

Net Earnings Per Common Share

The Company computes basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options and restricted stock, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recent Accounting Standards

Recently Adopted Accounting Standards. In June 2009, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards (FAS) No. 168, "The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles — a replacement of FAS 162." The new standard establishes only two levels of U.S. GAAP, authoritative and nonauthoritative. The FASB Accounting Standards Codification (ASC) became the single source of authoritative, nongovernmental U.S. GAAP, except for rules and interpretive releases of the SEC, which will continue to be sources of authoritative U.S. GAAP for SEC registrants. All other non-grandfathered, non-SEC accounting literature not included in the ASC became nonauthoritative upon adoption. The new guidance became effective for the Company's third quarter of 2009. Since the new standard did not change U.S. GAAP, there was no change to the Company's Consolidated Financial Statements other than to update all references to U.S. GAAP to be in conformity with the ASC.

The Company adopted the provisions of ASC Topic No. 820, "Fair Value Measurements and Disclosures" (ASC 820) as of January 1, 2008 for fair value measurements of certain financial assets and liabilities and for non-financial assets and liabilities measured at fair value on at least an annual basis. The provisions were adopted for non-financial assets and liabilities not measured at fair value on at least an annual basis as of January 1, 2009. These provisions define fair value, establish a framework for measuring fair value and expand disclosure requirements. The adoption did not have a material impact on the Consolidated Financial Statements.

In December 2007, the FASB issued guidance codified into ASC Topic No. 805, "Business Combinations," which replaced previous business combination accounting guidance. The new guidance revises how an acquirer

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recognizes and measures in its financial statements the identifiable assets acquired, the liabilities, any noncontrolling interest in the acquiree and the goodwill acquired. The guidance as amended includes recognition provisions for assets acquired and liabilities assumed that arise from contingencies and the treatment of contingent purchase price. It also requires additional disclosure requirements intended to enable users to evaluate the nature and financial effects of the business combination. The Company adopted the new guidance on January 1, 2009, and applied the provisions prospectively to all new acquisitions closing on or after that date. The adoption did not have a material impact on the Consolidated Financial Statements.

Recently Issued Accounting Standards. In October 2009, the FASB issued Accounting Standards Update (ASU) No. 2009-13, "Multiple-Deliverable Revenue Arrangements" (ASU 2009-13). This update removes the criterion that entities must use objective and reliable evidence of fair value in separately accounting for deliverables and provides entities with a hierarchy of evidence that must be considered when allocating arrangement consideration. The new guidance also requires entities to allocate arrangement consideration to the separate units of accounting based on the deliverables' relative selling price. The provisions will be effective for revenue arrangements entered into or materially modified in the Company's fiscal year 2011 and must be applied prospectively. The Company is currently evaluating the impact of the provisions of ASU 2009-13.

The Company has determined that all other recently issued accounting standards will not have a material impact on its Consolidated Financial Statements, or do not apply to its operations.

3. Acquisitions

On June 1, 2009, all of the outstanding shares of AIM Healthcare Services, Inc. (AIM) were acquired for approximately $440 million in cash. AIM is a leading provider of payment accuracy solutions for health care payer and hospital clients in all 50 states. On a preliminary basis, the total consideration paid exceeded the estimated fair value of the net tangible assets acquired by $425 million, of which $166 million has been allocated to finite-lived intangible assets and $259 million to goodwill. The allocation is pending completion of a valuation analysis. The acquired goodwill is deductible for income tax purposes. The results of operations and financial condition of AIM have been included in the Company's consolidated results and the results of the Ingenix reporting segment since the acquisition date. The pro forma effects of this acquisition on the Company's Consolidated Financial Statements were not material.

On May 30, 2008, the Company acquired all the outstanding shares of Unison Health Plans (Unison) for approximately $930 million in cash. Unison provides government-sponsored health plan coverage to people in Pennsylvania, Ohio, Tennessee, Delaware, South Carolina and Washington, D.C. through a network of independent health care professionals. The total consideration paid exceeded the estimated fair value of the net tangible assets acquired by $806 million, of which $89 million has been allocated to finite-lived intangible assets and $717 million to goodwill. The acquired goodwill is not deductible for income tax purposes. The results of operations and financial condition of Unison have been included in the Company's consolidated results and the results of the Health Benefits reporting segment since the acquisition date. The pro forma effects of this acquisition on the Company's Consolidated Financial Statements were not material.

On February 25, 2008, the Company acquired all of the outstanding shares of Sierra Health Services, Inc. (Sierra), a diversified health care services company based in Las Vegas, Nevada, for approximately $2.6 billion in cash, representing a price of $43.50 per share of Sierra common stock. The total consideration paid exceeded the estimated fair value of the net tangible assets acquired by $2.5 billion. Based on management's consideration of fair value, which included completion of a valuation analysis, $500 million has been allocated to finite-lived intangible assets and $2.0 billion to goodwill. The acquired goodwill is not deductible for income tax purposes.

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The U.S. Department of Justice approved the acquisition conditioned upon the divestiture of the Company's individual Medicare Advantage HMO plans in Clark and Nye Counties, Nevada, which represented approximately 30,000 members. The divestiture was completed on April 30, 2008. The Company received proceeds of $185 million for this transaction, which were recorded as a reduction to Operating Costs. Group Medicare Advantage plans offered through commercial contracts were excluded from the divestiture. Also, the Company retained Sierra's Medicare Advantage HMO plans in Nevada. The results of operations and financial condition of Sierra have been included in the Company's consolidated results and the results of the Health Benefits, OptumHealth and Prescription Solutions reporting segments since the acquisition date. The pro forma effects of this acquisition on the Company's Consolidated Financial Statements were not material.

On January 10, 2008, the Company acquired all of the outstanding shares of Fiserv Health, Inc. (Fiserv Health), a subsidiary of Fiserv, Inc., for approximately $740 million in cash. Fiserv Health is a leading administrator of medical benefits and also provides care facilitation services, specialty health solutions and PBM services. The total consideration paid exceeded the estimated fair value of the net tangible assets acquired by $752 million, of which $253 million has been allocated to finite-lived intangible assets and $499 million to goodwill. The acquired goodwill is deductible for income tax purposes. The results of operations and financial condition of Fiserv Health have been included in the Company's consolidated results and the results of the Health Benefits, OptumHealth, Ingenix and Prescription Solutions reporting segments since the acquisition date. The pro forma effects of this acquisition on the Company's Consolidated Financial Statements were not material.

The finite-lived intangible assets and related weighted-average useful lives, by acquisition, as of acquisition date, consisted of the following:

	AIM		Unison		Sierra		Fiserv	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer Contracts and Membership Lists	$146	14 years	$ 41	6 years	$443	14 years	$252	12 years
Trademarks	3	15 years	32	20 years	56	20 years	1	3 years
Physician and Hospital Networks	17	5 years	16	20 years	1	15 years	n/a	n/a
Total Acquired Finite-Lived Intangible Assets	$166	11 years	$ 89	9 years	$500	14 years	$253	12 years

For the years ended December 31, 2009, 2008 and 2007, aggregate consideration paid, net of cash assumed for smaller acquisitions was $95 million, $94 million and $262 million, respectively. These acquisitions were not material to the Company's Consolidated Financial Statements.

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4. Investments

The amortized cost, gross unrealized gains and losses, and fair value of investments, by type, were as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2009				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,566	$ 12	$ (11)	$ 1,567
State and municipal obligations	6,080	248	(11)	6,317
Corporate obligations	3,278	149	(6)	3,421
U.S. agency mortgage-backed securities	1,870	64	(3)	1,931
Non-U.S. agency mortgage-backed securities	535	8	(5)	538
Total debt securities — available-for-sale	13,329	481	(36)	13,774
Equity securities — available-for-sale	579	12	(14)	577
Debt securities — held-to-maturity:				
U.S. government and agency obligations	158	4	—	162
State and municipal obligations	17	—	—	17
Corporate obligations	24	—	—	24
Total debt securities—held-to-maturity	199	4	—	203
Total investments	$ 14,107	$ 497	$ (50)	$14,554
December 31, 2008				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,276	$ 65	$ (2)	$ 1,339
State and municipal obligations	6,440	134	(90)	6,484
Corporate obligations	2,802	33	(132)	2,703
U.S. agency mortgage-backed securities	2,245	62	—	2,307
Non-U.S. agency mortgage-backed securities	744	—	(105)	639
Total debt securities — available-for-sale	13,507	294	(329)	13,472
Equity securities — available-for-sale	489	8	(20)	477
Debt securities — held-to-maturity:				
U.S. government and agency obligations	157	10	—	167
State and municipal obligations	19	—	—	19
Corporate obligations	24	—	—	24
Total debt securities — held-to-maturity	200	10	—	210
Total investments	$ 14,196	$ 312	$ (349)	$14,159

Included in the Company's investment portfolio were sub-prime home equity lines of credit with fair values of $9 million and $25 million as of December 31, 2009 and 2008, respectively. Also included were Alt-A securities with fair values of $19 million and $36 million as of December 31, 2009 and 2008, respectively.

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The fair value of the Company's mortgage-backed securities by credit rating and non-U.S. agency mortgage-backed securities by origination as of December 31, 2009 were as follows:

(in millions)	AAA	AA	A	BBB	Non-Investment Grade	Total Fair Value
2007	$ 70	$—	$ 1	$ 8	$ 4	$ 83
2006	130	3	5	—	18	156
2005	135	4	2	5	7	153
Pre-2005	143	—	1	1	1	146
U.S agency mortgage-backed securities	1,931	—	—	—	—	1,931
Total	$2,409	$ 7	$ 9	$ 14	$ 30	$ 2,469

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2009, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,383	$ 1,394
Due after one year through five years	4,378	4,573
Due after five years through ten years	2,886	2,989
Due after ten years	2,277	2,349
U.S. agency mortgage-backed securities	1,870	1,931
Non-U.S. agency mortgage-backed securities	535	538
Total debt securities — available-for-sale	$ 13,329	$13,774

The amortized cost and fair value of held-to-maturity debt securities as of December 31, 2009, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 60	$ 61
Due after one year through five years	103	105
Due after five years through ten years	26	26
Due after ten years	10	11
Total debt securities — held-to-maturity	$ 199	$203

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The fair value of investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows (a):

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2009						
Debt Securities — available-for-sale						
U.S. government and agency obligations	$ 437	$ (11)	$ 4	$ —	$ 441	$ (11)
State and municipal obligations	392	(6)	100	(5)	492	(11)
Corporate obligations	304	(3)	69	(3)	373	(6)
U.S. agency mortgage-backed securities	355	(3)	2	—	357	(3)
Non-U.S. agency mortgage-backed securities	134	(1)	86	(4)	220	(5)
Total debt securities — available-for-sale	$1,622	$ (24)	$ 261	$ (12)	$1,883	$ (36)
Equity securities — available-for-sale	$ 169	$ (13)	$ 1	$ (1)	$ 170	$ (14)
December 31, 2008						
Debt securities — available-for-sale						
U.S. government and agency obligations	$ 72	$ (2)	$ —	$ —	$ 72	$ (2)
State and municipal obligations	1,414	(65)	113	(25)	1,527	(90)
Corporate obligations	1,543	(97)	179	(35)	1,722	(132)
U.S. agency mortgage-backed securities	17	—	5	—	22	—
Non-U.S. agency mortgage-backed securities	529	(83)	88	(22)	617	(105)
Total debt securities — available-for-sale	$3,575	$ (247)	$ 385	$ (82)	$3,960	$ (329)
Equity securities — available-for-sale	$ 195	$ (20)	$ —	$ —	$ 195	$ (20)

(a) Debt securities classified as held-to-maturity investments have been excluded from this analysis. These investments are predominantly held in U.S. government or agency obligations. Additionally, the fair values of these investments approximate their amortized cost.

The Company's mortgage-backed securities in an unrealized loss position by credit rating distribution were as follows:

	December 31, 2009		December 31, 2008	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
AAA	$ 543	$ (6)	$ 624	$ (105)
AA	31	(2)	1	—
A	—	—	—	—
BBB	1	—	13	—
Non-investment grade	2	—	1	—
Total	$ 577	$ (8)	$ 639	$ (105)

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The unrealized losses as of December 31, 2009 were generated from approximately 1,500 positions out of a total of approximately 12,000 positions. The Company believes that it will collect all principal and interest due on all investments that have an amortized cost in excess of fair value. The unrealized losses on investments in U.S. government and agency obligations, state and municipal obligations and corporate obligations as of December 31, 2009 were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for securities where the fair value of the investment is less than its amortized cost. The contractual cash flows of the U.S. government and agency obligations are guaranteed by either the U.S. government or an agency of the U.S. government. The Company expects that the securities would not be settled at a price less than the amortized cost of the Company's investment. The Company evaluated the underlying credit quality of the issuers and the credit ratings of the state and municipal obligations and the corporate obligations, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). The unrealized losses on mortgage-backed securities as of December 31, 2009 were primarily caused by higher interest rates in the marketplace, reflecting the higher perceived risk assigned by fixed-income investors to commercial mortgage-backed securities (CMBS). These unrealized losses represented less than 1% of the total amortized cost of the Company's mortgage-backed security holdings as of December 31, 2009. The Company believes these losses to be temporary. Approximately 94% of the Company's mortgage-backed securities in an unrealized loss position as of December 31, 2009 were rated "AAA" with no known deterioration or other factors leading to an OTTI. As of December 31, 2009, the Company did not have the intent to sell any of the securities in an unrealized loss position.

As of December 31, 2009, the Company's holdings of non-U.S. agency mortgage-backed securities included $10 million of commercial mortgage loans in default. These investments were acquired in the first quarter of 2008 pursuant to an acquisition and were recorded at fair value. They represented less than 1% of the Company's total mortgage-backed security holdings as of December 31, 2009.

A portion of the Company's investments in equity securities and venture capital funds consists of investments held in various public and nonpublic companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care and related technology stocks will likewise impact the value of the Company's equity portfolio. The equity securities and venture capital funds were evaluated for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains, before taxes, were from the following sources:

	Year Ended December 31,		
(in millions)	2009	2008	2007
Total OTTI	$ (64)	$ (121)	$ (6)
Portion of loss recognized in other comprehensive income	—	n/a	n/a
Net OTTI recognized in earnings	(64)	(121)	(6)
Gross realized losses from sales	(41)	(50)	(13)
Gross realized gains from sales	116	165	57
Net realized gains (losses)	$ 11	$ (6)	$ 38

For 2009, all of the recorded OTTI resulted from the Company's intent to sell certain impaired securities.

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. Fair Value

Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by its custodian, its investment consultant and third party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services, the Company has not historically adjusted the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset.

The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in non-active markets (e.g., few transactions, limited information, non-current prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (e.g., interest rates, yield curves, volatilities, default rates, etc.); and
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

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The following table presents information about the Company's financial assets, excluding AARP, that are measured at fair value on a recurring basis, according to the valuation techniques the Company used to determine their fair values. See Note 13 of Notes to the Consolidated Financial Statements for further detail on AARP.

(in millions, except percentages)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2009				
Cash and cash equivalents	$ 9,135	$ 665	$ —	$ 9,800
Debt securities — available for sale:				
U.S. government and agency obligations	1,024	543	—	1,567
State and municipal obligations	—	6,317	—	6,317
Corporate obligations	18	3,293	110	3,421
U.S. agency mortgage-backed securities	—	1,931	—	1,931
Non-U.S. agency mortgage-backed securities	—	528	10	538
Total debt securities — available for sale	1,042	12,612	120	13,774
Equity securities — available for sale	262	3	312	577
Total cash, cash equivalents and investments at fair value	$ 10,439	$ 13,280	$ 432	$ 24,151
Percentage of total fair value	43%	55%	2%	100%
December 31, 2008				
Cash and cash equivalents	$ 6,564	$ 862	$ —	$ 7,426
Debt securities — available-for-sale:				
U.S. government and agency obligations	800	539	—	1,339
State and municipal obligations	—	6,484	—	6,484
Corporate obligations	7	2,650	46	2,703
U.S. agency mortgage-backed securities	—	2,307	—	2,307
Non-U.S. agency mortgage-backed securities	—	623	16	639
Total debt securities — available-for-sale	807	12,603	62	13,472
Equity securities — available-for-sale	170	3	304	477
Total cash, cash equivalents and investments at fair value	7,541	13,468	366	21,375
Interest rate swaps	—	622	—	622
Total assets at fair value	$ 7,541	$ 14,090	$ 366	$ 21,997
Percentage of total fair value	34%	64%	2%	100%

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt Securities. The estimated fair values of debt securities held as available-for-sale are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. Fair values of debt securities that do not trade on a regular basis in active markets are classified as Level 2.

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NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Equity Securities. Equity securities are held as available-for-sale investments. Fair value estimates for Level 1 and Level 2 publicly traded equity securities are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. The fair values of Level 3 investments in venture capital portfolios are estimated using market modeling approaches that rely heavily on management assumptions and qualitative observations. These investments totaled $282 million as of December 31, 2009. The fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The key inputs utilized in the Company's market modeling include, as applicable, transactions for comparable companies in similar industries and having similar revenue and growth characteristics; similar preferences in the capital structure; discounted cash flows; liquidation values and milestones established at initial funding; and the assumption that the values of the Company's venture capital investments can be inferred from these inputs. The Company's remaining Level 3 equity securities holdings of $30 million mainly consist of preferred stock for which there is no active market.

Interest Rate Swaps. Fair values of the Company's interest rate swaps were estimated using the terms of the swaps and publicly available market yield curves. Because the swaps were unique and were not actively traded, the fair values were classified as Level 2 estimates. As of December 31, 2009, the Company had no outstanding interest rate swap contracts.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	December 31, 2009			December 31, 2008		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
Balance at beginning of period	$ 62	$ 304	$366	$ —	$ 133	$133
Purchases, net	64	22	86	14	202	216
Net unrealized gains in accumulated other comprehensive income	—	7	7	—	2	2
Net realized losses in investment and other income	(6)	(21)	(27)	—	(54)	(54)
Transfers into Level 3	—	—	—	48	21	69
Balance at end of period	$ 120	$ 312	$432	$ 62	$ 304	$366

There were no significant fair value adjustments recorded during the year ended December 31, 2009 for non-financial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis. These assets and liabilities are subject to fair value adjustments only in certain circumstances, such as when the Company records impairments.

The table below includes fair values for certain financial instruments for which it is practicable to estimate fair value. The carrying values and fair values of these financial instruments were as follows:

	December 31, 2009		December 31, 2008	
(in millions)	Carrying Value	Fair Value	Carrying Value	Fair Value
Assets				
Debt securities — available-for-sale	$13,774	$13,774	$13,472	$13,472
Equity securities — available-for-sale	577	577	477	477
Debt securities — held-to-maturity	199	203	200	210
AARP program-related investments	2,114	2,114	1,941	1,941
Interest rate swaps	—	—	622	622
Liabilities				
Senior unsecured notes	11,173	11,043	12,693	10,941

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In addition to the previously described methods and assumptions for debt and equity securities and interest rate swaps, the following are the methods and assumptions used to estimate the fair value of the other financial instruments:

AARP Program-related Investments. AARP Program-related investments consist of debt and equity securities held to fund costs associated with the AARP Program (see Note 13 of Notes to the Consolidated Financial Statements). The Company elected to measure the AARP Assets Under Management, of which the investments are a part, at fair value, pursuant to the fair value option. See the preceding discussion regarding the methods and assumptions used to estimate the fair value of debt and equity securities.

Senior Unsecured Notes. The fair values of the senior unsecured notes are estimated based on third-party quoted market prices for the same or similar issues.

The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, accounts and other current receivables, unearned revenue, accounts payable and accrued liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

6. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2009	December 31, 2008
Land	$ 32	$ 32
Buildings and improvements	662	595
Computer equipment	1,504	1,488
Furniture and fixtures	235	250
Less accumulated depreciation	(1,487)	(1,353)
Property and equipment, net	946	1,012
Capitalized software	2,445	2,179
Less accumulated amortization	(1,251)	(1,010)
Capitalized software, net	1,194	1,169
Total property, equipment and capitalized software, net	$ 2,140	$ 2,181

Depreciation expense for property and equipment for 2009, 2008 and 2007 was $436 million, $439 million and $359 million, respectively. Amortization expense for capitalized software for 2009, 2008 and 2007 was $314 million, $290 million and $245 million, respectively.

7. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reporting segment, were as follows:

(in millions)	Health Benefits	OptumHealth	Ingenix	Prescription Solutions	Consolidated
Balance at December 31, 2007	$14,139	$ 1,080	$ 958	$ 677	$ 16,854
Acquisitions	2,986	54	74	148	3,262
Subsequent payments and adjustments, net	(81)	18	20	15	(28)
Balance at December 31, 2008	17,044	1,152	1,052	840	20,088
Acquisitions	161	40	415	—	616
Subsequent payments and adjustments, net	61	(34)	(4)	—	23
Balance at December 31, 2009	$17,266	$ 1,158	$1,463	$ 840	$ 20,727

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The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2009			December 31, 2008		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer contracts and membership lists	$ 2,864	$ (796)	$ 2,068	$ 2,620	$ (585)	$ 2,035
Patents, trademarks and technology	437	(187)	250	392	(169)	223
Other	118	(55)	63	120	(49)	71
Total	$ 3,419	$ (1,038)	$ 2,381	$ 3,132	$ (803)	$ 2,329

Amortization expense relating to intangible assets for 2009, 2008 and 2007 was $241 million, $252 million and $192 million, respectively.

Estimated full year amortization expense relating to intangible assets for each of the next five years is as follows:

(in millions)	Estimated Amortization Expense
2010	$ 255
2011	249
2012	247
2013	239
2014	229

8. Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of the Company's 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. The Company develops estimates for medical costs 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, care provider contract rate changes, medical care consumption and other medical cost trends. The Company estimates 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, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical costs payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified.

None of the factors discussed above were individually material to the net favorable medical cost development for the years ended 2009, 2008 and 2007.

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The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2009	2008	2007
Medical costs payable, beginning of period	$ 8,664	$ 8,331	$ 8,076
Acquisitions	252	331	—
Reported medical costs:			
Current year	65,599	60,589	55,855
Prior years	(310)	(230)	(420)
Total reported medical costs	65,289	60,359	55,435
Claim payments:			
Payments for current year	(57,109)	(52,872)	(48,240)
Payments for prior year	(7,734)	(7,485)	(6,940)
Total claim payments	(64,843)	(60,357)	(55,180)
Medical costs payable, end of period	$ 9,362	$ 8,664	$ 8,331

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9. Commercial Paper and Long-Term Debt

Commercial paper and long-term debt consisted of the following:

	December 31, 2009		December 31, 2008	
(in millions)	Carrying Value (a)	Fair Value (b)	Carrying Value (c)	Fair Value (b)
Commercial Paper	$ —	$ —	$ 101	$ 101
$250 million par, 3.8% senior unsecured notes due February 2009	—	—	250	250
$650 million par, senior unsecured floating-rate notes due March 2009	—	—	650	644
$450 million par, 4.1% senior unsecured notes due August 2009	—	—	455	442
$500 million par, senior unsecured floating-rate notes due June 2010	500	499	500	450
$250 million par, 5.1% senior unsecured notes due November 2010	257	259	263	245
$250 million par, senior unsecured floating-rate notes due February 2011	250	251	250	219
$750 million par, 5.3% senior unsecured notes due March 2011 (e)	781	777	806	705
$450 million par, 5.5% senior unsecured notes due November 2012 (e)	480	481	493	410
$550 million par, 4.9% senior unsecured notes due February 2013 (e)	549	575	549	513
$450 million par, 4.9% senior unsecured notes due April 2013 (e)	464	472	473	419
$250 million par, 4.8% senior unsecured notes due February 2014 (e)	268	256	280	221
$500 million par, 5.0% senior unsecured notes due August 2014 (e)	540	518	567	460
$500 million par, 4.9% senior unsecured notes due March 2015 (e)	544	513	567	429
$750 million par, 5.4% senior unsecured notes due March 2016 (e)	847	772	883	661
$95 million par, 5.4% senior unsecured notes due November 2016	95	98	95	84
$500 million par, 6.0% senior unsecured notes due June 2017 (e)	587	523	620	450
$250 million par, 6.0% senior unsecured notes due November 2017 (e)	285	258	297	223
$1,100 million par, 6.0% senior unsecured notes due February 2018	1,099	1,136	1,098	1,015
$1,095 million par, zero coupon senior unsecured notes due November 2022 (d)	558	611	530	522
$850 million par, 5.8% senior unsecured notes due March 2036	844	762	844	648
$500 million par, 6.5% senior unsecured notes due June 2037	495	493	495	420
$650 million par, 6.6% senior unsecured notes due November 2037	645	651	645	548
$1,100 million par, 6.9% senior unsecured notes due February 2038	1,085	1,138	1,083	963
Total commercial paper and long-term debt	11,173	11,043	12,794	11,042
Less commercial paper and current maturities of long-term debt	(2,164)	(2,173)	(1,456)	(1,437)
Long-term debt, less current maturities	$ 9,009	$ 8,870	$11,338	$ 9,605

(a) The carrying value of the debt has been adjusted by the unamortized gain on related interest rate swaps, which terminated in January 2009.
(b) Estimated based on third-party quoted market prices for the same or similar issues.
(c) The carrying value of debt had been adjusted based upon the applicable interest rate swap fair values in accordance with the fair value hedge short-cut method of accounting.
(d) These notes have been classified with the current maturities of long-term debt in the Consolidated Balance Sheet as of December 31, 2009 due to the existence of a put feature. For further discussion, see “Long-Term Debt” below.
(e) A portion of these notes has been classified with the current maturities of long-term debt in the Consolidated Balance Sheet as of December 31, 2009 due to the debt tender offers discussed under “Long-Term Debt” below.

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Maturities of long-term debt for the years ending December 31 are as follows:

(in millions)	Maturities of Long-Term Debt
2010	$ 757
2011	985
2012	376
2013	954
2014	605
Thereafter	6,089
$1,095 million par, zero coupon senior unsecured notes due November 2022	558
Debt tender offers completed February 2010	849

Bank Credit Facilities

In November 2008, the Company entered into a $750 million 364-day revolving bank credit facility. The Company terminated this facility on July 31, 2009 in advance of its maturity.

There is currently $2.5 billion available under the Company's five-year revolving bank credit facility, which matures in May 2012. The interest rate is variable based on term and amount and is calculated based on the London Interbank Offered Rate (LIBOR) plus a spread. As of December 31, 2009, the interest rate on this facility, had it been drawn, would have ranged from 0.4% to 0.7%. This facility supports the Company's commercial paper program and is available for general working capital purposes. As of December 31, 2009, the Company had no amounts outstanding under this facility.

Long-Term Debt

In February 2010, the Company completed cash tender offers for $775 million aggregate principal amount of certain of its outstanding notes. The Company believes that this debt repurchase will improve the matching of floating rate assets and liabilities on its balance sheet and reduce its debt service cost. The Company used cash on hand to fund the purchase of the notes.

In February 2008, the Company issued a total of $3.0 billion in senior unsecured debt, which included: $250 million of floating-rate notes due February 2011, $550 million of 4.9% fixed-rate notes due February 2013, $1.1 billion of 6.0% fixed-rate notes due February 2018 and $1.1 billion of 6.9% fixed-rate notes due February 2038. The floating-rate notes are benchmarked to the London Interbank Offered Rate (LIBOR) and had an interest rate of 1.6% as of December 31, 2009.

In November 2007, the Company issued $500 million of zero coupon notes due November 2022. These zero coupon notes are original issue discount notes with an aggregate principal amount due at maturity of $1.1 billion and an accretion yield of 5.3%. These notes have a put feature that allows a note holder to require the Company to repurchase the notes at the accreted value at certain annual dates in the future, beginning on November 15, 2010; therefore, these notes have been classified with the current maturities of long-term debt in the Consolidated Balance Sheet as of December 31, 2009.

In November 2007, the Company issued a total of $1.6 billion in senior unsecured debt, which included: $250 million of 5.1% fixed-rate notes due November 2010, $450 million of 5.5% fixed-rate notes due November 2012, $250 million of 6.0% fixed-rate notes due November 2017 and $650 million of 6.6% fixed-rate notes due November 2037. These notes were issued pursuant to an exemption from registration under Section 4(2) of the

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Securities Act of 1933 (1933 Act). In February 2008, the Company completed an exchange offer in which then-existing noteholders exchanged each series of these notes for a new issue of substantially identical debt securities registered under the 1933 Act.

In June 2007, the Company issued a total of $1.5 billion in senior unsecured debt, which included: $500 million of floating-rate notes due June 2010, $500 million of 6.0% fixed-rate notes due June 2017 and $500 million of 6.5% fixed-rate notes due June 2037. The floating-rate notes are benchmarked to LIBOR and had an interest rate of 0.4% as of December 31, 2009. These notes were issued pursuant to an exemption from registration under Section 4(2) of the 1933 Act. In February 2008, the Company completed an exchange offer in which then-existing noteholders exchanged each series of these notes for a new issue of substantially identical debt securities registered under the 1933 Act.

Debt Covenants

The Company's bank credit facility contains various covenants, the most restrictive of which requires the Company 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 50%. The Company was in compliance with its debt covenants as of December 31, 2009.

Interest Rate Swap Contracts

In January 2009, the Company terminated interest rate swap contracts with $4.9 billion in notional value to lock-in the benefit of low market interest rates. As of the swap contracts' termination date, the cumulative adjustment to the carrying value of the Company's debt was $513 million, which is being amortized over a weighted-average period of 3.5 years as a reduction to interest expense. As of December 31, 2009, the Company had no outstanding interest rate swap contracts. As of December 31, 2008, the fair values of the interest rate swaps were $622 million with $7 million classified in Prepaid Expenses and Other Current Assets and $615 million classified in Other Assets in the Consolidated Balance Sheet.

10. Income Taxes

The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2009	2008	2007
Current Provision:			
Federal	$1,924	$1,564	$2,284
State and local	78	145	166
Total current provision	2,002	1,709	2,450
Deferred provision	(16)	(62)	201
Total provision for income taxes	$1,986	$1,647	$2,651

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows:

(in millions, except percentages)	2009		2008		2007	
Tax provision at the U.S. federal statutory rate	$2,033	35.0%	$1,618	35.0%	$2,557	35.0%
State income taxes, net of federal benefit	66	1.1	106	2.2	125	1.7
Settlement of state exams, net of federal benefit	(40)	(0.7)	(12)	(0.2)	(5)	—
Tax-exempt investment income	(70)	(1.2)	(69)	(1.5)	(52)	(0.7)
Other, net	(3)	—	4	0.1	26	0.3
Provision for income taxes	$1,986	34.2%	$1,647	35.6%	$2,651	36.3%

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In 2009, the Company released tax reserves related to the favorable resolution of various historical state income tax matters. Along with a change to an insurance premium tax in lieu of an income tax in one of the states in which the Company operates, this decreased the Company's effective income tax rate in 2009.

The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2009	2008
Deferred income tax assets:		
Share-based compensation	$ 419	$ 413
Medical costs payable and other policy liabilities	218	223
Net operating loss carryforwards	206	213
Accrued expenses and allowances	201	93
Long term liabilities	164	354
Unearned revenues	58	56
Unrecognized tax benefits	55	100
Net unrealized losses on investments	—	15
Other	190	181
Subtotal	1,511	1,648
Less: valuation allowances	(198)	(193)
Total deferred income tax assets	$ 1,313	$ 1,455
Deferred income tax liabilities:		
Intangible assets	$ (890)	$ (885)
Capitalized software development	(449)	(439)
Net unrealized gains on investments	(163)	—
Prepaid expenses	(90)	—
Depreciation and amortization	(80)	(5)
Interest rate swaps	—	(230)
Total deferred income tax liabilities	(1,672)	(1,559)
Net deferred income tax liabilities	$ (359)	$ (104)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain state net operating loss carryforwards. Federal net operating loss carryforwards of $36 million expire beginning in 2012 through 2026, and state net operating loss carryforwards expire beginning in 2010 through 2028.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2009	2008
Gross unrecognized tax benefits, beginning of period	$340	$271
Gross increases:		
Current year tax positions	10	14
Prior year tax positions	11	43
Acquired reserves	—	94
Gross decreases:		
Prior year tax positions	(62)	(29)
Settlements	(61)	(4)
Statute of limitations lapses	(18)	(49)
Gross unrecognized tax benefits, end of period	$220	$340

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The favorable resolution of historical state income tax matters resulted in a decrease in the gross unrecognized tax benefits as of December 31, 2009.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Financial Statements. During the year ended December 31, 2009, the Company recognized a net tax benefit of $7 million generated from the reduction in interest accrued from the release of previously accrued tax matters. During the year ended December 31, 2008, the Company recognized $23 million of net interest expense. As of December 31, 2009 and 2008, the Company had $44 million and $65 million, respectively, of accrued interest for uncertain tax positions, which were reported in Accounts Payable and Accrued Liabilities in the Consolidated Balance Sheets. These amounts are not included in the reconciliation above. As of December 31, 2009, the total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $101 million.

The Company currently files income tax returns in the U.S. federal jurisdiction, various states and foreign jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2007 and prior. The Company's 2008 and 2009 tax returns are under advance review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to 2003 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be significant.

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $92 million or less as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

11. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated subsidiaries are subject to regulations and standards in their respective states of domicile. Most of these regulations and standards conform to those established by the National Association of Insurance Commissioners. 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. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally can be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2009, based on the 2008 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could be paid was $3.1 billion. For the year ended December 31, 2009, the Company's regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $2.5 billion of extraordinary dividends. For the year ended December 31, 2008, the Company's regulated subsidiaries paid their parent companies dividends of $4.2 billion, including $1.2 billion of extraordinary dividends. The increase in the proportion of extraordinary dividends to total dividends in 2009 primarily reflects the acceleration of dividend timing, as well as the size of specific dividends beyond ordinary levels. As of December 31, 2009, $2.3 billion of the Company's $24.4 billion of cash and investments was held by non-regulated entities.

The Company's regulated subsidiaries had aggregate statutory capital and surplus of approximately $10 billion as of December 31, 2009, which exceeds aggregate minimum regulatory requirements.

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Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program (Repurchase Program). The objectives of the Repurchase Program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time at prevailing prices in the open market. During 2009, the Company repurchased 74.3 million shares at an average price of approximately $24 per share and an aggregate cost of $1.8 billion. As of December 31, 2009, the Company had Board of Directors' authorization to purchase up to an additional 28.7 million shares of its common stock. In February 2010, the Board renewed and increased the Company's share repurchase program, and authorized the Company to repurchase up to 120 million shares of its common stock.

12. Share-Based Compensation and Other Employee Benefit Plans

The Company's 2002 Stock Incentive Plan (Plan), as amended and restated May 15, 2002, is intended to attract and retain employees and non-employee directors, offer them incentives to put forth maximum efforts for the success of the Company's business and afford them an opportunity to acquire a proprietary interest in the Company. The Plan allows the Company to grant stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards or other stock-based awards to eligible employees and non-employee directors. The Plan incorporates the following prior plans: 1991 Stock and Incentive Plan, 1998 Broad-Based Stock Incentive Plan and Non-employee Director Stock Option Plan. All outstanding stock options, restricted stock and other awards issued under the prior plans shall remain subject to the terms and conditions of these plans under which they were issued.

As of December 31, 2009, the Company had 63.5 million shares available for future grants of share-based awards under its share-based compensation plan, including, but not limited to, incentive or non-qualified stock options, stock-settled stock appreciation rights (SARs), and up to 15.3 million of awards in restricted stock and restricted stock units (collectively, restricted shares). The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares.

Stock Options and SARs

Stock options and SARs generally vest ratably over four to six years and may be exercised up to 10 years from the date of grant. Stock option and SAR activity for the year ended December 31, 2009 is summarized in the table below:

	Shares (in thousands)	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in millions)
Outstanding, beginning of period	150,752	$ 36		
Granted	15,026	30		
Exercised	(19,421)	13		
Forfeited	(22,211)	34		
Outstanding, end of period	124,146	$ 39	5.5	$ 304
Exercisable, end of period	87,664	$ 39	4.4	$ 287
Vested and expected to vest at end of period	118,962	$ 39	5.3	$ 302

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To determine compensation expense related to the Company's stock options and SARs, the fair value of each award is estimated on the date of grant using an option-pricing model. For purposes of estimating the fair value of the Company's employee stock option and SAR grants, the Company uses a binomial model. The principal assumptions the Company used in applying the option-pricing models were as follows:

	2009	2008	2007
Risk free interest rate	1.7% - 2.4%	2.2% - 3.4%	3.8% - 5.2%
Expected volatility	41.3% - 46.8%	29.5%	24.2%
Expected dividend yield	0.1%	0.1%	0.1%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.4 - 5.1	4.3	4.1

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Beginning in 2009, the Company changed the weighting of historical and implied volatilities used in the calculation of expected volatility to 90% and 10%, respectively. Before the change, the Company had weighted historical and implied volatility equally. Due to the significant economic turbulence and resulting instability of the exchange-traded options throughout 2008, the Company concluded that they were no longer as representative of the fair value of its common stock over the expected life of its options and SARs. The change had no impact on the Company's reported Net Earnings nor Earnings per Share. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

The weighted-average grant date fair value of stock options and SARs granted for 2009, 2008 and 2007 was approximately $10 per share, $9 per share and $14 per share. The total intrinsic value of stock options and SARs exercised during 2009, 2008 and 2007 was $282 million, $244 million and $1.1 billion, respectively.

Restricted Shares

Restricted shares generally vest ratably over two to five years. Compensation expense related to restricted shares is based on the share price on date of grant. Restricted share activity for the year ended December 31, 2009 is summarized in the table below:

(shares in thousands)	Shares	Weighted-Average Grant Date Fair Value
Nonvested, Beginning of Period	6,282	$ 36
Granted	6,587	29
Vested	(1,655)	29
Forfeited	(594)	34
Nonvested, End of Period	10,620	$ 33

The weighted-average grant date fair value of restricted shares granted during 2009, 2008 and 2007 was approximately $29 per share, $34 per share and $51 per share, respectively. The total fair value of restricted shares vested during 2009, 2008 and 2007 was $47 million, $17 million and $35 million, respectively.

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Employee Stock Purchase Plan

The Company's Employee Stock Purchase Plan (ESPP) is intended to enhance employee commitment to the goals of the Company, by providing a means of achieving stock ownership at advantageous terms to eligible employees of the Company. Eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. During 2009, 2008 and 2007, 3.7 million shares, 2.9 million shares and 1.9 million shares of common stock, respectively, were purchased under the ESPP. The compensation expense is included in the compensation expense amounts recognized and discussed below. As of December 31, 2009, there were 9.3 million shares of common stock available for issuance under the ESPP.

Share-Based Compensation Recognition

The Company recognizes compensation expense for share-based awards, including stock options, SARs and restricted shares, on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Beginning with share-based awards granted in 2009, the Company's equity award program includes a retirement provision that treats all employees who are age 55 or older with at least ten years of recognized employment with the Company as retirement-eligible. For 2009, 2008 and 2007, the Company recognized compensation expense related to its share-based compensation plans of $334 million ($220 million net of tax effects), $305 million ($202 million net of tax effects) and $505 million ($325 million net of tax effects), respectively. Share-based compensation expense is recognized in Operating Costs in the Company's Consolidated Statements of Operations. As of December 31, 2009, there was $490 million of total unrecognized compensation cost related to share awards that is expected to be recognized over a weighted-average period of 1.4 years. For 2009, 2008 and 2007, the income tax benefit realized from share-based award exercises was $94 million, $106 million and $399 million, respectively.

Included in the share-based compensation expense for the year ended December 31, 2007 is $176 million ($112 million net of tax benefit) of expenses recorded in the first quarter of 2007 related to application of deferred compensation rules under Section 409A of the Internal Revenue Code (Section 409A) to the Company's historical stock option practices. As part of its review of the Company's historical stock option practices, the Company determined that certain stock options granted to individuals who were nonexecutive officer employees at the time of grant were granted with an exercise price that was lower than the closing price of the Company's common stock on the applicable accounting measurement date, subjecting these individuals to additional tax under Section 409A. The Company elected to pay these individuals for the additional tax costs relating to such stock options exercised in 2006 and early 2007. For any outstanding stock options subject to additional tax under Section 409A that were granted to nonexecutive officer employees, the Company increased the exercise price and committed to make cash payments to these optionholders for their vested options based on the difference between the original stock option price and the revised increased stock option price. Payments of $142 million were made from January 2008 through January 2010 for options vested through December 31, 2009. If the modified stock options are subsequently exercised, the Company will recover these cash payments at that time from exercise proceeds at the revised increased stock option exercise prices.

The $176 million Section 409A charge includes $87 million of expense ($55 million net of tax benefit) for the payment of certain optionholders' tax obligations for stock options exercised in 2006 and early 2007 and $89 million of expense ($57 million net of tax benefit) for the modification related to increasing the exercise price of unexercised stock options granted to nonexecutive officer employees and the related cash payments. These amounts have been recorded in the corporate segment.

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As further discussed in Note 11 of Notes to the Consolidated Financial Statements, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure, cost of capital and return to shareholders, as well as to offset the dilutive impact of shares issued for share-based award exercises.

Other Employee Benefit Plans

The Company also offers a 401(k) plan for all employees. Compensation expense related to this plan was not significant for the years 2009, 2008 and 2007.

The Company has provided Supplemental Executive Retirement Plan (SERP) benefits, which are non-qualified defined benefit plans, for its CEO, as well as for certain nonexecutive officers under plans that were assumed in acquisitions. No additional amounts are accruing to the SERP for the Company's CEO. The SERPs are non-contributory, unfunded and provide benefits based on years of service and compensation during employment. The total SERP liability as of December 31, 2009 was $20 million, which was recorded in Other Liabilities in the Consolidated Balance Sheets. The total SERP liability as of December 31, 2008 was $159 million, of which $51 million was recorded in Accounts Payable and Accrued Liabilities and $108 million was recorded in Other Liabilities in the Consolidated Balance Sheets. In 2009, a SERP accrual of $91 million relating to the Company's former CEO was reversed as a result of the resolution of the SEC settlement pertaining to the stock option matter. See Note 14 of Notes to the Consolidated Financial Statements for further discussion of stock option matters.

In addition, the Company maintains non-qualified, unfunded deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within Long-Term Investments with an approximately equal amount in Other Liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $216 million and $182 million as of December 31, 2009 and 2008, respectively.

13. AARP

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the Program), and separate Medicare Advantage and Medicare Part D arrangements. The products and services under the Program include supplemental Medicare benefits (AARP Medicare Supplement Insurance), hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

In October 2007, the Company entered into four agreements with AARP, effective January 1, 2008, that amended its existing AARP arrangements. These agreements extended the Company's arrangements with AARP on the Program to December 31, 2017, extended the Company's arrangement with AARP on the Medicare Part D business to December 31, 2014, and gave the Company an exclusive right to use the AARP brand on the Company's Medicare Advantage offerings until December 31, 2014, subject to certain limited exclusions.

Under the Program, the Company is compensated for transaction processing and other services, as well as for assuming underwriting risk. The Company is also engaged in product development activities to complement the insurance offerings. Premium revenues from the Company's portion of the Program for 2009, 2008 and 2007 were $6.0 billion, $5.7 billion and $5.3 billion, respectively.

The Company's agreement with AARP on the Program provides for the maintenance of the Rate Stabilization Fund (RSF) that is held by the Company on behalf of policyholders. Underwriting gains or losses related to the

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AARP Medicare Supplement Insurance business are directly recorded as an increase or decrease to the RSF. The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service 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, losses would be borne by the Company. Deficits may be recovered by underwriting gains in future periods of the contract. To date, the Company has not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the Consolidated Balance Sheets and changes in the RSF are reported in Medical Costs in the Consolidated Statement of Operations. In January 2008, $127 million in cash was transferred out of the RSF to an external insurance entity that offers an AARP branded age 50 to 64 comprehensive insurance product. The Company believes the RSF balance as of December 31, 2009 is sufficient to cover potential future underwriting and other risks and liabilities associated with the contract.

The effects of changes in balance sheet amounts associated with the Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Under the Company's agreement with AARP, the Company separately manages the assets that support the Program. These assets are held at fair value in the Consolidated Balance Sheets as Assets Under Management. These assets are invested at the Company's discretion, within investment guidelines approved by the Program and are used to pay costs associated with the Program. The Company does not guarantee any rates of investment return on these investments and upon any transfer of the Program to another entity, the Company would transfer cash in an amount equal to the fair value of these investments at the date of transfer. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF and, thus, are not included in the Company's earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the AARP RSF and were $99 million, $82 million and $108 million in 2009, 2008 and 2007, respectively.

The Company elected to measure the entirety of the AARP Assets Under Management at fair value, pursuant to the fair value option.

The following AARP Program-related assets and liabilities were included in the Company's Consolidated Balance Sheets:

(in millions)	December 31, 2009	December 31, 2008
Accounts receivable	$ 509	$ 482
Assets under management	2,383	2,199
Other assets	—	7
Medical costs payable	1,182	1,160
Accounts payable and accrued liabilities	40	52
Other policy liabilities	1,145	1,047
Future policy benefits	482	429
Other liabilities	43	—

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The fair value of cash, cash equivalents and investments associated with the Program, reflected as Assets Under Management, and the fair value of Other Assets and Other Liabilities were classified in accordance with the fair value hierarchy as discussed in Note 5 of Notes to the Consolidated Financial Statements and were as follows:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value
December 31, 2009				
Cash and cash equivalents	$ 269	$ —	$ —	$ 269
Debt securities:				
U.S. government and agency obligations	358	298	—	656
State and municipal obligations	—	9	—	9
Corporate obligations	—	955	—	955
U.S. agency mortgage-backed securities	—	343	—	343
Non-U.S. agency mortgage-backed securities	—	149	—	149
Total debt securities	358	1,754	—	2,112
Equity securities — available-for-sale	—	2	—	2
Total cash, cash equivalents and investments at fair value	$ 627	$ 1,756	$ —	$ 2,383
Other liabilities	$ —	$ —	$ 43	$ 43
Total liabilities at fair value	$ —	$ —	$ 43	$ 43
December 31, 2008				
Cash and cash equivalents	$ 240	$ 18	$ —	$ 258
Debt securities:				
U.S. government and agency obligations	291	293	—	584
State and municipal obligations	—	6	—	6
Corporate obligations	—	786	—	786
U.S. agency mortgage-backed securities	—	421	—	421
Non-U.S. agency mortgage-backed securities	—	142	—	142
Total debt securities	291	1,648	—	1,939
Equity securities — available-for-sale	—	2	—	2
Total cash, cash equivalents and investments at fair value	531	1,668	—	2,199
Other assets	—	—	7	7
Total assets at fair value	$ 531	$ 1,668	$ 7	$ 2,206

14. Commitments and Contingencies

The Company leases facilities, computer hardware and other equipment under long-term operating leases that are noncancelable and expire on various dates through 2028. Rent expense under all operating leases for 2009, 2008 and 2007 was $303 million, $264 million and $223 million, respectively.

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As of December 31, 2009, future minimum annual lease payments, net of sublease income, under all noncancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2010	$ 255
2011	221
2012	199
2013	152
2014	120
Thereafter	644

The Company contracts on an administrative services only (ASO) basis with customers who fund their own claims. The Company charges these customers administrative fees based on the expected cost of administering their self-funded programs. In some cases, the Company provides performance guarantees related to its administrative function. If these standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. Amounts accrued for performance guarantees were not material as of December 31, 2009 and 2008.

As of December 31, 2009, the Company has outstanding, undrawn letters of credit with financial institutions of $62 million and surety bonds outstanding with insurance companies of $247 million, primarily to bond contractual performance.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries related to, among other things, the design and management of its service offerings. The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to certain business practices.

Litigation Matters

MDL Litigation. Beginning in 1999, a series of class action lawsuits were filed against the Company by health care providers alleging various claims relating to the Company's reimbursement practices, including alleged violations of the Racketeer Influenced Corrupt Organization Act (RICO) and state prompt payment laws and breach of contract claims. Many of these lawsuits were consolidated in a multi-district litigation in the United States District Court for the Southern District Court of Florida (MDL). In the lead MDL lawsuit, the court certified a class of health care providers for certain of the RICO claims. In 2006, the trial court dismissed all of the claims against the Company in the lead MDL lawsuit, and the Eleventh Circuit Court of Appeals later affirmed that dismissal, leaving eleven related lawsuits that had been stayed during the litigation of the lead MDL lawsuit. In August 2008, the trial court, applying its rulings in the lead MDL lawsuit, dismissed seven of the 11 related lawsuits, and all but one claim in an eighth lawsuit. The plaintiffs have appealed these dismissals to the Eleventh Circuit. The trial court ordered the final claim in the eighth lawsuit to arbitration. In December 2008, at the plaintiffs' request, the trial court dismissed without prejudice one of the three remaining lawsuits. The court also denied the plaintiffs' request to remand the remaining two lawsuits to state court and a federal magistrate judge recommended dismissal of those suits. On April 16, 2009, the plaintiffs in these last two suits filed amended class action complaints alleging breach of contract. In addition, the Company is party to a number of arbitrations in various jurisdictions involving similar claims. The Company is vigorously defending against the remaining claims in these cases.

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AMA Litigation. On March 15, 2000, a group of plaintiffs including the American Medical Association (AMA) filed a lawsuit against the Company in state court in New York, which was removed to federal court. The complaint and subsequent amended complaints asserted antitrust claims and claims based on the Employee Retirement Income Security Act of 1974, as amended (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 health care providers by the Company's affiliates. On January 14, 2009, after almost nine years of litigation and many rulings from the court on various motions, the parties announced an agreement to settle the lawsuit, along with a similar case filed in 2008 in federal court in New Jersey. Under the terms of the proposed settlement, the Company and its affiliated entities will be released from claims relating to their out-of-network reimbursement policies from March 15, 1994 through the date of final court approval of the settlement. The Company will pay a total of $350 million to fund the settlement for health plan members and out-of-network providers in connection with out-of-network procedures performed since March 15, 1994. The agreement contains no admission of wrongdoing. The proposed settlement is subject to final court approval. In addition, the Company has the right to terminate the settlement if a certain number of class members elect to opt-out of the settlement. A splinter group of plaintiffs' counsel is challenging the proposed settlement. The court granted preliminary approval of the proposed settlement over the objections of certain plaintiffs' counsel on December 1, 2009, and a final approval hearing following notice to members of the class is scheduled for July 2010. Other lawsuits in various jurisdictions relating to the calculation of reasonable and customary reimbursement rates for non-network health care providers remain pending against a number of health insurers, including the Company.

NYAG Investigation. On February 13, 2008, the Office of the Attorney General of the State of New York (NYAG) announced that it was conducting an industry-wide investigation into out-of-network provider reimbursement practices of health insurers, including the Company, and served the Company with a notice of intent to initiate litigation. On January 13, 2009, the Company announced it had reached an agreement with the NYAG regarding the investigation. Under the terms of the agreement, the Company agreed to pay $50 million to fund a not-for-profit entity to develop and own a new, independent database product to replace the Prevailing Health Charges System (PHCS) and Medical Data Research (MDR) database products owned by Ingenix, Inc. Both products are used by a number of health plans and employers as tools that help determine the amount to reimburse members who receive physician services outside their managed care networks. When the new database product is ready, the Company will cease using the PHCS and MDR databases and will use the new database for a period of at least five years in connection with out-of-network reimbursement in those benefit plans that employ a reasonable and customary standard for out-of-network reimbursements. On October 2, 2009, the Company paid the $50 million required under the settlement agreement into an account designated by the NYAG. Following the announcement of the NYAG settlement, the Company received inquiries from a number of state and federal regulators, including the U.S. Senate Commerce Committee, regarding out-of-network reimbursement practices of health insurers.

California Claims Processing Matter. As previously disclosed, in 2007, the California Department of Insurance (CDI) examined the Company's PacifiCare health insurance plan in California. The examination findings related to the timeliness and accuracy of claims processing, interest payments, provider contract implementation, provider dispute resolution, and other related matters. On January 25, 2008, the CDI issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations in connection with the CDI's examination findings. On June 3, 2009, the Company filed a Notice of Defense to the Order to Show Cause denying all material allegations and asserting certain defenses. The matter is now the subject of an administrative hearing before a California administrative law judge.

Historical Stock Option Practices. In 2006, a consolidated shareholder derivative action, captioned *In re UnitedHealth Group Incorporated Shareholder Derivative Litigation* was filed against certain of the Company's

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current and former officers and directors in the United States District Court for the District of Minnesota. The consolidated amended complaint was brought on behalf of the Company by several pension funds and other shareholders and named certain of the Company's current and former officers and directors as defendants, as well as the Company as a nominal defendant. The consolidated amended complaint generally alleged that the defendants breached their fiduciary duties to the Company, were unjustly enriched, and violated the securities laws in connection with the Company's historical stock option practices. On June 26, 2006, the Company's Board of Directors created a Special Litigation Committee under Minnesota Statute 302A.241, consisting of two former Minnesota Supreme Court Justices, with the power to investigate the claims raised in the derivative actions and shareholder demands and determine whether the Company's rights and remedies should be pursued.

A consolidated derivative action, captioned *In re UnitedHealth Group Incorporated Derivative Litigation*, was also filed in Hennepin County District Court, State of Minnesota. The action was brought by two individual shareholders and named certain of the Company's current and former officers and directors as defendants, as well as the Company as a nominal defendant.

On December 6, 2007, the Special Litigation Committee concluded its review of claims relating to the Company's historical stock option practices and published a report. The Special Litigation Committee reached settlement agreements on behalf of the Company with its former Chairman and Chief Executive Officer William W. McGuire, M.D., former General Counsel David J. Lubben, and former director William G. Spears. In addition, the Special Litigation Committee concluded that all claims against all named defendants in the derivative actions, including current and former Company officers and directors, should be dismissed. Each settlement agreement is conditioned upon dismissal of claims in the derivative actions and resolution of any appeals. Following notice to shareholders, the federal court granted the parties' motion for final approval of the proposed settlements on July 1, 2009, and entered final judgment dismissing the federal case with prejudice on July 2, 2009. The state court granted the parties' motion for final approval of the proposed settlements and dismissed the state case with prejudice on May 14, 2009, and entered final judgment on July 17, 2009. The federal and state courts also awarded plaintiffs' counsel fees and expenses of $30 million and $6 million, respectively, which have been paid by the Company. A shareholder has filed an appeal with the U.S. Court of Appeals for the Eighth Circuit challenging only the federal plaintiffs' counsel's fee award. Federal plaintiffs' counsel is contesting the appeal.

As previously disclosed, the Company also received inquiries from a number of federal and state regulators from 2006 through 2008 regarding its historical stock option practices. Many of those inquiries have been closed, resolved or inactive since 2008.

The Company may be subject to additional litigation or other proceedings or actions arising out of the Company's historical stock option practices and the related restatement of its historical Consolidated Financial Statements. Litigation and any potential regulatory proceeding or action may be time consuming, expensive and distracting from the conduct of the Company's business. The adverse resolution of any specific lawsuit or any potential regulatory proceeding or action could have a material adverse effect on the Company's business, financial condition and results of operations.

Government Regulation

The Company's business is regulated at federal, state, local and international levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. State legislatures and Congress continue to focus on health care issues as the subject of proposed legislation. In connection with these activities, the Company periodically receives inquiries and requests for information from state or federal legislative bodies. For instance, during the third and fourth quarters of 2009, the Company received requests for information and

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testimony from Congressional committees in connection with health care reform legislative proposals. The Company is cooperating with these requests. Existing or future laws and rules could force us to change how the Company does business, restrict revenue and enrollment growth, increase the Company's health care and administrative costs and capital requirements, and increase the Company's liability in federal and state courts for coverage determinations, contract interpretation and other actions. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been and is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor and other governmental authorities.

Examples of audits include a review by the U.S. Department of Labor of the Company's administration of applicable customer employee benefit plans with respect to ERISA compliance and audits of the Company's Medicare health plans to validate the coding practices of and supporting documentation maintained by its care providers.

Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs and could have a material adverse effect on the Company's financial results. The coding audits may result in prospective and retrospective adjustments to payments made to health plans pursuant to CMS Medicare contracts.

15. Segment Financial Information

Factors used in determining the Company's reporting segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision-maker to evaluate its results of operations.

The Company's accounting policies for reporting segment operations are the same as those described in the Summary of Significant Accounting Policies (see Note 2 of Notes to the Consolidated Financial Statements). Transactions between reporting segments principally consist of sales of pharmacy benefit products and services to Health Benefits customers by Prescription Solutions, certain product offerings sold to Health Benefits customers by OptumHealth, and medical benefits cost, quality and utilization data and predictive modeling sold to Health Benefits by Ingenix. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reporting segment using estimates of pro-rata usage. Cash and investments are assigned such that each reporting segment has at least minimum specified levels of regulatory capital or working capital for non-regulated businesses.

Substantially all of the Company's assets are held and operations are conducted in the United States. In accordance with accounting principles generally accepted in the United States, reporting segments with similar economic characteristics may be combined. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been aggregated in the Health Benefits segment column in the following tables 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. These businesses also share significant common assets, including the Company's contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 27% for the year ended December 31, 2009, and 25% for the years ended December 31, 2008 and 2007 most of which were generated by Ovations and included in the Health Benefits segment.

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The following table presents reporting segment financial information as of and for the years ended December 31:

(in millions)	Health Benefits	OptumHealth	Ingenix	Prescription Solutions	Corporate and Intersegment Eliminations	Consolidated
2009						
Revenues — External Customers:						
Premiums	$ 76,882	$ 2,433	$ —	$ —	$ —	$ 79,315
Services	3,937	277	1,042	50	—	5,306
Products	—	—	90	1,835	—	1,925
Total revenues — external customers	80,819	2,710	1,132	1,885	—	86,546
Total revenues — intersegment	—	2,753	691	12,562	(16,006)	—
Investment and other income	522	65	—	5	—	592
Total revenues	$ 81,341	$ 5,528	$ 1,823	$ 14,452	$ (16,006)	$ 87,138
Earnings from operations	$ 4,788	$ 636	$ 246	$ 689	$ —	$ 6,359
Interest expense	—	—	—	—	(551)	(551)
Earnings before income taxes	$ 4,788	$ 636	$ 246	$ 689	$ (551)	$ 5,808
Total assets	$ 49,068	$ 4,395	$ 2,415	$ 3,061	$ 106	$ 59,045
Purchases of property, equipment and capitalized software	$ 452	$ 78	$ 142	$ 67	$ —	$ 739
Depreciation and Amortization	$ 668	$ 116	$ 129	$ 78	$ —	$ 991
2008						
Revenues — External Customers:						
Premiums	$ 71,298	$ 2,310	$ —	$ —	$ —	$ 73,608
Services	3,871	311	925	45	—	5,152
Products	—	—	95	1,560	—	1,655
Total Revenues — External Customers	75,169	2,621	1,020	1,605	—	80,415
Total Revenues — Intersegment	—	2,529	532	10,960	(14,021)	—
Investment and Other Income	688	75	—	8	—	771
Total Revenues	$ 75,857	$ 5,225	$ 1,552	$ 12,573	$ (14,021)	$ 81,186
Earnings from Operations	$ 5,068	$ 718	$ 229	$ 363	$ (1,115)	$ 5,263
Interest expense	—	—	—	—	(639)	(639)
Earnings before income taxes	$ 5,068	$ 718	$ 229	$ 363	$ (1,754)	$ 4,624
Total Assets	$ 46,459	$ 4,195	$ 1,755	$ 2,603	$ 803	$ 55,815
Purchases of Property, Equipment and Capitalized Software	$ 522	$ 100	$ 112	$ 57	$ —	$ 791
Depreciation and Amortization	$ 691	$ 120	$ 105	$ 65	$ —	$ 981
2007						
Revenues — External Customers:						
Premiums	$ 66,625	$ 2,156	$ —	$ —	$ —	$ 68,781
Services	3,530	292	767	19	—	4,608
Products	—	—	100	798	—	898
Total Revenues — External Customers	70,155	2,448	867	817	—	74,287
Total Revenues — Intersegment	—	2,385	437	12,420	(15,242)	—
Investment and Other Income	1,044	88	—	12	—	1,144
Total Revenues	$ 71,199	$ 4,921	$ 1,304	$ 13,249	$ (15,242)	$ 75,431
Earnings from Operations	$ 6,595	$ 895	$ 266	$ 269	$ (176)	$ 7,849
Interest expense	—	—	—	—	(544)	(544)
Earnings before income taxes	$ 6,595	$ 895	$ 266	$ 269	$ (720)	$ 7,305
Total Assets	$ 43,343	$ 3,714	$ 1,596	$ 2,420	$ (174)	$ 50,899
Purchases of Property, Equipment and Capitalized Software	$ 623	$ 108	$ 121	$ 19	$ —	$ 871
Depreciation and Amortization	$ 559	$ 111	$ 81	$ 45	$ —	$ 796

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UNITEDHEALTH GROUP

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

16. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2009 and 2008 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2009				
Revenues	$22,004	$21,655	$ 21,695	$ 21,784
Operating costs	20,336	20,215	20,019	20,209
Earnings from operations	1,668	1,440	1,676	1,575
Net earnings	984	859	1,035	944
Basic net earnings per common share	0.82	0.73	0.90	0.82
Diluted net earnings per common share	0.81	0.73	0.89	0.81
2008				
Revenues	$20,304	$20,272	$ 20,156	$ 20,454
Operating costs	18,591	19,599	18,558	19,175
Earnings from operations	1,713	673	1,598	1,279
Net earnings	994	337	920	726
Basic net earnings per common share	0.80	0.28	0.76	0.61
Diluted net earnings per common share	0.78	0.27	0.75	0.60

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

The Company maintains disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by the Company in reports that it files or submits under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to the Company's management, including its principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-K, management evaluated, under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of the Company's disclosure controls and procedures as of December 31, 2009. Based upon that evaluation, the Company's Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2009.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2009 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

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Report of Management on Internal Control over Financial Reporting as of December 31, 2009

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2009. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control — Integrated Framework*. Based on our assessment and those criteria, we believe that, as of December 31, 2009, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2009, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses an unqualified opinion on the effectiveness of the Company's internal controls over financial reporting as of December 31, 2009.

/s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Executive Officer

/s/ GEORGE L. MIKAN III

George L. Mikan III
Executive Vice President and Chief Financial Officer

/s/ ERIC S. RANGEN

Eric S. Rangen
Senior Vice President and Chief Accounting Officer

February 10, 2010

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of UnitedHealth Group Incorporated and subsidiaries:

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2009, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2009. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on the criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2009 of the Company and our reports dated February 10, 2010 expressed an unqualified opinion on those consolidated financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2010

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ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 25, 2010, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 25, 2010, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2009, concerning shares of common stock authorized for issuance under all of our equity compensation plans.

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights (3)	(b) Weighted-average exercise price of outstanding options, warrants and rights (3)	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by shareholders (1)	80,727,176	$ 34.61	72,777,932(4)
Equity compensation plans not approved by shareholders (2)	—	—	—
Total (2)	80,727,176	$ 34.61	72,777,932

(1) Consists of the UnitedHealth Group Incorporated 2002 Stock Incentive Plan, as amended, and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended. Includes 6,170,280 options to acquire shares of common stock that were originally issued under the United HealthCare Corporation 1998 Broad-Based Stock Incentive Plan, as amended, which was not approved by the Company's shareholders, but the shares issuable under the 1998 Broad-Based Stock Incentive Plan were subsequently included in the number of shares approved by the Company's shareholders when approving the 2002 Stock Incentive Plan.

(2) Excludes 950,529 shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average

exercise price of $23.51 and an average remaining term of approximately 2.7 years. The options are administered pursuant to the terms of the plan under which the option originally was granted. No future awards will be granted under these acquired plans.

(3) Excludes SARs to acquire 42,467,803 shares of common stock of the Company with exercise prices above $30.48, the closing price of a share of our common stock as reported on the NYSE on December 31, 2009.

(4) Includes 9,326,472 shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2009, and 63,451,460 shares available under the 2002 Stock Incentive Plan as of December 31, 2009. Shares available under the 2002 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 15,274,665 of these shares are available for future grants of awards other than stock options or SARs.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 25, 2010, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 25, 2010, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 25, 2010, and such required information is incorporated herein by reference.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

Consolidated Statements of Operations for the year ended December 31, 2009, 2008 and 2007.

Consolidated Balance Sheets as of December 31, 2009 and 2008.

Consolidated Statements of Changes in Shareholders' Equity for the year ended December 31, 2009, 2008 and 2007.

Consolidated Statements of Cash Flows for the year ended December 31, 2009, 2008 and 2007.

Notes to the Consolidated Financial Statements.

Reports of Independent Registered Public Accounting Firm.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

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

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

3. *Exhibits***

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)

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*10.1	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10.2	Amendment to the UnitedHealth Group Incorporated 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.3	Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.4	Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.5	Form of Agreement for Initial Restricted Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.6	Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(e) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.7	Form of Agreement for Stock Option Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.8	Form of Agreement for Restricted Stock Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.9	Form of Agreement for Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.10	Form of Agreement for Stock Appreciation Rights Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.11	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.12	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.15	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 31, 2006)

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*10.16	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.17	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.18	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
*10.19	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010
*10.21	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.22	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.23	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.24	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.25	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.26	Employment Agreement, effective as of November 7, 2006, by and between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 30, 2007)
*10.27	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.28	Employment Agreement, dated as of April 10, 2007, between United HealthCare Services, Inc. and William A. Munsell (incorporated by reference to Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.29	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and William A. Munsell (incorporated by reference to Exhibit 10.27 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.30	Employment Agreement, effective as of April 12, 2007, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)

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*10.31	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.32	Employment Agreement, effective as of January 29, 2009, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
12.1	Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of the Company
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009, filed on February 10, 2010, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Changes in Shareholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements, tagged as blocks of text.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request(c) Financial Statement Schedule

(c) Financial Statement Schedule

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

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Schedule I

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and subsidiaries:

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2009 and 2008, and for each of the three years in the period ended December 31, 2009, and the Company's internal control over financial reporting as of December 31, 2009, and have issued our reports thereon dated February 10, 2010; such consolidated financial statements and reports are included in your 2009 Annual Report to Stockholders and are incorporated herein by reference. Our audits also included the consolidated financial statement schedule of the Company listed in Item 15. This consolidated financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion based on our audits. In our opinion, the consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, MN
February 10, 2010

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2009	2008
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,309	$ 880
Deferred income taxes	163	169
Prepaid expenses and other current assets	61	196
Total current assets	2,533	1,245
Equity in net assets of subsidiaries	32,812	32,636
Other assets	60	685
TOTAL ASSETS	$35,405	$34,566
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 522	$ 805
Note payable to subsidiary	100	100
Commercial paper and current maturities of long-term debt	2,164	1,456
Total current liabilities	2,786	2,361
Long-term debt, less current maturities	9,009	11,338
Deferred income taxes and other liabilities	4	87
Total liabilities	11,799	13,786
Commitments and contingencies (Note 3)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 1,147 and 1,201 issued and outstanding	11	12
Additional paid-in capital	—	38
Retained earnings	23,342	20,782
Accumulated other comprehensive (loss) income:		
Net unrealized gains (losses) on investments, net of tax effects	277	(30)
Foreign currency translation loss	(24)	(22)
Total shareholders' equity	23,606	20,780
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$35,405	$34,566

See Notes to the Condensed Financial Statements of Registrant.

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Operations

(in millions)	For the Year Ended December 31, 2009	2008	2007
REVENUES:			
Investment and other income	$ 10	$ 20	$ 78
Total revenues	10	20	78
OPERATING COSTS:			
Operating costs	5	1,256	57
Interest expense	509	565	458
Total operating costs	514	1,821	515
LOSS BEFORE INCOME TAXES	(504)	(1,801)	(437)
Benefit for income taxes	172	641	159
LOSS OF PARENT COMPANY	(332)	(1,160)	(278)
Equity in undistributed income of subsidiaries	4,154	4,137	4,932
NET EARNINGS	$ 3,822	$ 2,977	$ 4,654

See Notes to the Condensed Financial Statements of Registrant.

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Year Ended December 31, 2009	2008	2007
OPERATING ACTIVITIES			
Cash flows from operating activities	$ 5,065	$ 3,962	$ 4,178
INVESTING ACTIVITIES			
Capital contributions to subsidiaries	(90)	(7)	(1,272)
Cash paid for acquisitions	(1,045)	(4,419)	(270)
Cash received from dispositions	—	185	—
Cash flows used for investing activities	(1,135)	(4,241)	(1,542)
FINANCING ACTIVITIES			
(Repayments of) proceeds from commercial paper, net	(99)	(1,346)	947
Proceeds from issuance of long-term debt	—	2,981	3,582
Payments for retirement of long-term debt	(1,350)	(500)	(950)
Proceeds from interest rate swap termination	513	—	—
Repayment of note to subsidiary	—	—	(60)
Proceeds from issuance of note to subsidiary	—	100	—
Common stock repurchases	(1,801)	(2,684)	(6,599)
Proceeds from common stock issuances	282	299	712
Share-based compensation excess tax benefits	38	62	303
Dividends paid	(36)	(37)	(40)
Other	(48)	(143)	(30)
Cash flows used for financing activities	(2,501)	(1,268)	(2,135)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	1,429	(1,547)	501
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	880	2,427	1,926
CASH AND CASH EQUIVALENTS, END OF PERIOD	$ 2,309	$ 880	$ 2,427
Supplemental cash flow disclosures			
Cash paid for interest	$ 485	$ 547	$ 469
Cash paid for income taxes	$ 2,048	$ 1,882	$ 2,277

See Notes to the Condensed Financial Statements of Registrant.

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Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements
For the Years Ended December 31, 2009, 2008 and 2007

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in the Summary of Significant Accounting Policies in Note 2 of Notes to the Consolidated Financial Statements.

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.4 billion, $1.8 billion and $3.8 billion in 2009, 2008 and 2007, respectively.

3. Commercial Paper and Long-Term Debt

Further discussion of maturities of commercial paper and long-term debt can be found in Note 9 of Notes to the Consolidated Financial Statements.

4. Commitments and Contingencies

Operating costs for 2008 included $350 million for the settlement of class action litigation related to reimbursement for out-of-network medical services. For detail on the proposed settlement and other commitments and contingencies, see Note 14 of Notes to the Consolidated Financial Statements.

5. Acquisitions

See Note 3 of Notes to the Consolidated Financial Statements for a description of acquisitions.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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.

Dated: February 10, 2010

UNITEDHEALTH GROUP INCORPORATED

By /s/ STEPHEN J. HEMSLEY
Stephen J. Hemsley
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	Director, President and Chief Executive Officer (principal executive officer)	February 10, 2010
/S/ GEORGE L. MIKAN III **George L. Mikan III**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 10, 2010
/S/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 10, 2010
* **William C. Ballard, Jr.**	Director	February 10, 2010
* **Richard T. Burke**	Director	February 10, 2010
* **Robert J. Darretta**	Director	February 10, 2010
* **Michele J. Hooper**	Director	February 10, 2010
* **Douglas W. Leatherdale**	Director	February 10, 2010
* **Glenn M. Renwick**	Director	February 10, 2010
Kenneth I. Shine	Director	February 10, 2010
* **Gail R. Wilensky**	Director	February 10, 2010

*By /s/ CHRISTOPHER J. WALSH
Christopher J. Walsh,
As Attorney-in-Fact

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EXHIBIT INDEX[**]

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated November 15, 1988, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10.2	Amendment to the UnitedHealth Group Incorporated 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.3	Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.4	Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.5	Form of Agreement for Initial Restricted Stock Unit Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007 (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007)
*10.6	Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan, as amended on October 31, 2006 (incorporated by reference to Exhibit 10(e) to the Company's Annual Report on Form 10-K for the year ended December 31, 2006)
*10.7	Form of Agreement for Stock Option Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.8	Form of Agreement for Restricted Stock Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated October 23, 2009)

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*10.9	Form of Agreement for Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.10	Form of Agreement for Stock Appreciation Rights Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.11	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, effective as of October 23, 2009 (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated October 23, 2009)
*10.12	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.13	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.15	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated October 31, 2006)
*10.16	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.17	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.18	Summary of Non-Management Director Compensation, effective as of July 1, 2009 (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009)
*10.19	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010
*10.21	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)
*10.22	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.23	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K dated November 7, 2006)

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*10.24	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.25	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.26	Employment Agreement, effective as of November 7, 2006, by and between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 30, 2007)
*10.27	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and George L. Mikan III (incorporated by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.28	Employment Agreement, dated as of April 10, 2007, between United HealthCare Services, Inc. and William A. Munsell (incorporated by reference to Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.29	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and William A. Munsell (incorporated by reference to Exhibit 10.27 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.30	Employment Agreement, effective as of April 12, 2007, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.31	Amendment to Employment Agreement, effective as of December 31, 2008, between United HealthCare Services, Inc. and Anthony Welters (incorporated by reference to Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.32	Employment Agreement, effective as of January 29, 2009, between United HealthCare Services, Inc. and Larry C. Renfro (incorporated by reference to Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
12.1	Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of the Company
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009, filed on February 10, 2010, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Changes in Shareholders' Equity, (iv) Consolidated Statements of Cash Flows, and (v) Notes to the Consolidated Financial Statements, tagged as blocks of text.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request(c) Financial Statement Schedule