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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, 2007

or

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

For the transition period from _____ to _____

Commission file number: 1-10864

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Minnesota	**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)**

(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 is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐

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 April 30, 2007, there were 1,340,048,950 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

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UNITEDHEALTH GROUP

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PART I. FINANCIAL INFORMATION

Item 1. *Financial Statements (unaudited)*

UNITEDHEALTH GROUP

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

	March 31, 2007	December 31, 2006
ASSETS		
Current Assets		
Cash and Cash Equivalents	$ 12,059	$ 10,320
Short-Term Investments	796	620
Accounts Receivable, net	1,311	1,323
Assets Under Management	1,925	1,970
Deferred Income Taxes	583	561
Other Current Assets	1,733	1,250
Total Current Assets	18,407	16,044
Long-Term Investments	10,023	9,642
Property, Equipment and Capitalized Software, net	1,884	1,894
Goodwill	16,889	16,822
Other Intangible Assets, net	1,845	1,904
Other Assets	1,961	2,014
TOTAL ASSETS	$ 51,009	$ 48,320
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current Liabilities		
Medical Costs Payable	$ 8,554	$ 8,076
Accounts Payable and Accrued Liabilities	3,581	3,713
Other Policy Liabilities	4,719	3,957
Commercial Paper and Current Maturities of Long-Term Debt	1,581	1,483
Unearned Premiums	2,847	1,268
Total Current Liabilities	21,282	18,497
Long-Term Debt, less current maturities	5,473	5,973
Future Policy Benefits for Life and Annuity Contracts	1,830	1,850
Deferred Income Taxes and Other Liabilities	1,356	1,190
Commitments and Contingencies (Note 13)		
Shareholders' Equity		
Common Stock, $0.01 par value — 3,000 shares authorized; 1,330 and 1,345 issued and outstanding	13	13
Additional Paid-In Capital	5,788	6,406
Retained Earnings	15,243	14,376
Accumulated Other Comprehensive Income:		
Net Unrealized Gains on Investments, net of tax effects	24	15
Total Shareholders' Equity	21,068	20,810
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ 51,009	$ 48,320

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP

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

	Three Months Ended March 31,	
	2007	2006
REVENUES		
Premiums	$ 17,464	$ 16,179
Services	1,116	1,038
Products	197	165
Investment and Other Income	270	199
Total Revenues	19,047	17,581
OPERATING COSTS		
Medical Costs	14,440	13,283
Operating Costs	2,664	2,531
Cost of Products Sold	170	137
Depreciation and Amortization	191	157
Total Operating Costs	17,465	16,108
EARNINGS FROM OPERATIONS	1,582	1,473
Interest Expense	(116)	(82)
EARNINGS BEFORE INCOME TAXES	1,466	1,391
Provision for Income Taxes	(539)	(500)
NET EARNINGS	$ 927	$ 891
BASIC NET EARNINGS PER COMMON SHARE	$ 0.69	$ 0.66
DILUTED NET EARNINGS PER COMMON SHARE	$ 0.66	$ 0.63
BASIC WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	1,343	1,353
DILUTIVE EFFECT OF COMMON STOCK EQUIVALENTS	56	66
DILUTED WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	1,399	1,419

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP

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

	Three Months Ended March 31,	
	2007	2006
OPERATING ACTIVITIES		
Net Earnings	$ 927	$ 891
Noncash Items:		
Depreciation and Amortization	191	157
Deferred Income Taxes and Other	(136)	(227)
Stock-Based Compensation	260	90
Net Change in Other Operating Items, net of effects from acquisitions and changes in AARP balances:		
Accounts Receivable and Other Current Assets	(331)	(606)
Medical Costs Payable	411	720
Accounts Payable and Other Accrued Liabilities	(300)	365
Unearned Premiums	1,566	1,500
Cash Flows From Operating Activities	2,588	2,890
INVESTING ACTIVITIES		
Cash Paid for Acquisitions, net of cash assumed and other effects	(54)	(555)
Purchases of Property, Equipment and Capitalized Software	(224)	(171)
Purchases of Investments	(994)	(930)
Maturities and Sales of Investments	460	580
Cash Flows Used For Investing Activities	(812)	(1,076)
FINANCING ACTIVITIES		
Proceeds From/(Repayments of) Commercial Paper, net	2	(2,193)
(Repayments of)/Proceeds From Issuance of Long-Term Debt	(400)	3,000
Repayments of Convertible Subordinated Debentures	(1)	(91)
Common Stock Repurchases	(903)	(1,754)
Proceeds from Common Stock Issuances under Stock-Based Compensation Plans	135	145
Stock-Based Compensation Excess Tax Benefits	86	143
Customer Funds Administered	1,048	1,412
Other	(4)	(53)
Cash Flows (Used For)/From Financing Activities	(37)	609
INCREASE IN CASH AND CASH EQUIVALENTS	1,739	2,423
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	10,320	5,421
CASH AND CASH EQUIVALENTS, END OF PERIOD	$ 12,059	$ 7,844

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

1. Basis of Presentation and Use of Estimates

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

The accompanying unaudited condensed consolidated financial statements reflect all adjustments, consisting solely of normal recurring adjustments needed to present the financial results for these interim periods fairly. In accordance with the rules and regulations of the Securities and Exchange Commission, we have omitted certain footnote disclosures that would substantially duplicate the disclosures contained in our annual audited consolidated financial statements. Read together with the disclosures below, we believe the interim financial statements are presented fairly. However, these unaudited condensed consolidated financial statements should be read together with the consolidated financial statements and the notes included in our Annual Report on Form 10-K for the year ended December 31, 2006 as filed with the Securities and Exchange Commission.

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

2. Medicare Part D Pharmacy Benefits Contract

Beginning January 1, 2006, the Company began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with the Centers for Medicare & Medicaid Services ("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 of $3,850. A settlement is made based on actual cost experience subsequent to 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 experience, subsequent to the end of the plan year.
- *CMS Risk-Share* — If the ultimate per member per month benefit costs of any Medicare Part D regional plan varies more than 2.5% above or below the level estimated in the original bid submitted by the Company and approved by CMS, there is a risk-share settlement with CMS subsequent to the end of the plan year. The risk-share adjustment, if any, is recorded as an adjustment to premium revenues and other receivables or liabilities.

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 Condensed Consolidated Statements of Operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. We record premium payments received in advance of the applicable service period as unearned premiums.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidies 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, with the related liability recorded in Other Policy Liabilities in the Condensed Consolidated Balance Sheets. Related cash flows are presented as Customer Funds Administered within financing cash flows 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 Condensed Consolidated Statements of Operations.

As a result of the Medicare Part D product benefit design, the Company incurs a disproportionate amount of pharmacy benefit costs early in the contract year. While the Company is responsible for approximately 67% of a Medicare Part D beneficiary's drug costs up to $2,400, the beneficiary is responsible for 100% of their drug costs from $2,400 up to $5,451 (at the Company's discounted purchase price). Consequently, the Company incurs a disproportionate amount of benefit costs in the first half of the contract year as compared with the last half of the contract year, when comparatively more members will be incurring claims above the $2,400 initial coverage limit. The uneven timing of Medicare Part D pharmacy benefit claims results in losses in the first half of year that entitle the Company to risk-share adjustment payments from CMS. Accordingly, during the interim periods within the contract year we record a net risk-share receivable from CMS in other current assets in the Condensed Consolidated Balance Sheets and a corresponding retrospective premium adjustment in premium revenues in the Condensed Consolidated Statement of Operations. This represents the estimated amount payable by CMS to the Company under the risk share contract provisions if the program were terminated based on estimated costs incurred through that interim period. Those losses reverse in the second half of the year and final risk share amounts due to or from CMS, if any, are settled approximately six months after the contract year-end. The projected net risk-share receivable to be received from CMS as of March 31, 2007 was $206 million.

Total premium revenues from CMS related to the Medicare Part D program and all other Medicare-related programs were approximately 24% of total consolidated revenues in the first quarter of 2007.

3. Acquisitions

On March 12, 2007, we announced that we had signed a definitive merger agreement under which the Company will acquire all of the outstanding shares of Sierra Health Services, Inc., a diversified health care services company based in Las Vegas, for approximately $2.6 billion in cash, representing a price of $43.50 per acquired share of common stock. The transaction, which has been approved by the Boards of Directors of both companies and is expected to close prior to the end of 2007, is subject to state and federal regulatory approvals, including Nevada, California and Texas, approval by Sierra's stockholders, and other customary conditions. This acquisition would strengthen our position in the rapidly growing southwest region and broaden our senior health capabilities.

On December 1, 2006, our Health Care Services business segment acquired the Student Insurance Division (Student Resources) of The MEGA Life and Health Insurance Company through an asset purchase agreement.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Student Resources primarily serves college and university students. This acquisition strengthened our position in this market and provided expanded distribution opportunities for our other UnitedHealth Group businesses. In exchange and under the terms of the asset purchase agreement, we issued a 10-year, $95 million promissory note bearing a 5.4% fixed interest rate and paid approximately $1 million in cash. The results of operations and financial condition of Student Resources have been included in our Consolidated Financial Statements since the acquisition date. The pro forma effects of the Student Resources acquisition on our Consolidated Financial Statements were not material.

On February 24, 2006, the Company acquired John Deere Health Care, Inc. (JDHC). JDHC serves employers primarily in Iowa, central and western Illinois, eastern Tennessee and southwestern Virginia. This acquisition strengthened our resources and capabilities in these areas. The operations of JDHC reside primarily within our Health Care Services and Uniprise segments. We paid approximately $515 million in cash, including transaction costs, in exchange for all of the outstanding equity of JDHC. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately $376 million. Based on management's consideration of fair value, which included the completion of a valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of $53 million and goodwill of $323 million. The finite-lived intangible assets consist primarily of member lists and physician and hospital networks, with estimated fair values of $51 million and $2 million, respectively, and an estimated weighted-average useful life of approximately 11 years. The acquired goodwill is deductible for income tax purposes. The results of operations and financial condition of JDHC have been included in our consolidated financial statements since the acquisition date. The pro forma effects of the JDHC acquisition on our consolidated financial statements were not material. Acquired net tangible assets and liabilities are categorized as follows: cash and cash equivalents of $46 million; investments of $197 million; accounts receivable and other current assets of $60 million; property, equipment, capitalized software and other assets of $29 million; medical payables of $131 million and other liabilities of $62 million. JDHC has been renamed UnitedHealthcare Services Company of the River Valley, Inc.

On December 20, 2005, the Company acquired PacifiCare Health Systems, Inc. (PacifiCare). PacifiCare provides health care and benefit services to individuals and employers, principally in markets in the western United States. This merger significantly strengthened our resources by enhancing our capabilities on the Pacific Coast and in other western states and broadening the scope of our product offerings for a host of specialized services. The operations of PacifiCare reside primarily within our Health Care Services and Specialized Care Services segments.

We record liabilities related to integration activities in connection with business combinations when integration plans are finalized and approved by management within one year of the acquisition date in accordance with the requirements of the Emerging Issues Task Force (EITF) Issue No. 95-3, "Recognition of Liabilities in Connection with a Purchase Business Combination." Liabilities recorded relate to activities that have no future economic benefit to the Company and represent contractual obligations. These liabilities result in an increase to goodwill acquired. At each reporting date, we evaluate our liabilities associated with integration activities and make adjustments as appropriate. Integration activities relate primarily to severance costs for certain workforce reductions largely in the Health Care Services segment, costs of terminated or vacated leased facilities and other contract termination costs.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table illustrates the changes in employee termination benefit costs and other integration costs related to the PacifiCare acquisition, for the three-month period ended March 31, 2007 (in millions):

	Employee Termination Benefit Costs	Other Integration Activities	Total
Accrued integration liabilities at December 31, 2006	$ 27	$ 28	$ 55
Additional integration costs accrued and estimate adjustments	—	(2)	(2)
Payments made against liabilities	(3)	(7)	(10)
Accrued integration liabilities at March 31, 2007	$ 24	$ 19	$ 43

4. Cash, Cash Equivalents and Investments

As of March 31, 2007, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments were as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Cash and Cash Equivalents	$ 12,059	$ —	$ —	$12,059
Debt Securities — Available for Sale	10,198	60	(42)	10,216
Equity Securities — Available for Sale	343	21	(1)	363
Debt Securities — Held to Maturity	240	—	—	240
Total Cash and Investments	$ 22,840	$ 81	$ (43)	$22,878

During the three-month periods ended March 31, we recorded realized gains and losses on the sale of investments, as follows (in millions):

	Three Months Ended March, 31,	
	2007	2006
Gross Realized Gains	$ 2	$ 29
Gross Realized Losses	(3)	(3)
Net Realized (Losses) Gains	$ (1)	$ 26

5. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by segment, for the three months ended March 31, 2007 and 2006, were as follows (in millions):

	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Consolidated Total
Balance at December 31, 2006	$13,996	$ 946	$ 1,054	$ 826	$ 16,822
Acquisitions and Subsequent Payments / Adjustments	14	1	(2)	54	67
Balance at March 31, 2007	$14,010	$ 947	$ 1,052	$ 880	$ 16,889

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Consolidated Total
Balance at December 31, 2005	$13,864	$ 917	$ 732	$ 725	$ 16,238
Acquisitions and Subsequent Payments / Adjustments	217	50	48	42	357
Balance at March 31, 2006	$14,081	$ 967	$ 780	$ 767	$ 16,595

The weighted-average useful life, gross carrying value, accumulated amortization and net carrying value of other intangible assets as of March 31, 2007 and December 31, 2006 were as follows (in millions):

		March 31, 2007			December 31, 2006		
	Weighted-Average Useful Life	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer Contracts and Membership Lists	14 years	$ 1,866	$ (284)	$ 1,582	$ 1,871	$ (246)	$ 1,625
Patents, Trademarks and Technology	13 years	300	(100)	200	303	(89)	214
Other	12 years	104	(41)	63	103	(38)	65
Total	14 years	$ 2,270	$ (425)	$ 1,845	$ 2,277	$ (373)	$ 1,904

Amortization expense relating to intangible assets was approximately $52 million and $44 million for the three months ended March 31, 2007 and 2006, respectively. Estimated amortization expense relating to intangible assets for the years ending December 31 are as follows: $186 million in 2007, $180 million in 2008, $162 million in 2009, $153 million in 2010, and $148 million in 2011.

6. Medical Costs and 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 we have either not yet received or processed claims, and for liabilities for physician, hospital and other medical cost disputes. We develop 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. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. For example, in every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Our consolidated medical costs payable estimates as of December 31, 2006 developed favorably by approximately $180 million in the first quarter of 2007. Our consolidated medical costs payable estimates as of December 31, 2005 developed favorably by approximately $220 million in the first quarter of 2006. Management believes the amount of medical costs payable is reasonable and adequate to cover the Company's liability for unpaid claims as of March 31, 2007.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

7. Commercial Paper and Debt

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

	March 31, 2007		December 31, 2006	
	Carrying Value (1)	Fair Value (2)	Carrying Value (1)	Fair Value (2)
Commercial Paper	$ 500	$ 500	$ 498	$ 498
3.0% Convertible Subordinated Debentures	30	30	34	34
$400 million par, 5.2% Senior Unsecured Notes due January 2007	—	—	400	400
$550 million par, 3.4% Senior Unsecured Notes due August 2007	545	545	540	543
$500 million par, 3.3% Senior Unsecured Notes due January 2008	494	490	489	489
$250 million par, 3.8% Senior Unsecured Notes due February 2009	246	244	243	243
Senior Unsecured Floating-Rate Notes due March 2009	650	650	650	649
$450 million par, 4.1% Senior Unsecured Notes due August 2009	443	441	438	438
$750 million par, 5.3% Senior Unsecured Notes due March 2011	752	752	748	747
$450 million par, 4.9% Senior Unsecured Notes due April 2013	445	440	444	436
$250 million par, 4.8% Senior Unsecured Notes due February 2014	244	241	242	239
$500 million par, 5.0% Senior Unsecured Notes due August 2014	491	487	489	485
$500 million par, 4.9% Senior Unsecured Notes due March 2015	483	481	488	479
$750 million par, 5.4% Senior Unsecured Notes due March 2016	743	743	741	743
$95 million par, 5.4% Senior Unsecured Notes due November 2016	95	95	95	95
$850 million par, 5.8% Senior Unsecured Notes due March 2036	844	818	844	839
Interest Rate Swaps	49	49	73	73
Total Commercial Paper and Debt	7,054	7,006	7,456	7,430
Less Current Maturities	(1,581)	(1,577)	(1,483)	(1,475)
Long-Term Debt, less current maturities	$ 5,473	$ 5,429	$ 5,973	$ 5,955

(1) The carrying value of debt has been adjusted based upon the applicable interest rate swap fair values in accordance with the fair value hedge short-cut method of accounting described below.
(2) Estimated based on third-party quoted market prices for the same or similar issues.

As of March 31, 2007, our outstanding commercial paper had interest rates ranging from 5.3% to 5.4%.

In April 2007 we launched an amendment and restatement of our $1.3 billion credit facility, which we established in December 2005, to extend the maturity date to May 2012 and to increase the amount to $2.6 billion. We expect to close the amended and restated credit facility in the second quarter of 2007.

On December 1, 2006, our Health Care Services business segment acquired the Student Insurance Division (Student Resources) of The MEGA Life and Health Insurance Company through an asset purchase agreement. Under the terms of the asset purchase agreement, we issued a 10-year, 5.4% promissory note for approximately $95 million and paid approximately $1 million in cash in exchange for the net assets of Student Resources.

On October 16, 2006, we executed a $7.5 billion 364-day revolving credit facility in order to ensure the Company's immediate and continued access to additional liquidity, if necessary. The credit facility is available for working capital purposes as well as to pay or repay any outstanding borrowings of the Company. As of March 31, 2007, we had no amounts outstanding under our $7.5 billion credit facility.

In March 2006, we refinanced outstanding commercial paper by issuing $650 million of floating-rate notes due March 2009, $750 million of 5.3% fixed-rate notes due March 2011, $750 million of 5.4% fixed-rate notes due

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

March 2016 and $850 million of 5.8% fixed-rate notes due March 2036. The floating-rate notes due March 2009 are benchmarked to the London Interbank Offered Rate (LIBOR) and had an interest rate of 5.4% at March 31, 2007.

In December 2005, we amended and restated our $1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the credit facility to $1.3 billion and extended the maturity date to December 2010. As of March 31, 2007, we had no amounts outstanding under our $1.3 billion credit facility.

To more closely align interest costs with floating interest rates received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from fixed rates to variable rates. These interest rate swap agreements have aggregate notional amounts of $4.9 billion as of March 31, 2007 with variable rates that are benchmarked to LIBOR, and are recorded on our Condensed Consolidated Balance Sheets. As of March 31, 2007, the aggregate liability, recorded at fair value, for all existing interest rate swaps was approximately $49 million. These fair value hedges are accounted for using the short-cut method under Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities" (FAS 133), whereby the hedges are reported on our Condensed Consolidated Balance Sheets at fair value, and the carrying value of the long-term debt is adjusted for an offsetting amount representing changes in fair value attributable to the hedged risk. Since these amounts completely offset, we have reported both the swap liability and the debt liability within debt on our Condensed Consolidated Balance Sheets and there have been no net gains or losses recognized in our Condensed Consolidated Statements of Operations. At March 31, 2007, the rates used to accrue interest expense on these agreements ranged from 4.7% to 5.5%.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio (calculated as the sum of commercial paper and debt divided by the sum of commercial paper, debt and shareholders' equity) below 50%. After giving effect to the credit agreement amendments and waivers that we obtained from our lenders, we believe we were in compliance with the requirements of all debt covenants as of March 31, 2007. On August 28, 2006, we received a purported notice of default from persons claiming to hold certain of our debt securities alleging a violation of our indenture governing our debt securities. This followed our announcement that we would delay filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. On or about November 2, 2006, we received a purported notice of acceleration from the holders who previously sent the notice of default that purports to declare an acceleration of our 5.8% Senior Unsecured Notes due March 15, 2036 as a result of our not timely filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. Our indenture requires us to provide to the trustee copies of the reports we are required to file with the SEC, such as our quarterly reports, within 15 days of filing such reports with the SEC. On October 25, 2006, we filed an action in the United States District Court for the District of Minnesota seeking a declaratory judgment that we are not in default under the terms of the indenture. We filed our quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006, as well as our annual report on Form 10-K for the year ended December 31, 2006 on March 6, 2007. Should the Company ultimately be unsuccessful in this matter, we may be required to retire all or a portion of the $850 million of Senior Unsecured Notes due March 2036. We intend to prosecute the declaratory judgment action vigorously.

PacifiCare had approximately $100 million par value of 3% convertible subordinated debentures (convertible notes) which were convertible into approximately 5.2 million shares of UnitedHealth Group's common stock and $102 million of cash as of December 31, 2005. In December 2005, we initiated a consent solicitation to all of the holders of outstanding convertible notes pursuant to which we offered to compensate all holders who elected to convert their notes in accordance with existing terms and consent to an amendment to a covenant in the indenture governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest redemption date, plus a pro rata share of $1 million. On January 31, 2006, approximately $91 million of the convertible notes were tendered pursuant to the offer, for which we issued approximately

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

4.8 million shares of UnitedHealth Group common stock, valued at $282 million, and cash of $93 million. On March 28, 2007, approximately $1 million of the convertible notes were tendered for conversion, for which we issued 51,071 shares of UnitedHealth Group common stock, valued at approximately $3 million, and cash of $1 million.

8. Stock Repurchase Program

Under our Board of Directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the three months ended March 31, 2007, we purchased 16.5 million shares which were settled for cash on or before March 31, 2007 at an average price of approximately $55 per share and an aggregate cost of approximately $903 million. As of March 31, 2007, we had Board of Directors' authorization to purchase up to an additional 115.7 million shares of our common stock.

9. Stock-Based Compensation and Other Employee Benefit Plans

We adopted FAS 123R as of January 1, 2006. FAS 123R requires companies to measure compensation expense for all share-based payments (including employee stock options, stock appreciation rights and restricted stock) at fair value and recognize the expense over the related service period. We adopted FAS 123R using the modified retrospective transition method, under which all prior period financial statements were restated to recognize compensation cost as calculated under FAS 123.

As of March 31, 2007, we had approximately 83.0 million shares available for future grants of stock-based awards under our stock-based compensation plan, including, but not limited to, incentive or non-qualified stock options, stock appreciation rights, restricted stock and restricted stock units. Our existing stock-based awards consist mainly of non-qualified stock options and stock-settled stock appreciation rights (SARs). Stock options and SARs generally vest ratably over four years and may be exercised up to 10 years from the date of grant. Stock option and SAR activity is summarized in the table below (shares in millions):

	Three Months Ended March 31, 2007	
	Shares	Weighted-Average Exercise Price
Outstanding at Beginning of Period	180.2	$ 28
Granted	0.6	$ 52
Exercised	(7.0)	$ 16
Forfeited	(1.7)	$ 33
Outstanding at End of Period	172.1	$ 30
Exercisable or Projected to Vest in Future	166.2	$ 29
Exercisable at End of Period	120.8	$ 22

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As of March 31, 2007 (shares in millions):

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Option Term (years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$ 1.68 – $15.63	47.8	2.5	$ 11	47.8	$ 11
$15.65 – $27.09	45.5	4.8	$ 21	43.8	$ 21
$27.14 – $48.57	43.3	6.9	$ 40	23.4	$ 39
$48.58 – $63.65	35.5	8.4	$ 52	5.8	$ 55
$ 1.68 – $63.65	172.1	5.4	$ 30	120.8	$ 22

To determine compensation expense related to our stock options and SARs, the fair value of each award grant is estimated on the date of grant using an option-pricing model. For purposes of estimating the fair value of our employee stock option and SAR grants, we utilize a binomial model. The principal assumptions we used in applying the option-pricing models were as follows:

	Three Months Ended	
	March 31, 2007	March 31, 2006
Risk-Free Interest Rate	4.9% – 5.2%	4.1% – 4.5%
Expected Volatility	22.8%	24.2%
Expected Dividend Yield	0.1%	0.1%
Forfeiture Rate	5.0%	5.0%
Expected Life in Years	4.1	4.1

The risk-free interest rate is based on U.S Treasury yields in effect at the time of grant. Expected volatilities are based on a blend of the implied volatilities from traded options on our common stock and the historical volatility of our common stock. We use historical data to estimate option and SAR exercises and employee terminations within the valuation model. The expected term 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 fair value of stock options and SARs granted in the three months ended March 31, 2007 and 2006 was $13 per share and $14 per share, respectively. The aggregate fair value of stock options and SARs that vested during the three months ended March 31, 2007 and 2006 was $62 million and $113 million, respectively. As of March 31, 2007, the aggregate intrinsic value of outstanding stock options and SARs was $4.1 billion, with a weighted-average remaining contractual term of 5.4 years. The aggregate intrinsic value of exercisable stock options and SARs at that same date was $3.8 billion, with a weighted-average remaining contractual term of 4.4 years. The total intrinsic value of options and SARs exercised during the three months ended March 31, 2007 and 2006 was $270 million and $423 million, respectively.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Restricted stock awards generally vest ratably over two to four years. Compensation expense related to restricted stock awards is determined based upon the fair value of each award on the date of grant. Restricted stock award activity is summarized in the table below (shares in millions):

	March 31, 2007	
	Shares	Weighted-Average Grant-Date Fair Value
Outstanding at Beginning of Period	1.3	$ 59
Granted	—	$ —
Vested	(0.1)	$ 59
Outstanding at End of Period	1.2	$ 59

We recognize compensation cost for stock-based awards, including stock options, SARs, restricted stock and restricted stock units, 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 the three months ended March 31, 2007, we recognized compensation expense related to our stock-based compensation plans of $260 million ($167 million net of tax effects). For the three months ended March 31, 2006, we recognized compensation expense of $90 million ($57 million net of tax effects). Stock-based compensation expense is recognized within Operating Costs in the Condensed Consolidated Statements of Operations. As of March 31, 2007, there was $553 million of total unrecognized compensation cost related to stock awards that is expected to be recognized over a weighted-average period of approximately 2.3 years.

For the three months ended March 31, 2007 and 2006, the income tax benefit realized from stock-based awards was $100 million and $161 million, respectively.

Included in the stock-based compensation expense for the first quarter of 2007 is $176 million ($112 million net of tax benefit) of expenses related to Section 409A of the Internal Revenue Code (Section 409A). As part of our review of the Company's historic stock option practices, we determined that certain stock options granted to nonexecutive officer employees were granted with an exercise price that was lower than the closing price of our common stock on the applicable accounting measurement date, subjecting these individuals to additional tax under Section 409A. The Company elected to pay these individuals' additional tax costs for 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 officers under its 2002 Stock Incentive Plan, 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 exercise price and the revised increased stock option exercise price. The payments will be made on a quarterly basis upon vesting of the applicable awards, beginning in January 2008. Aggregate payments, assuming all applicable options vest, will be approximately $150 million. If the modified stock options are subsequently exercised, the Company will recover these cash payments 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 officers and the related cash payments. These amounts have been recorded as corporate expenses and have not been allocated to individual business segments.

As previously disclosed, on December 29, 2006, the Company entered into agreements to increase the exercise price of outstanding stock options with all individuals who were executive officers of the Company at the time of grant of an applicable stock option. No compensation was payable to any of those individuals.

As further discussed in Note 8, we maintain a common stock repurchase program. The objective of our share repurchase program is to optimize our capital structure, cost of capital and return to shareholders, as well as to offset the dilutive impact of shares issued for stock-based award exercises.

Our Employee Stock Purchase Plan allows employees to purchase the Company's stock at a discounted price based on the lower of the price on the first day or the last day of the six-month purchase period. The compensation expense is included in the compensation expense amounts recognized and discussed above. We also offer a 401(k) plan for all employees of the Company.

We have provided Supplemental Executive Retirement Plan benefits (SERPs), which are non-qualified defined benefit plans, for our current Chief Executive Officer (CEO) and our former CEO as well as for certain nonexecutive officers under a plan that was assumed in an acquisition. No additional amounts will accrue under the SERPs to our current CEO and former CEO. The SERPs are non-contributory, unfunded and provide benefits based on years of service and compensation during employment. Pension expense is determined using various actuarial methods to estimate the total benefits ultimately payable to executives, and is allocated to service periods. The actuarial assumptions used to calculate pension costs are reviewed annually.

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 equal amount in Long-Term Other Liabilities in the Condensed Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods as elected under the plan.

10. AARP

In 1998, we began a contract with AARP to provide health insurance products and services to members of AARP. These products include coverage which supplements benefits provided under traditional Medicare (Medicare Supplement Insurance), as well as other indemnity products. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. Premium revenues from our portion of the AARP insurance offerings were approximately $5.1 billion over the past twelve months.

The underwriting gains or losses related to the AARP Medicare Supplement Insurance business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member 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, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the accompanying Condensed Consolidated Balance Sheets and changes in the RSF are reported in Medical Costs in the Condensed Consolidated Statements of Operations. We believe the RSF balance at March 31, 2007 is sufficient to cover potential future underwriting and other risks associated with the contract.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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

	Balance as of	
	March 31, 2007	December 31, 2006
Accounts Receivable	$ 462	$ 417
Assets Under Management	$ 1,888	$ 1,924
Medical Costs Payable	$ 1,070	$ 1,004
Other Policy Liabilities	$ 939	$ 1,008
Other Current Liabilities	$ 341	$ 329

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

Pursuant to our agreement, AARP assets under management are managed separately from our general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at our discretion, within investment guidelines approved by the AARP Medicare Supplement Insurance program. We do not guarantee any rates of investment return on these investments and, upon transfer of the AARP contract to another entity, we would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. 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 our earnings. Assets under management are reported at their fair market value, and unrealized gains and losses are included directly in the RSF associated with the AARP program. As of March 31, 2007, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments associated with the AARP insurance program, included in Assets Under Management, were as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Cash and Cash Equivalents	$ 392	$ —	$ —	$ 392
Debt Securities — Available for Sale	1,502	6	(12)	1,496
Total Cash and Investments	$ 1,894	$ 6	$ (12)	$1,888

Under a separate license agreement with AARP, we sell AARP-branded Medicare Prescription Drug benefit plans. We pay AARP a royalty and assume all operational and underwriting risks.

On April 13, 2007, we entered into an agreement to extend and expand our relationship with AARP through December 31, 2014. The agreement was expanded to give us a right to use the AARP brand on our Medicare Advantage offerings and to extend our arrangement to use the AARP brand on our Medicare Supplement products and services and Medicare Part D offerings.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

11. Comprehensive Income

The table below presents comprehensive income, defined as changes in the equity of our business excluding changes resulting from investments by and distributions to our shareholders, for the three-month periods ended March 31 (in millions):

	Three Months Ended March 31,	
	2007	2006
Net Earnings	$ 927	$ 891
Change in Net Unrealized (Losses) Gains on Investments, net of tax effects	9	(81)
Comprehensive Income	$ 936	$ 810

12. Segment Financial Information

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

- *Health Care Services* consists of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for the public sector, small and mid-sized employers and individuals nationwide. Ovations provides health and well-being services to individuals age 50 and older, including the administration of supplemental health insurance coverage on behalf of AARP. AmeriChoice provides network-based health and well-being services to beneficiaries of state Medicaid, Children's Health Insurance Programs and other government-sponsored health care programs. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been combined in the Health Care Services segment column in the tables presented below because these businesses have similar economic characteristics and have similar products and services, types of customers, distribution methods and operational processes, and operate in a similar regulatory environment, typically within the same legal entity.
- *Uniprise* provides network-based health and well-being services, business-to-business transaction processing services, consumer connectivity and technology support services nationwide to large employers and health plans, and provides health-related consumer and financial transaction products and services.
- *Specialized Care Services* offers a comprehensive platform of specialty health, wellness and ancillary benefits, services and resources to specific customer markets nationwide.
- *Ingenix* offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a national and international basis.

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

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table presents segment financial information for the three-month periods ended March 31, 2007 and 2006 (in millions):

Three Months Ended March 31, 2007	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Corporate and Intersegment Eliminations	Consolidated
Revenues — External Customers	$16,856	$ 1,140	$ 596	$ 185	$ —	$ 18,777
Revenues — Intersegment	—	279	503	78	(860)	—
Investment and Other Income	236	20	14	—	—	270
Total Revenues	$17,092	$ 1,439	$ 1,113	$ 263	$ (860)	$ 19,047
Earnings from Operations	$ 1,300	$ 215	$ 205	$ 38	$ (176)	$ 1,582

Three Months Ended March 31, 2006	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Corporate and Intersegment Eliminations	Consolidated
Revenues — External Customers	$15,621	$ 1,044	$ 573	$ 144	$ —	$ 17,382
Revenues — Intersegment	—	276	397	64	(737)	—
Investment and Other Income	174	14	11	—	—	199
Total Revenues	$15,795	$ 1,334	$ 981	$ 208	$ (737)	$ 17,581
Earnings from Operations	$ 1,057	$ 209	$ 177	$ 30	$ —	$ 1,473

In 2007, we began transitioning our operating structure into the following three new market groups:

- Commercial Services Group, which will include Specialized Care Services, Ingenix and Exante Financial Services;
- Individual and Employer Markets Group, which will include UnitedHealthcare and Uniprise; and
- Public and Senior Markets Group, which will include Ovations and AmeriChoice.

This operating structure will continue to evolve as we add new executive positions and realign enterprise-wide functions to strengthen our capabilities and performance. We have not currently realigned assets or changed the way our senior executives evaluate financial performance. Therefore, until we have completed the transition of our operating structure into the new market groups, we will continue to describe and report our results of operations using the four business segments described above.

13. Commitments and Contingencies

Legal Matters Relating to Historic Stock Option Practices

Regulatory Inquiries

In March 2006, we received an informal inquiry from the SEC relating to our historic stock option practices.

On May 17, 2006, we received a document request from the Internal Revenue Service seeking documents relating to stock option grants and other compensation for the persons who from 2003 to the present were the named executive officers in our annual proxy statements.

On May 17, 2006, we received a subpoena from the U.S. Attorney for the Southern District of New York requesting documents from 1999 to the present relating to our stock option practices.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

On June 6, 2006, we received a Civil Investigative Demand from the Minnesota Attorney General requesting documents from January 1, 1997 to the present concerning our executive compensation and stock option practices. After filing an action in Ramsey County Court, State of Minnesota, captioned *UnitedHealth Group Incorporated vs. State of Minnesota, by Lori Swanson, Attorney General*, we filed a Motion for Protective Order, which was denied by the trial court. We are pursuing an appeal of the Order denying the Protective Order.

On December 19, 2006, we received from the SEC staff a formal order of investigation into the Company's historic stock option practices.

We have also received requests for documents from U.S. Congressional committees relating to our historic stock option practices and compensation of executives. With the exception of the Civil Investigative Demand from the Minnesota Attorney General, we have generally cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of these regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or other contingent liabilities, which could be material.

Litigation Matters

On March 29, 2006, the first of several shareholder derivative actions was filed against certain of our current and former officers and directors in the United States District Court for the District of Minnesota. The action has been consolidated with six other actions and is captioned *In re UnitedHealth Group Incorporated Shareholder Derivative Litigation*. The consolidated amended complaint is brought on behalf of the Company by several pension funds and other shareholders and names certain of our current and former directors and officers as defendants, as well as the Company as a nominal defendant. The consolidated amended complaint generally alleges that defendants breached their fiduciary duties to the Company, were unjustly enriched, and violated the securities laws in connection with our historic stock option practices. The consolidated amended complaint seeks unspecified money damages, injunctive relief and rescission of the options. On June 26, 2006, our 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 a shareholder demand, and determine whether the Company's rights and remedies should be pursued. Defendants have moved to dismiss or in the alternative to stay the litigation pending resolution of the Special Litigation Committee process. In an Order dated March 14, 2007, the Court stayed the action, but allowed limited discovery, which the Court is supervising. On April 30, 2007, the United States moved to intervene in this action to limit certain discovery. That motion is scheduled to be heard on May 21, 2007. A consolidated derivative action, reflecting a consolidation of two actions, is also pending in Hennepin County District Court, State of Minnesota. The consolidated complaint is captioned *In re UnitedHealth Group Incorporated Derivative Litigation*. The action was brought by two individual shareholders and names certain of our current and former officers and directors as defendants, as well as the Company as nominal defendant. On February 6, 2007, the state court judge entered an order staying the action pending resolution of the Special Litigation Committee process.

On May 5, 2006, the first of seven putative class actions alleging a violation of the federal securities laws was brought by an individual shareholder against certain of our current and former officers and directors in the United States District Court for the District of Minnesota. On December 8, 2006, a consolidated amended complaint was filed consolidating the actions into a single action. The action is captioned *In re UnitedHealth Group Incorporated PSLRA Litigation*. The action was brought by lead plaintiff California Public Employees Retirement System against the Company and certain of our current and former officers and directors. The consolidated amended complaint alleges that defendants, in connection with the same alleged course of conduct identified in the shareholder derivative actions described above, made misrepresentations and omissions during the period January 20, 2005 and May 17, 2006, in press releases and public filings that artificially inflated the

price of our common stock. The consolidated amended complaint also asserts that during the class period, certain defendants sold shares of our common stock while in possession of material, non-public information concerning the matters set forth in the complaint. The consolidated amended complaint alleges claims under Sections 10(b), 14(a), 20(a) and 20A of the Securities and Exchange Act of 1934 and Sections 11 and 15 of the Securities Act of 1933. The action seeks unspecified money damages and equitable relief. Defendants moved to dismiss the consolidated amended complaint on February 6, 2007. We intend to vigorously defend against the action.

On June 6, 2006, a purported class action captioned *Zilhaver v. UnitedHealth Group Incorporated*, was filed against the Company and certain of our current and former officers and directors in the United State District Court for the District of Minnesota. On May 1, 2007, plaintiffs amended the complaint. This action alleges that the fiduciaries to the Company-sponsored 401(k) plan violated the Employee Retirement Income Security Act ("ERISA") by allowing the plan to continue to hold company stock. Defendants intend to move to dismiss the action. We intend to vigorously defend against the action.

On August 28, 2006, we received a purported notice of default from persons claiming to hold certain of our debt securities alleging a violation of our indenture governing our debt securities. This follows our announcement that we would delay filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. On October 25, 2006, we filed an action in the United States District Court for the District of Minnesota, captioned *UnitedHealth Group Incorporated v. Cede & Co. and the Bank of New York*, seeking a declaratory judgment that we are not in default under the terms of the indenture. On or about November 2, 2006, we received a purported notice of acceleration from the holders who previously sent the notice of default that purports to declare an acceleration of our 5.8% Senior Unsecured Notes due March 15, 2036 as a result of our not filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. Should the Company ultimately be unsuccessful in this matter, we may be required to retire all or a portion of the $850 million of Senior Unsecured Notes due March 2036. We intend to vigorously prosecute the declaratory judgment action.

In addition, we may be subject to additional litigation or other proceedings or actions arising out of the Independent Committee's review, the Special Litigation Committee's review and the related restatement of our historical financial statements. Litigation and any potential regulatory proceeding or action may be time consuming, expensive and distracting from the conduct of our business. The adverse resolution of any specific lawsuit or any potential regulatory proceeding or action could have a material adverse effect on our business, financial condition and results of operations.

In addition, other adjustments for non-operating cash charges may be required in connection with the resolution of stock option-related matters arising under litigation, and regulatory reviews by the SEC, IRS, U.S. Attorney, U.S. Congressional committees and Minnesota Attorney General, the amount and timing of which are uncertain but which could be material.

Other Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel

consolidated several litigation cases involving the Company and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and the Racketeer Influenced Corrupt Organization Act (RICO) in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare, and on June 19, 2006, the trial court dismissed all remaining claims against UnitedHealthcare brought by the lead plaintiff. The tag-along lawsuits remain outstanding. On July 27, 2006, the plaintiffs filed a notice of appeal to the Eleventh Circuit Court of Appeals challenging the dismissal of UnitedHealthcare. We intend to vigorously defend against the action.

On March 15, 2000, the American Medical Association filed a lawsuit against the Company in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations. On December 29, 2006, the trial court granted plaintiffs' motion to amend the complaint. We intend to vigorously defend against the action.

Government Regulation

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

We typically 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 and U.S. Attorneys. 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.

We also are subject to investigations of our historic stock option practices by the SEC, Internal Revenue Service, U.S. Attorney for the Southern District of New York, and Minnesota Attorney General, and a related review by the Special Litigation Committee of the Company, and we have received requests for documents from U.S. Congressional committees as described in Part II, Item 1 — "Legal Proceedings." With the exception of the Civil Investigative Demand from the Minnesota Attorney General, we generally have cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of these regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or contingent liabilities, which could be material.

In conjunction with the PacifiCare acquisition we committed to make $50 million in charitable contributions to the benefit of California health care consumers, which has been accrued on our Condensed Consolidated Balance Sheets. Additionally, we agreed to invest $200 million in companies who focus on providing services to the underserved populations of the California marketplace. The timing and amount of individual contributions and investments are at our discretion subject to the advice and oversight of the local regulatory authorities; however, our goal is to have the investment commitment fully funded by the end of 2010. The investment commitment remains in place for 20 years after funding. We have committed to specific projects totaling $12 million of the $50 million charitable commitment at this time.

As previously disclosed in our 2006 Annual Report on Form 10-K, we believe that compensation expense related to prior exercises of certain stock options granted to certain of the Company's executive officers will no longer qualify as deductible performance-based compensation in accordance with Internal Revenue Code Section 162(m) as a result of the revision of measurement dates that occurred as part of our review of the Company's historic stock option matters. For the year ended December 31, 2006, we accrued additional tax liabilities relating to these lost tax deductions of $90 million with corresponding interest of $11 million. Although we may incur other penalties relating to this tax matter, we do not expect any additional amounts to be material.

14. Recent Accounting Standards

Recently Adopted Accounting Standards

In June 2006, the FASB issued Interpretation No. 48 (FIN 48), "Accounting for Uncertainty in Income Taxes – an interpretation of FASB Statement No. 109". FIN 48 clarifies the accounting for income taxes by prescribing a minimum recognition threshold a tax position is required to meet before being recognized in the financial statements. FIN 48 also provides guidance on derecognition, measurement, classification, interest and penalties, disclosure and transition. We have adopted FIN 48 as of January 1, 2007.

The cumulative effect of adopting FIN 48 has resulted in an increase to our liability for unrecognized tax benefits of $88 million, which was accounted for as a reduction of $62 million in retained earnings and an increase of $26 million in goodwill. The total amount of unrecognized tax benefits as of the date of adoption is $341 million.

The total amount of unrecognized tax benefits as of the date of adoption that, if recognized, would affect the effective tax rate is $128 million. We classify interest and penalties associated with uncertain income tax positions as income taxes within our consolidated financial statements. The total amount of accrued interest as of the date of adoption is $34 million, and has not been included in the total unrecognized tax benefits amount discussed above. No amount has been accrued for penalties.

We currently file income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. With the exception of a few states, we are no longer subject to income tax examinations prior to 2001 in major tax jurisdictions.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

We do not have any individual uncertain tax positions that are expected to significantly increase or decrease within twelve months of March 31, 2007.

Recently Issued Accounting Standards

In September 2006, the FASB issued FAS No. 157, "Fair Value Measurements" (FAS 157), which establishes a framework for reporting fair value and expands disclosures about fair value measurements. FAS 157 is effective for our 2008 fiscal year. We are currently evaluating the impact of this standard on our Condensed Consolidated Financial Statements.

In February 2007, the FASB issued FAS No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities" (FAS 159). FAS 159 permits an entity to elect fair value as the initial and subsequent measurement attribute for many financial assets and liabilities. Entities electing the fair value option would be required to recognize changes in fair value in earnings. Entities electing the fair value option are required to distinguish on the face of the statement of financial position, the fair value of assets and liabilities for which the fair value option has been elected and similar assets and liabilities measured using another measurement attribute. FAS 159 is effective for our fiscal year 2008. The adjustment to reflect the difference between the fair value and the carrying amount would be accounted for as a cumulative-effect adjustment to retained earnings as of the date of initial adoption. We are currently evaluating the impact, if any, of FAS 159 on our Consolidated Financial Statements.

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

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

Summary highlights of our first quarter 2007 results include:

- Diluted net earnings per common share of $0.66, an increase of 5% from $0.63 per share reported in the first quarter of 2006.
- Consolidated revenues of $19.0 billion increased $1.5 billion, or 8%, over the first quarter of 2006.
- Earnings from operations of $1.6 billion, up $109 million, or 7%, over the prior year.
- Cash flows from operations of $2.6 billion during the first quarter of 2007, a decrease of $302 million, or 10%, compared to $2.9 billion during the first quarter of 2006.
- The consolidated medical care ratio of 82.7% increased from 82.1% in the first quarter of 2006.
- The operating cost ratio of 14.0% for the first quarter of 2007 improved from 14.4% in the first quarter of 2006.
- First quarter 2007 results include $176 million ($112 million net of tax benefit) of expenses related to Section 409A of the Internal Revenue Code involving the Company's payment of certain employees' tax obligations under Section 409A for options exercised in 2006 and early 2007 as well as the modification expense for increasing the exercise price of unexercised stock options granted to nonexecutive officers. These matters are discussed more fully in the "Operating Costs" section of Management's Discussion and Analysis of Financial Condition and Results of Operations.

	Three Months Ended March 31,		
(In millions, except per share data)	**2007**	**2006**	**Percent Change**
Revenues	$19,047	$17,581	8%
Earnings from Operations	$ 1,582	$ 1,473	7%
Net Earnings	$ 927	$ 891	4%
Diluted Net Earnings Per Common Share	$ 0.66	$ 0.63	5%
Medical Care Ratio	82.7%	82.1%	
Operating Cost Ratio	14.0%	14.4%	
Return on Equity (annualized)	17.7%	20.2%	
Operating Margin	8.3%	8.4%	

Recent Leadership Additions

- On April 17, 2007, the Board of Directors of the Company appointed Robert J. Darretta to serve as a director of the Company. Mr. Darretta is the former vice chairman and chief financial officer of Johnson & Johnson.
- On April 24, 2007, the Company announced that it has appointed Thomas L. Strickland as Executive Vice President and Chief Legal Officer, effective May 28, 2007. Mr. Strickland will be responsible for overseeing all legal matters for the Company. Previously, Mr. Strickland was the managing partner of the Colorado offices of the Hogan and Hartson law firm and a member of the firm's executive committee.

Results of Operations

Consolidated Financial Results

Revenues

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

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers' health care services and related administrative costs. Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. For both premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; customer, consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals. Through our Prescription Solutions pharmacy benefit management (PBM) business, revenues are derived from both products sold and administrative services. Product revenues are recognized upon sale or shipment because the price is fixed and the member cannot return the drugs or receive a refund. Service revenues are recognized when the prescription claim is adjudicated. Product revenues also include sales of Ingenix syndicated content products, which are recognized as revenue upon shipment.

Consolidated revenues increased by $1.5 billion, or 8%, year-over-year in the first quarter of 2007 to $19.0 billion driven primarily by rate increases on premium-based and fee-based services, growth in the total number of individuals served and growth in our Medicare Part D program. Following is a discussion of first quarter consolidated revenue trends for each of our revenue components.

Premium Revenues

Consolidated premium revenues totaled $17.5 billion in the first quarter of 2007, an increase of $1.3 billion, or 8%, over the first quarter of 2006.

UnitedHealthcare premium revenues increased by $187 million, or 2%, to $8.5 billion in the first quarter of 2007. This increase was primarily driven by average net premium rate increases of 7% to 8% on UnitedHealthcare's renewing commercial risk-based products and by premiums from businesses acquired since the beginning of 2006, partially offset by a decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations premium revenues increased by $932 million, or 16%, to $6.9 billion in the first quarter of 2007. The increase was driven primarily by an increase in the number of individuals served by Medicare Advantage and Medicare supplement products and the related rate increases on these products and continued growth in the Medicare Part D program. Specialized Care Services premium revenues increased by approximately $72 million, or 9%, in the first quarter of 2007 over the comparable period of 2006. The increase was primarily due to the strong growth in the number of individuals served by several Specialized Care Services' businesses under premium-based arrangements. The remaining premium revenue increase was primarily driven by AmeriChoice's Medicaid programs which contributed premium revenue increases of $84 million, or 10%, over the first quarter of 2006 due primarily to a combination of rate increases and an increase in the number of individuals served.

Service Revenues

Service revenues during the first quarter of 2007 totaled $1.1 billion, an increase of $78 million, or 8%, over the first quarter of 2006. The increase in service revenues was driven primarily by aggregate growth of 3% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements since the first quarter of 2006, as well as annual rate increases. In addition, Ingenix service revenues increased by

approximately 26% due to new business growth in the health information and contract research businesses and from businesses acquired since the beginning of 2006.

Product Revenues

Product revenues during the first quarter of 2007 totaled $197 million, an increase of $32 million, or 19%, over the comparable period of 2006. This was primarily due to increased pharmacy revenues at our PBM business.

Investment and Other Income

Investment and other income during the first quarter of 2007 totaled $270 million, representing an increase of $71 million from the comparable period in 2006. Interest income increased by $98 million in the first quarter of 2007 from the comparable period in 2006, principally due to the impact of increased levels of cash and fixed-income investments, due in part to the reduced level of share repurchases, as well as higher yields on fixed-income investments. Net capital losses on sales of investments were $1 million in the first quarter of 2007 compared with net capital gains of $26 million in the first quarter of 2006.

Medical Costs

The combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts is reflected in the medical care ratio (medical costs as a percentage of premium revenues). The consolidated medical care ratio increased from 82.1% in the first quarter of 2006 to 82.7% in the first quarter of 2007. The medical care ratio increase resulted primarily from an increase in UnitedHealthcare's commercial medical care ratio due largely to a shift from favorable medical cost development in the first quarter of 2006 to unfavorable medical cost development in the first quarter of 2007 within this business unit and growth in the Medicare Part D program, which carries a higher medical care ratio than the historic UnitedHealth Group businesses, partially offset by a decrease in the medical care ratio related to Ovations Medicare programs.

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. Medical costs for the first quarter of 2007 include approximately $180 million of favorable medical cost development related to prior fiscal years. Medical costs for the first quarter of 2006 also include approximately $220 million of favorable medical cost development related to prior fiscal years. This decrease was primarily the result of UnitedHealthcare experiencing favorable development in the first quarter of 2006 and unfavorable development in the first quarter of 2007. This unfavorable development was partially driven by costs from higher benefit utilization in December 2006 relating primarily to our high-deductible risk-based products.

Medical costs for first quarter 2007 increased $1.2 billion, or 9%, to $14.4 billion, due primarily to an annual medical cost trend of 7% to 8% on commercial risk-based business due to both medical cost inflation and increases in health care consumption as well as growth in the Medicare Part D program.

Operating Costs

The operating cost ratio (operating costs as a percentage of total revenues) for the first quarter of 2007 was 14.0%, down from 14.4% in the comparable 2006 period. This decrease was primarily driven by productivity gains from technology deployment and other cost management initiatives, including cost savings associated with the PacifiCare acquisition integration, partially offset by expenses associated with Section 409A of the Internal Revenue Code (Section 409A), as described below.

Operating costs for the first quarter of 2007 totaled $2.7 billion, an increase of $133 million, or 5%, over the first quarter of 2006. This increase was primarily due to expenses associated with Section 409A, as described below.

Also contributing to the change in operating costs were revenue growth and general operating cost inflation, more than offset by productivity gains from technology deployment and other cost management initiatives, including cost savings associated with PacifiCare acquisition integration.

Included in the operating costs for the first quarter of 2007 is $176 million ($112 million net of tax benefit) of expenses related to Section 409A. As part of our review of the Company's historic stock option practices, we determined that certain stock options granted to nonexecutive officer employees were granted with an exercise price that was lower than the closing price of our common stock on the applicable accounting measurement date, subjecting these individuals to additional tax under Section 409A. The Company elected to pay these individuals' additional tax costs for 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 officers under its 2002 Stock Incentive Plan, 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. The payments will be made on a quarterly basis upon vesting of the applicable awards, beginning in January 2008. Aggregate payments, assuming all applicable options vest, will be approximately $150 million. If the modified stock options are subsequently exercised, the Company will recover these cash payments from exercise proceeds at the revised increased stock option exercise prices.

The $176 million 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 officers and the related cash payments. These amounts have been recorded as corporate expenses and have not been allocated to individual business segments.

As previously disclosed, on December 29, 2006, the Company entered into agreements to increase the exercise price of outstanding stock options with all individuals who were executive officers of the Company at the time of grant of an applicable stock option. No compensation was payable to any of those individuals.

Cost of Products Sold

Cost of products sold during the first quarter of 2007 totaled $170 million, an increase of $33 million, or 24%, over the comparable period of 2006. This was primarily due to costs associated with increased pharmacy sales at our PBM business.

Depreciation and Amortization

Depreciation and amortization was $191 million and $157 million for the three-month periods ended March 31, 2007 and 2006, respectively. The $34 million increase is primarily related to higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2006 as well as separately identifiable intangible assets acquired in business acquisitions since the beginning of 2006.

Income Taxes

Our effective income tax rate increased to 36.8% in the first quarter of 2007 from 35.9% for the first quarter of 2006 largely due to business and income mix in states with differing income tax rates.

Business Segments

The following summarizes the operating results of our business segments for three-month periods ended March 31 (in millions):

Revenues

	Three Months Ended March 31,		
	2007	2006	Percent Change
Health Care Services	$17,092	$15,795	8%
Uniprise	1,439	1,334	8%
Specialized Care Services	1,113	981	13%
Ingenix	263	208	26%
Eliminations	(860)	(737)	nm
Consolidated Revenues	$19,047	$17,581	8%

nm = not meaningful

Earnings from Operations

	Three Months Ended March 31,		
	2007	2006	Percent Change
Health Care Services	$1,300	$1,057	23%
Uniprise	215	209	3%
Specialized Care Services	205	177	16%
Ingenix	38	30	27%
Corporate	(176)	—	nm
Consolidated Earnings from Operations	$1,582	$1,473	7%

nm = not meaningful

Health Care Services

The Health Care Services segment, comprised of the UnitedHealthcare, Ovations and AmeriChoice businesses, had first quarter 2007 revenues of $17.1 billion, representing an increase of $1.3 billion, or 8%, over the first quarter of 2006.

UnitedHealthcare revenues increased by $203 million, or 2%, to $8.9 billion in the first quarter of 2007. This increase was driven mainly by average net premium rate increases of 7% to 8% on UnitedHealthcare's renewing commercial risk-based products, an increase in the number of individuals served by UnitedHealthcare's fee-based products and business acquired since the beginning of 2006, partially offset by a decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations revenues increased by $1.0 billion, or 16%, to $7.2 billion in the first quarter of 2007. This increase was driven primarily by an increase in the number of individuals served by Medicare Advantage and Medicare supplement products, rate increases on these products and growth in our Medicare Part D program. The remaining increase in Health Care Services revenues is attributable to an $88 million, or 10%, increase in AmeriChoice revenues which were due primarily to a combination of rate increases and an increase in the number of individuals served by Medicaid products.

The Health Care Services segment had first quarter 2007 earnings from operations of $1.3 billion, representing an increase of $243 million, or 23%, over the first quarter of 2006. This increase was principally driven by earnings from increases in the number of individuals served by Ovations' Medicare products and UnitedHealthcare's fee-based products as well as a decrease in the medical care ratio related to Ovations Medicare programs due to favorable medical cost trends, partially offset by a decrease in individuals served by UnitedHealthcare's commercial risk-based products and an increase in the related medical care ratio. UnitedHealthcare's commercial medical care ratio increased to 81.2% in the first quarter of 2007 from 79.4% in the first quarter of 2006, mainly due to a shift from favorable medical cost development of approximately $90 million in the first quarter of 2006 to unfavorable medical cost development of approximately $100 million in the first quarter of 2007. This was partially driven by higher benefit utilization in December 2006 relating primarily to UnitedHealthcare's high-deductible risk-based products. Health Care Services' first quarter 2007 operating margin was 7.6%, an increase of 90 basis points over the first quarter of 2006, which reflected productivity gains from technology deployment and disciplined operating cost management.

The following table summarizes individuals served by Health Care Services, by major market segment and funding arrangement, as of March 31 (in thousands) (1):

	2007	2006
Commercial		
Risk-based	9,800	9,955
Fee-based	4,775	4,600
Total Commercial	14,575	14,555
Medicare Advantage	1,310	1,295
Medicare Part D Stand-alone	4,640	3,315
Medicaid	1,445	1,345
Total Health Care Services	21,970	20,510

(1) Excludes individuals served by Ovations' Medicare supplement products provided to AARP members as well as Medicare institutional and Medicaid long-term care members.

The number of individuals served by UnitedHealthcare's commercial business as of March 31, 2007 increased 20,000 over the first quarter of 2006. This included an increase of approximately 175,000 in the number of individuals served with commercial fee-based products, driven by new customer relationships and customers converting from risk-based products to fee-based products, offset by a decrease of approximately 155,000 in the number of individuals served with commercial risk-based products due primarily to the Company's internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of individuals to fee-based products.

The number of individuals served by Ovations' Medicare Advantage products increased by 15,000 from the first quarter of 2006 due to new customer relationships. The number of individuals served by Medicare Part D increased by 1.3 million from the first quarter of 2006 to the first quarter of 2007 due to new customer relationships gained in the initial contract year of the program. AmeriChoice's Medicaid enrollment increased by 100,000 due to new customer gains as well as from acquisitions completed since the first quarter of 2006.

Uniprise

Uniprise revenues in the first quarter of 2007 were $1.4 billion, representing an increase of $105 million, or 8%, over the 2006 comparable period. The increase in revenue was driven primarily by growth of 2% in the number of individuals served by Uniprise in the first quarter of 2007 and annual rate increases related to both risk-based

and fee-based arrangements. Uniprise served 11.2 million and 10.9 million individuals as of March 31, 2007 and 2006, respectively.

Uniprise first quarter 2007 earnings from operations were $215 million, an increase of $6 million, or 3%, over the first quarter of 2006. Operating margin decreased to 14.9% in the first quarter of 2007 from 15.7% in the comparable 2006 period. Operating results were affected by an increase in operating costs aimed at advancing service levels and supporting strategic growth initiatives on an enterprise-wide basis.

Specialized Care Services

Specialized Care Services had revenues of $1.1 billion in the first quarter of 2007, an increase of $132 million, or 13%, over the comparable 2006 period. This increase was principally driven by strong growth in the number of individuals served and rate increases.

Earnings from operations in the first quarter of 2007 of $205 million increased $28 million, or 16%, over the first quarter of 2006. Specialized Care Services' operating margin improved to 18.4% in the first quarter of 2007 from 18.0% in the comparable 2006 period. This improvement was due to operational and productivity improvements within Specialized Care Services' businesses, which more than offset a business mix shift toward higher revenue, lower margin products.

Ingenix

Ingenix revenues in the first quarter of 2007 of $263 million increased by $55 million, or 26%, over the comparable 2006 period due primarily to new business growth in the health information and contract research businesses as well as revenue from businesses acquired since the beginning of 2006.

Earnings from operations were $38 million in the first quarter of 2007, up $8 million, or 27%, from the comparable 2006 period. The operating margin was unchanged at 14.4% from the first quarter of 2006. The increase to earnings from operations was driven primarily by growth in the health information and contract research businesses and earnings from businesses acquired since the beginning of 2006. Ingenix typically generates higher revenues and operating margins in the second half of the year due to seasonally strong demand for higher margin health information products.

Financial Condition and Liquidity at March 31, 2007

Liquidity and Capital Resources

We manage our cash, investments and capital structure so we are able to meet the short- and long-term obligations of our business while maintaining strong financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from operations. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceed our short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. Factors we consider in making these investment decisions include our Board of Directors' approved investment policy, regulatory limitations, return objectives, tax implications, risk tolerance and maturity dates. Our long-term investments are also available for sale to meet short-term liquidity and other needs. Cash in excess of the capital needs of our regulated entities are paid to their non-regulated parent companies, typically in the form of dividends, for general corporate use, when and as permitted by applicable regulations.

Our non-regulated businesses also generate significant cash flows from operations for general corporate use. Cash flows generated by these entities, combined with the issuance of commercial paper, long-term debt and the

availability of committed credit facilities, further strengthen our operating and financial flexibility. We generally use these cash flows to reinvest in our businesses in the form of capital expenditures, to expand the depth and breadth of our services through business acquisitions, and to repurchase shares of our common stock, depending on market conditions.

Cash flows generated from operating activities, our primary source of liquidity, are principally from net earnings, prior to depreciation and amortization and other non-cash expenses. As a result, any future decline in our profitability may have a negative impact on our liquidity. The level of profitability of our risk-based insured business depends in large part on our ability to accurately predict and price for health care and operating cost increases. This risk is partially mitigated by the diversity of our other businesses, the geographic diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs. In 2006, a hypothetical unexpected 1% increase in commercial insured medical costs would have reduced net earnings by approximately $170 million.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, debt covenants and other contractual restrictions, regulatory requirements and market conditions. We believe that our strategies and actions toward maintaining financial flexibility mitigate much of this risk.

Cash and Investments

We maintained a strong financial condition and liquidity position, with cash and investments of $22.9 billion at March 31, 2007. Total cash and investments increased by $2.3 billion since December 31, 2006, primarily due to strong operating cash flows and funds received from CMS under the Medicare Part D program in advance of required benefit payments, partially offset by share repurchases, repayments on debt and capital expenditures.

As further described under Regulatory Capital and Dividend Restrictions, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At March 31, 2007, approximately $1.5 billion of our $22.9 billion of cash and investments was held by non-regulated subsidiaries and was available for general corporate use, including acquisitions and share repurchases.

Cash flows from operating activities were $2.6 billion in the first quarter of 2007, representing a decrease over the comparable 2006 period of $302 million, or 10%, due to a reduction in working capital of $633 million partially offset by an increase of $331 million in net income excluding depreciation, amortization and other noncash items. The decrease in working capital resulted primarily from growth in the Medicare Part D business and the related risk-share receivables in the first quarter of 2007. Additionally, first quarter 2006 operating cash flows benefited from the initial establishment of the medical costs payable balance related to this program. First quarter 2007 and 2006 operating cash flows included $1.5 billion and $1.3 billion, respectively, of advanced receipts related to the April Medicare premium payments from CMS.

As a result of our announcement in November 2006 that our previously issued financial statements should no longer be relied upon, we were unable to issue shares registered under the Securities Act of 1933, as amended, under our employee stock plans and we temporarily suspended any exercise of stock options until we became current in our SEC filings. To address the impact to holders of options that would expire or terminate during the suspension period, the Company offered cash settlement of the affected awards. This resulted in additional stock compensation expense for the fourth quarter of 2006 of $31 million. This amount was paid in full during the first quarter of 2007.

Financing and Investing Activities

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of March 31, 2007 and December 31, 2006, we had

commercial paper and debt outstanding of approximately $7.1 billion and $7.5 billion, respectively. Our debt-to-total-capital ratio was 25.1% and 26.4% as of March 31, 2007 and December 31, 2006, respectively. We believe the prudent use of debt optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

As of March 31, 2007, our outstanding commercial paper had interest rates ranging from 5.3% to 5.4%.

In March 2006, we refinanced commercial paper by issuing $650 million of floating-rate notes due March 2009, $750 million of 5.3% fixed-rate notes due March 2011, $750 million of 5.4% fixed-rate notes due March 2016 and $850 million of 5.8% fixed-rate notes due March 2036. The floating-rate notes due March 2009 are benchmarked to the London Interbank Offered Rate (LIBOR) and had an interest rate of 5.4% at March 31, 2007.

In December 2005, we amended and restated our $1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the credit facility to $1.3 billion and extended the maturity date to December 2010. As of March 31, 2007 we had no amounts outstanding under our $1.3 billion credit facility.

To more closely align interest costs with the floating interest rates received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from fixed rates to variable rates. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of $4.9 billion with variable rates that are benchmarked to the LIBOR, and are recorded on our Condensed Consolidated Balance Sheets. The aggregate liability recorded for all existing swaps was $49 million as of March 31, 2007. These fair value hedges are accounted for using the short-cut method under Statement of Financial Accounting Standards No. 133, "Accounting for Derivative Instruments and Hedging Activities," whereby the hedges are reported on our Condensed Consolidated Balance Sheet at fair value, and the carrying value of the long-term debt is adjusted for an offsetting amount representing changes in fair value attributable to the hedged risk. Since these amounts completely offset, we have reported both the swap liability and the debt liability within debt on our Condensed Consolidated Balance Sheet and there have been no net gains or losses recognized in our Condensed Consolidated Statements of Operations. At March 31, 2007, the rates used to accrue interest expense on these agreements ranged from 4.7% to 5.5%.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 50%. After giving effect to the credit agreement amendments and waivers that we obtained from our lenders, we believe we are in compliance with the requirements of all debt covenants. On August 28, 2006, we received a purported notice of default from persons claiming to hold certain of our debt securities alleging a violation of our indenture governing our debt securities. This followed our announcement that we would delay filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. On or about November 2, 2006, we received a purported notice of acceleration from the holders who previously sent the notice of default that purports to declare an acceleration of our 5.8% Senior Unsecured Notes due March 15, 2036 as a result of our not timely filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. Our indenture requires us to provide to the trustee copies of the reports we are required to file with the SEC, such as our quarterly reports, within 15 days of filing such reports with the SEC. On October 25, 2006, we filed an action in the United States District Court for the District of Minnesota seeking a declaratory judgment that we are not in default under the terms of the indenture. We filed our quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006, as well as our annual report on Form 10-K for the year ended December 31, 2006 on March 6, 2007. Should the Company ultimately be unsuccessful in this matter, we may be required to retire all or a portion of the $850 million of Senior Unsecured Notes due March 2036. We intend to prosecute the declaratory judgment action vigorously.

PacifiCare had approximately $100 million par value of 3% convertible subordinated debentures (convertible notes) which were convertible into approximately 5.2 million shares of UnitedHealth Group's common stock and $102 million of cash as of December 31, 2005. In December 2005, we initiated a consent solicitation to all of the holders of outstanding convertible notes pursuant to which we offered to compensate all holders who elected to

convert their notes in accordance with existing terms and consent to an amendment to a covenant in the indenture governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest mandatory redemption date, plus a pro rata share of $1 million. On January 31, 2006, approximately $91 million of the convertible notes were tendered pursuant to the offer, for which we issued 4.8 million shares of UnitedHealth Group common stock, valued at $282 million, and cash of $93 million. On March 28, 2007, approximately $1 million of the convertible notes were tendered for conversion, for which we issued 51,071 shares of UnitedHealth Group common stock, valued at approximately $3 million, and cash of $1 million.

Our senior debt is rated "A" with a negative outlook by Standard & Poor's (S&P), "A" with a stable outlook by Fitch, and "A3" with a negative outlook by Moody's. Our commercial paper is rated "A-1" with a negative outlook by S&P, "F-1" with a stable outlook by Fitch, and "P-2" with a negative outlook by Moody's. A significant downgrade in our debt or commercial paper ratings could adversely affect our borrowing capacity and costs. See " — Cautionary Statements Relating to Our Historic Stock Option Practices — Credit Ratings" for additional information.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the three months ended March 31, 2007, we purchased 16.5 million shares which were settled for cash on or before March 31, 2007 at an average price of approximately $55 per share and an aggregate cost of approximately $903 million. As of March 31, 2007, we had Board of Directors' authorization to purchase up to an additional 115.7 million shares of our common stock. Our common stock repurchase program is discretionary as we are under no obligation to repurchase shares.

We currently have $1.0 billion remaining under our universal S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities), although we will be unable to issue securities registered under the Securities Act of 1933, as amended, on Form S-3 on a primary basis until we have timely filed all reports required to be filed with the SEC for a twelve-month period. After that date, we may publicly offer securities from time to time at prices and terms to be determined at the time of offering. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of 48.6 million shares of our common stock in connection with acquisition activities.

Contractual Obligations, Off-Balance Sheet Arrangements And Commitments

An updated summary of future obligations under our various contractual obligations, off-balance sheet arrangements and commitments as of December 31, 2006 was disclosed in our 2006 Annual Report on Form 10-K filed with the Securities and Exchange Commission. During the quarter ended March 31, 2007, there were no significant changes to the amounts of these obligations other than those items disclosed under the "Financial Condition and Liquidity at March 31, 2007" section. However, we continually evaluate opportunities to expand our operations. This includes internal development of new products, programs and technology applications, and may include acquisitions.

In conjunction with the PacifiCare acquisition we committed to make $50 million in charitable contributions to the benefit of California health care consumers, which has been accrued on our Condensed Consolidated Balance Sheets. Additionally, we agreed to invest $200 million in California's health care infrastructure to further health care services to the underserved populations of the California marketplace. The timing and amount of individual contributions and investments are at our discretion subject to the advice and oversight of the local regulatory authorities; however, our goal is to have the investment commitment fully funded by the end of 2010. The investment commitment remains in place for 20 years after funding. We have committed to specific projects totaling $12 million of the $50 million charitable commitment at this time.

As previously disclosed in our 2006 Annual Report on Form 10-K, we believe that compensation expense related to prior exercises of certain stock options granted to certain of the Company's executive officers will no longer qualify as deductible performance-based compensation in accordance with Internal Revenue Code Section 162(m) as a result of the revision of measurement dates that occurred as part of the review of the Company's historic stock option matters. For the year ended December 31, 2006, we accrued additional tax liabilities relating to these lost tax deductions of $90 million with corresponding interest of $11 million. Although we may incur other penalties relating to this tax matter, we do not expect any additional amounts to be material.

Medicare Part D Pharmacy Benefits Contract

Beginning January 1, 2006, the Company began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with the Centers for Medicare & Medicaid Services ("CMS"). The Company contracts with CMS on an annual basis. Under Medicare Part D, members have access to a standard drug benefit that features a monthly premium, typically with an initial annual deductible, coinsurance of 25% for the member and 75% for the Company up to an initial coverage limit of $2,400 of annual drug costs, no insurance coverage between $2,400 and $5,451 (except the member gets the benefit of the Company's significant drug discounts), and catastrophic coverage for annual drug costs in excess of $5,451 covered approximately 80% by CMS, 15% by the Company and 5% by the member up to an annual out-of-pocket maximum of $3,850.

The Company's contract with CMS includes risk-sharing provisions, wherein CMS retains approximately 75% to 80% of the losses or profits outside a pre-defined risk corridor. The risk-sharing provisions take effect if actual pharmacy benefit costs are more than 2.5% above or below expected cost levels as submitted by the Company in its initial contract application. Contracts are generally non-cancelable by enrollees; however, they may change plans every year between November 15 and December 31 to take effect January 1 of the following year.

As a result of the Medicare Part D benefit design, the Company incurs benefit costs unevenly during the annual contract year. While the Company is responsible for approximately 67% of a Medicare member's drug costs up to $2,400, the member is responsible for 100% of their drug costs from $2,400 up to $5,451 (at the Company's discounted purchase price). Consequently, the Company incurs disproportionately higher benefit claims in the first half of the contract year as compared with last half of the contract year, when comparatively more members will be incurring claims above the $2,400 initial coverage limit. Although the Company also incurs costs for individuals with annual pharmacy claims in excess of $5,451, these costs represent a much smaller portion of total contract costs, and will be incurred primarily in the second half of the year. The uneven timing of Medicare Part D pharmacy benefit claims resulted in first quarter 2007 losses that would entitle the Company to risk-share adjustment payments from CMS. Accordingly, as of and for the three months ended March 31, 2007, we recorded a risk-share receivable from CMS in other current assets in the Condensed Consolidated Balance Sheets and a corresponding retrospective premium adjustment in premium revenues in the Condensed Consolidated Statement of Operations of $206 million. This represents the estimated amount payable by CMS to the Company under the risk-share contract provisions if the program were terminated at March 31, 2007 based on estimated costs incurred through that date. The final risk-share amounts due to or from CMS, if any, will be determined approximately six months after the contract year-end.

AARP

In 1998, we began a contract with AARP to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare (Medicare Supplement Insurance), hospital indemnity insurance, health insurance focused on persons between 50 to 64 years of age, and other products. Under the terms of this Supplemental Health Insurance contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings were approximately $5.1 billion over the past twelve months.

The underwriting gains or losses related to the AARP Medicare Supplement Insurance business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. As further described in Note 10 to the Condensed Consolidated Financial statements, the RSF balance is reported in Other Policy Liabilities in the accompanying Condensed Consolidated Balance Sheets. We believe the RSF balance at March 31, 2007 is currently sufficient to cover potential future underwriting and other risks associated with the contract.

Under a separate license agreement with AARP, we sell AARP-branded Medicare Prescription Drug benefit plans. We pay AARP a royalty and assume all operational and underwriting risks.

On April 13, 2007, we entered into an agreement to extend and expand our relationship with AARP for an additional seven years through December 31, 2014. The agreement was expanded to give us a right to use the AARP brand on our Medicare Advantage offerings and to extend our arrangement to use the AARP brand on our Medicare Supplement products and services and Medicare Part D offerings.

Regulatory Capital And Dividend Restrictions

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

In 2006, based on 2005 statutory net income and statutory capital and surplus levels, the maximum amount of dividends which could be paid without prior regulatory approval was approximately $2.2 billion. For the year ended December 31, 2006, the Company's regulated subsidiaries paid over $2.5 billion in dividends to their parent companies, including approximately $300 million of special dividends approved by state insurance regulators. Our regulated subsidiaries have paid us dividends of approximately $431 million through March 31, 2007.

The inability of the Company's regulated subsidiaries to pay dividends to their parent companies would 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. In addition, the inability to pay regulated dividends could impact our ability to repay our debt; however, our cash flows from operating activities generated from our non-regulated businesses greatly mitigate this risk. As of March 31, 2007, approximately $1.5 billion of our $22.9 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use.

Critical Accounting Policies And Estimates

Critical accounting policies are those policies 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 policies involve judgments and uncertainties that are sufficiently sensitive to result in materially different results under different assumptions and conditions. The

following provides a summary of our accounting policies and estimation procedures surrounding medical costs. For a detailed description of all our critical accounting policies, see the Results of Operations section of the Consolidated Financial Statements included in the 2006 Annual Report on Form 10-K.

Medical Costs

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical care services incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, seasonal variances in medical care consumption, provider contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to 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). Historically, the net impact of estimate developments has represented less than 1% of annual medical costs, less than 5% of annual earnings from operations and less than 4% of medical costs payable.

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 the Company as of the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date in order to estimate the expected amount of ultimate incurred claims for those months. We do not believe that completion factors are a reliable basis for estimating claims incurred for the most recent three months as there is typically insufficient claim data available for those months to calculate credible completion factors. Accordingly, 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 for which more complete claim data is available 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 completion factors in developing medical cost estimates for the most recent months. 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 March 31, 2007:

Completion Factor Increase (Decrease) in Factor	Increase (Decrease) in Medical Costs Payable (1) (in millions)
(0.75)%	$ 135
(0.50)%	$ 90
(0.25)%	$ 45
0.25%	$ (45)
0.50%	$ (90)
0.75%	$ (135)

Medical cost PMPM trend factors are the most significant factors we use in estimating our medical costs payable 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 March 31, 2007:

Medical Cost PMPM Trend Increase (Decrease) in Factor	Increase (Decrease) in Medical Costs Payable (2) (in millions)
3%	$ 262
2%	$ 175
1%	$ 87
(1)%	$ (87)
(2)%	$ (175)
(3)%	$ (262)

(1) Reflects estimated potential changes in medical costs and medical costs payable caused by changes in completion factors used in developing medical cost payable estimates for older periods, generally periods prior to the most recent three months.

(2) Reflects estimated potential changes in medical costs and medical costs payable caused by changes in medical costs PMPM trend data used in developing medical cost payable estimates for the most recent three months.

The analyses above include those outcomes that are considered reasonably likely based on the Company's historical experience in estimating its liabilities incurred but not reported benefit claims.

In order to evaluate the impact of changes in medical cost estimates for any particular discrete period, one should consider both the amount of development recorded in the current period pertaining to prior periods and the amount of development recorded in subsequent periods pertaining to the current period. The accompanying table provides a summary of the net impact of favorable development on medical costs and earnings from operations (in millions).

	Favorable Development	Net Impact on Medical Costs (a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted (b)	As Reported	As Adjusted (b)
2004	$ 210	$ (190)	$ 27,858	$ 27,668	$ 3,858	$ 4,048
2005	$ 400	$ (30)	$ 33,669	$ 33,639	$ 5,080	$ 5,110
2006	$ 430	$ 250 (c)	$ 53,308	$ 53,558	$ 6,984	$ 6,734 (c)

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

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

(c) For the first quarter of 2007, the Company recorded net favorable development of $180 million pertaining to 2006. The amount of prior period development in 2007 pertaining to 2006 will change as our December 31, 2006 medical costs payable estimate continues to develop throughout 2007.

Our estimate of medical costs payable represents management's best estimate of the Company's liability for unpaid medical costs as of March 31, 2007, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover the Company's liability for unpaid claims as of March 31, 2007; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our March 31, 2007 estimates of medical costs payable and actual medical costs payable, first quarter 2007 earnings from operations would increase or decrease by $75 million and diluted net earnings per common share would increase or decrease by $0.03 per share.

Inflation

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

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

Concentrations Of Credit Risk

Investments in financial instruments such as marketable securities and accounts receivable may subject UnitedHealth Group to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. Government and Agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups that constitute our customer base. In October 2005, we sold the life insurance and annuity business to OneAmerica Financial Partners, Inc. (OneAmerica) through an indemnity reinsurance arrangement. Under the arrangement, OneAmerica assumes the risks associated with the future policy benefits for the life and annuity contracts. We remain liable for claims if OneAmerica fails to meet its obligations to policy holders. Because we remain primarily liable to the policy holders, the liabilities and obligations associated with the reinsured contracts remain on our Consolidated Balance Sheet with a corresponding reinsurance receivable from OneAmerica of $2.0 billion, of which $1.8 billion is classified in other noncurrent assets as of March 31, 2007. 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 March 31, 2007, there were no other significant concentrations of credit risk.

Cautionary Statements

The statements, estimates, projections, guidance or outlook contained in this Quarterly Report on Form 10-Q include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Quarterly Report on Form 10-Q 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 "believes," "anticipates," "expects," "plans," "seeks," "intends," "will likely result," "estimates," "projects" 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. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-Q 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.

Cautionary Statements Relating to Our Historic Stock Option Practices

Matters relating to or arising out of our historic stock option practices, including regulatory inquiries, litigation matters, downgrades in our credit ratings, and potential additional cash and noncash charges could have a material adverse effect on the Company.

On October 15, 2006, we announced that an Independent Committee of the Board of Directors and its counsel had completed a review of the Company's stock option practices and reported the findings to the non-management directors of the Company. After completing an internal review of the accounting treatment for all stock option grants, we restated previously filed financial statements, we are subject to various regulatory inquiries, litigation matters and credit rating downgrades, and we may be subject to further cash and noncash charges, any or all of which could have a material adverse effect on us.

Regulatory Inquiries

As previously disclosed, the SEC and the U.S. Attorney for the Southern District of New York are conducting investigations into the Company's historic stock option practices and the Company has received requests for documents from the Internal Revenue Service, the Minnesota Attorney General and various Congressional committees in connection with these issues and the Company's executive compensation practices. We have not resolved these matters. We cannot provide assurance that the Company will not be subject to adverse publicity, regulatory or criminal fines, penalties, or other sanctions or contingent liabilities or adverse customer reactions in connection with these matters. See Part II, Item 1 — "Legal Proceedings" for a more detailed description of these inquiries and document requests.

Litigation Matters

We and certain of our current and former directors and officers are defendants in a consolidated federal securities class action, an ERISA class action, and state and federal shareholder derivative actions relating to our historic stock option practices. We also have received shareholder demands relating to those practices. Our Board of Directors has designated an unaffiliated Special Litigation Committee, consisting of two former Minnesota Supreme Court Justices, to investigate and decide whether to pursue the claims raised in the derivative actions and shareholder demands.

In addition, following our announcement that we would delay filing our Quarterly Report on Form 10-Q for the quarter ended June 30, 2006, we received a purported notice of default from persons claiming to hold certain of our debt securities alleging a violation of the indenture governing our debt securities. Subsequently, we filed an action in the U.S. District Court for the District of Minnesota, seeking a declaratory judgment that the Company was not in default. The Company subsequently received a purported notice of acceleration from those persons purporting to declare an acceleration of the Company's 5.80% Senior Unsecured Notes due March 15, 2036, of which an aggregate of $850 million principal amount is outstanding.

In connection with the departure of William W. McGuire, M.D., our former Chairman and Chief Executive Officer, the U.S. District Court for the District of Minnesota issued an Order in November 2006 preliminarily enjoining Dr. McGuire from exercising any Company stock options and the Company and Dr. McGuire from taking any action with respect to Dr. McGuire's employment agreement and related agreements, including making any payments to Dr. McGuire under those agreements.

These actions are in preliminary stages, and we cannot provide assurance that their ultimate outcome will not have a material adverse effect on our business, financial condition or results of operations. See Part II, Item 1 — "Legal Proceedings" for a more detailed description of these proceedings and shareholder demands.

In addition, we may be subject to additional litigation or other proceedings or actions arising out of the Independent Committee's review, the Special Litigation Committee's review and the related restatement of our historical financial statements. Litigation and any potential regulatory proceeding or action may be time consuming, expensive and distracting from the conduct of our business. The adverse resolution of any specific lawsuit or any potential regulatory proceeding or action could have a material adverse effect on our business, financial condition and results of operations.

Credit Ratings

As a result of their concerns related to our historic stock option practices, Moody's downgraded our A2 senior debt rating to A3 with a negative outlook in October 2006 and AM Best downgraded our financial strength ratings from A+ to A with a negative outlook in November 2006. Standard & Poor's and FitchRatings confirmed their existing ratings and their negative outlook (Standard & Poor's) and negative watch (FitchRatings) on the Company's ratings. If our business results deteriorate significantly, or if there is an event, outcome or action as a result of the regulatory inquiries and document requests or the pending civil litigation, which is materially adverse to the Company, our credit ratings may be further downgraded. A significant downgrade in ratings may increase the cost of borrowing for the Company or limit the Company's access to capital.

Potential Additional Cash and Noncash Charges

While we believe we have made appropriate judgments in our restated financial statements in determining the financial and tax impacts of our historic stock option practices, we cannot provide assurance that the SEC or the IRS will agree with the manner in which we have accounted for and reported, or not reported, the financial and tax impacts. If the SEC or the IRS disagrees with our financial or tax adjustments and such disagreement results in material changes to our historical financial statements, we may have to further restate our prior financial statements, amend prior filings with the SEC, or take other actions not currently contemplated.

In addition, other adjustments for non-operating cash charges may be required in connection with the resolution of stock option-related matters arising under litigation and the above-referenced regulatory reviews, the amount and timing of which are uncertain but which could be material.

Cautionary Statements Relating to Our Business

We must effectively manage our health care costs.

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 health care costs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue is typically fixed in price for a 12-month period and is generally priced one to four months before the contract commences. We base the premiums we charge on our estimate of future health care costs over the fixed premium period; however, medical cost inflation, regulations and other factors may cause actual costs to exceed what was estimated and reflected in premiums. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments 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 cost on our financial results, relatively small differences between predicted and actual medical costs or utilization rates as a percentage of premium 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 UnitedHealthcare's commercial insured products, our annual net earnings for 2006 would have been reduced by approximately $170 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. If these estimates prove too high or too low, the effect of the change in estimate will be included in future results. That change can be either positive or negative to our results. Additionally, our participation in the Medicare program is 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 otherwise, our results could be materially affected.

We face competition in many of our markets and customers have flexibility in moving between competitors.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which they operate. For our Uniprise and Health Care Services segments, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., Kaiser Permanente and WellPoint, Inc., numerous for-profit organizations and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and enterprises that serve more limited geographic areas. Our Specialized Care Services and Ingenix segments also compete with a number of businesses. 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 provider 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 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.

Our relationship with AARP is important.

Under our agreements with AARP, we provide AARP-branded Medicare Supplement insurance, hospital indemnity insurance, Medicare Part D prescription drug plans, and other products to AARP members. Our recently renewed agreement with AARP expands the relationship to include AARP-branded Medicare Advantage plans, and contains commitments regarding corporate governance, corporate social responsibility, diversity and measures intended to improve and simplify the health care experience for AARP members. The AARP agreement may be terminated by us or AARP at the end of its term and may also be terminated early under certain circumstances, including a material breach by either party, insolvency of either party, a material adverse change in the financial condition of either party, 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 revenues.

We are subject to funding risks with respect to revenue received from participation in Medicare and Medicaid programs.

We participate as a payer in Medicare Advantage, Medicare Part D, and Medicaid programs and receive revenues from the Medicare and Medicaid programs to provide benefits under these programs. Revenues for these programs are dependent upon annual funding from the federal government or applicable state governments. Funding for these programs is dependent upon many factors outside of our control including general economic conditions at the federal or applicable state level and general political issues and priorities. An unexpected reduction in government funding for these programs may adversely affect our revenues and financial results.

Our business is subject to routine government scrutiny, and we must respond quickly and appropriately to frequent changes in government regulations.

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

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

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

We typically are 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 and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the U.S. Department of Justice and U.S. Attorneys. Such government actions can result in 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. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services.

Relationships with physicians, hospitals and other health care providers are important to our business.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices. In any particular market, these

physicians and health care professionals could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the provider receives a fixed percentage of premium to cover all 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 provider. To the extent that a capitated 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 provider and for which we have already paid the provider under the capitation arrangement.

The nature of our business exposes us to litigation risks.

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, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by provider groups. See Part II, Item 1 — "Legal Proceedings" for a more detailed description of our pending litigation matters.

The Company is largely self-insured with regard to litigation risks; however, we maintain excess liability insurance with outside insurance carriers to minimize risks associated with catastrophic claims. Although we believe that we are adequately insured for claims in excess of our self-insurance, certain types of damages, such as punitive damages, are not covered by insurance. We record liabilities for our estimates of the probable costs resulting from self-insured matters. Although we believe the liabilities established for these risks are adequate, it is possible that the level of actual losses may exceed the liabilities recorded.

Our businesses providing PBM services face regulatory and other risks associated with the pharmacy benefits management industry that may differ from the risks of providing managed care and health insurance products.

In connection with the PacifiCare merger, we acquired a PBM business, Prescription Solutions. We also provide pharmacy benefits management services through UnitedHealth Pharmaceutical Solutions. Prescription Solutions and UnitedHealth Pharmaceutical Solutions are 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. While we do not believe that the PBM is a fiduciary, if a court were to determine that our PBM business acts as a fiduciary under ERISA, we could be subject to claims for alleged breaches of fiduciary obligations in implementation of formularies, preferred drug listings and drug management programs, contracting network practices, specialty drug distribution and other transactions. Our PBM also conducts business as a mail order pharmacy, which subjects it to extensive federal, state and local laws and regulations, as well as risks inherent in the packaging and distribution of pharmaceuticals and other health care products. The failure to adhere to these laws and regulations could expose our PBM subsidiary to civil and criminal penalties. We also face potential claims in connection with purported errors by our mail order pharmacy.

Our businesses depend on effective information systems and the integrity of the data in our information systems.

Our ability to adequately price our products and services, to provide effective and efficient service to our customers, and to accurately report our financial results depends on the integrity of the data in our information systems. As a result of technology initiatives, changes in our system platforms and integration of new business acquisitions, we have been taking steps to consolidate the number of systems we operate and have upgraded and expanded our information systems capabilities. If the information we rely upon to run our businesses were found to be inaccurate or unreliable or if we fail to maintain 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 disputes with customers, physicians and other health care providers, have regulatory problems, have increases in operating expenses or suffer other adverse consequences. In addition, failure to consolidate 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 operating results.

The value of our intangible assets may become impaired.

Due largely to our recent acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately $18.7 billion as of March 31, 2007, representing approximately 40% of our total assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our books. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. Any future evaluations requiring an asset 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.

Our knowledge and information-related businesses depend on our ability to maintain proprietary rights to our databases and related products.

We rely on our agreements with customers, confidentiality agreements with employees, and our 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.

We must comply with restrictions on patient privacy and information security, including taking steps to ensure that our business associates who obtain access to sensitive patient information maintain its confidentiality.

The use of individually identifiable data by our businesses is regulated at the international, federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and disclosure of individually identifiable health data. Most are derived from the privacy and security provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA also requires that we impose privacy and security requirements on our business associates (as this term is defined in the HIPAA regulations). Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Compliance with these proposals, requirements, and new regulations may result in cost increases due to necessary systems changes, the development of new administrative processes, and the effects of potential noncompliance by our business associates. They also may impose further restrictions on our use of patient identifiable data that is housed in one or more of our administrative databases.

Item 3. ***Quantitative And Qualitative Disclosures About Market Risk***

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

Approximately $10.5 billion of our investments at March 31, 2007 were debt securities. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed-income investment portfolio at March 31, 2007, the fair value of our fixed-income investments would decrease or increase by approximately $360 million. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

To mitigate the financial impact of changes in interest rates, we have entered into interest rate swap agreements to more closely match the interest rates of our long-term debt with those of our cash equivalents and short-term investments. Including the impact of our interest rate swap agreements, approximately $6.2 billion of our commercial paper and debt had variable rates of interest and $1.3 billion had fixed rates as of March 31, 2007. A hypothetical 1% increase or decrease in interest rates would not be material to the fair value of our commercial paper and debt.

At March 31, 2007, we had $363 million of equity investments, a portion of which were held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures

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) 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-Q, 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 March 31, 2007. 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 March 31, 2007.

Changes in Internal Control Over Financial Reporting

There have been no changes in the Company's internal control over financial reporting that occurred during the Company's quarter ended March 31, 2007 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***

Legal Matters Relating to Our Historic Stock Option Practices

Regulatory Inquiries

In March 2006, we received an informal inquiry from the SEC relating to our historic stock option practices.

On May 17, 2006, we received a document request from the Internal Revenue Service seeking documents relating to stock option grants and other compensation for the persons who from 2003 to the present were the named executive officers in our annual proxy statements.

On May 17, 2006, we received a subpoena from the U.S. Attorney for the Southern District of New York requesting documents from 1999 to the present relating to our stock option practices.

On June 6, 2006, we received a Civil Investigative Demand from the Minnesota Attorney General requesting documents from January 1, 1997 to the present concerning our executive compensation and stock option practices. After filing an action in Ramsey County Court, State of Minnesota, captioned *UnitedHealth Group Incorporated vs. State of Minnesota, by Lori Swanson, Attorney General*, we filed a Motion for Protective Order which was denied by the trial court. We are pursuing an appeal of the Order denying the Protective Order.

On December 19, 2006, we received from the SEC staff a formal order of investigation into the Company's historic stock option practices.

We have also received requests for documents from U.S. Congressional committees relating to our historic stock option practices and compensation of executives. With the exception of the Civil Investigative Demand from the Minnesota Attorney General, we have generally cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of these regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or other contingent liabilities, which could be material.

Litigation Matters

On March 29, 2006, the first of several shareholder derivative actions was filed against certain of our current and former officers and directors in the United States District Court for the District of Minnesota. The action has been consolidated with six other actions and is captioned *In re UnitedHealth Group Incorporated Shareholder Derivative Litigation*. The consolidated amended complaint is brought on behalf of the Company by several pension funds and other shareholders and names certain of our current and former directors and officers as defendants, as well as the Company as a nominal defendant. The consolidated amended complaint generally alleges that defendants breached their fiduciary duties to the Company, were unjustly enriched, and violated the securities laws in connection with our historic stock option practices. The consolidated amended complaint seeks unspecified money damages, injunctive relief and rescission of the options. On June 26, 2006, our 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 a shareholder demand, and determine whether the Company's rights and remedies should be pursued. Defendants have moved to dismiss or in the alternative to stay the litigation pending resolution of the Special Litigation Committee process. In an Order dated March 14, 2007, the Court stayed the action, but allowed limited discovery, which the Court is supervising. On April 30, 2007, the United States moved to intervene in this action to limit certain discovery. That motion is scheduled to be heard on May 21, 2007. A consolidated derivative action, reflecting a consolidation of two actions, is also pending in Hennepin County District Court, State of Minnesota. The consolidated complaint is captioned *In re UnitedHealth Group Incorporated Derivative Litigation*. The action was brought by two individual shareholders and names certain of our current and former

officers and directors as defendants, as well as the Company as nominal defendant. On February 6, 2007, the state court judge entered an order staying the action pending resolution of the Special Litigation Committee process.

On May 5, 2006, the first of seven putative class actions alleging a violation of the federal securities laws was brought by an individual shareholder against certain of our current and former officers and directors in the United States District Court for the District of Minnesota. On December 8, 2006, a consolidated amended complaint was filed consolidating the actions into a single action. The action is captioned *In re UnitedHealth Group Incorporated PSLRA Litigation*. The action was brought by lead plaintiff California Public Employees Retirement System against the Company and certain of our current and former officers and directors. The consolidated amended complaint alleges that defendants, in connection with the same alleged course of conduct identified in the shareholder derivative actions described above, made misrepresentations and omissions during the period between January 20, 2005 and May 17, 2006, in press releases and public filings that artificially inflated the price of our common stock. The consolidated amended complaint also asserts that during the class period, certain defendants sold shares of our common stock while in possession of material, non-public information concerning the matters set forth in the complaint. The consolidated amended complaint alleges claims under Sections 10(b), 14(a), 20(a) and 20A of the Securities and Exchange Act of 1934 and Sections 11 and 15 of the Securities Act of 1933. The action seeks unspecified money damages and equitable relief. Defendants moved to dismiss the consolidated amended complaint on February 6, 2007. We intend to vigorously defend against the action.

On June 6, 2006, a purported class action captioned *Zilhaver v. UnitedHealth Group Incorporated*, was filed against the Company and certain of our current and former officers and directors in the United State District Court for the District of Minnesota. On May 1, 2007, plaintiffs amended the complaint. This action alleges that the fiduciaries to the Company-sponsored 401(k) plan violated ERISA by allowing the plan to continue to hold company stock. Defendants intend to move to dismiss the action. We intend to vigorously defend against the action.

On August 28, 2006, we received a purported notice of default from persons claiming to hold certain of our debt securities alleging a violation of our indenture governing our debt securities. This follows our announcement that we would delay filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. On October 25, 2006, we filed an action in the United States District Court for the District of Minnesota, captioned *UnitedHealth Group Incorporated v. Cede & Co. and the Bank of New York*, seeking a declaratory judgment that we are not in default under the terms of the indenture. On or about November 2, 2006, we received a purported notice of acceleration from the holders who previously sent the notice of default that purports to declare an acceleration of our 5.8% Senior Unsecured Notes due March 15, 2036 as a result of our not timely filing our quarterly report on Form 10-Q for the quarter ended June 30, 2006. Should the Company ultimately be unsuccessful in this matter, we may be required to retire all or a portion of the $850 million of Senior Unsecured Notes due March 2036. We intend to vigorously prosecute the declaratory judgment action.

Other Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving the Company and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and the

Racketeer Influenced Corrupt Organization Act (RICO) in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare, and on June 19, 2006, the trial court dismissed all remaining claims against UnitedHealthcare brought by the lead plaintiff. The tag-along lawsuits remain outstanding. On July 27, 2006, the plaintiffs filed a notice of appeal to the Eleventh Circuit Court of Appeals challenging the dismissal of the claims against UnitedHealthcare. We intend to vigorously defend against the action.

On March 15, 2000, the American Medical Association filed a lawsuit against the Company in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by the American Medical Association, a third amended complaint was filed on January 11,2002. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations. On December 29, 2006, the trial court granted plaintiffs' motion to amend the complaint. We intend to vigorously defend against the action.

Government Regulation

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

We typically have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare & Medicaid Services (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 Department of Justice, and U.S. Attorneys. Such government actions can result in 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. We are also subject to investigations of our historic stock option practices by the SEC, IRS, U.S. Attorney for the Southern District of New York, and Minnesota Attorney General, and a related review by the Special Litigation Committee of the Company, and we have received requests for documents from U.S. Congressional committees as described in "Legal Matters Relating to Our Historic Stock Option Practices" above. We generally have

cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of these regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or other contingent liabilities, which could be material. With the exception of the Civil Investigative Demand from the Minnesota Attorney General, we generally have cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of the regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or other contingent liabilities which could be material.

In conjunction with the PacifiCare acquisition we committed to make $50 million in charitable contributions to the benefit of California health care consumers, which has been accrued on our Consolidated Balance Sheet. Additionally, we agreed to invest $200 million in companies who focus on providing services to the underserved populations of the California marketplace. The timing and amount of individual contributions and investments are at our discretion subject to the advice and oversight of the local regulatory authorities; however, our goal is to have the investment commitment fully funded by the end of 2010. The investment commitment remains in place for 20 years after funding. We have committed to specific projects totaling $12 million of the $50 million charitable commitment at this time.

Item 1A. ***Risk Factors***

A description of our risk factors is included in Part I, Item 2 — "Management's Discussion and Analysis of Financial Condition and Results of Operations — Cautionary Statements" and is incorporated by reference herein. The description updates and replaces the risk factors previously disclosed in our Annual Report on Form 10-K for the year ended December 31, 2006. Set forth below is a summary of the material changes to the risk factors that we previously disclosed:

- We have updated the risk factors relating to our relationship with AARP; and
- To the extent applicable, we have updated the numbers in the risk factors to reflect financial results as of March 31, 2007.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities (1)
First Quarter 2007

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
January 31, 2007	1,770 (2)	$ 52.13	—	136,650,000
February 28, 2007	1,927 (2)	$ 53.21	—	136,650,000
March 31, 2007	21,000,000 (3)	$ 54.45	21,000,000	115,650,000
TOTAL	21,003,697	$ 54.45	21,000,000	

(1) In November 1997, the Company's Board of Directors adopted a share repurchase program, which the Board evaluates periodically and renews as necessary. On May 2, 2006, the Board renewed the share repurchase program and authorized the Company to repurchase up to 140 million shares of our common stock at prevailing market prices. There is no established expiration date for the program.

(2) Represents shares of common stock withheld by the Company, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

(3) Represents the total number of shares repurchased during the period, of which 16.5 million of these shares were settled for cash on or before March 31, 2007.

Item 6. ***Exhibits***

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

Exhibit Number	Description
3(a)	Articles of Amendment to Second Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3(a) to the Company's Current Report on From 8-K dated May 24, 2005)
3(b)	Articles of Amendment to Second Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)
3(c)	Articles of Merger amending the Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
3(d)	Second Restated Articles of Incorporation of United HealthCare Corporation (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1995)
3(e)	Second Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
4(a)	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, filed on January 11, 1999)
4(b)	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)
10.1	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
10.2	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
10.3	Form of Agreement for Stock Option Award to Executives under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007
10.4	Form of Agreement for Restricted Stock Award to Executives under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007
10.5	Form of Agreement for Restricted Stock Unit Award to Executives under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007
10.6	Form of Agreement for Stock Appreciation Rights Award to Executives under the Company's 2002 Stock Incentive Plan, as amended on April 17, 2007
10.7	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan, effective as of April 17, 2007
10.8	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and Richard H. Anderson
10.9	Amendment to Employment Agreement, effective as of April 16, 2007, between United HealthCare Services, Inc. and Lois E. Quam

Exhibit Number	Description
10.10	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)
10.11	Employment Agreement, effective as of December 1, 2006, between United HealthCare Services, Inc. and David S. Wichmann
31	Certifications Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32	Certifications Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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SIGNATURES

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

UNITEDHEALTH GROUP INCORPORATED

/S/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	President and Chief Executive Officer (principal executive officer)	Dated: May 9, 2007
/S/ GEORGE L. MIKAN III **George L. Mikan III**	Executive Vice President and Chief Financial Officer (principal financial officer)	Dated: May 9, 2007
/S/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	Dated: May 9, 2007

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