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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 SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2005

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** *(Address of principal executive offices)*	**55343** *(Zip Code)*

(952) 936-1300
(Registrant's telephone number, including area code)

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

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

As of April 29, 2005, 633,079,551 shares of the registrant's Common Stock, $.01 par value per share, were issued and outstanding.

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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, 2005	December 31, 2004
ASSETS		
Current Assets		
Cash and Cash Equivalents	$ 4,073	$ 3,991
Short-Term Investments	277	514
Accounts Receivable, net	908	906
Assets Under Management	1,862	1,930
Deferred Income Taxes and Other	937	900
Total Current Assets	8,057	8,241
Long-Term Investments	8,213	7,748
Property, Equipment, Capitalized Software, and Other Assets, net	1,270	1,215
Goodwill	9,489	9,470
Other Intangible Assets, net	1,189	1,205
TOTAL ASSETS	$ 28,218	$ 27,879
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current Liabilities		
Medical Costs Payable	$ 5,875	$ 5,540
Accounts Payable and Accrued Liabilities	2,277	2,107
Other Policy Liabilities	1,854	1,933
Commercial Paper and Current Maturities of Long-Term Debt	400	673
Unearned Premiums	879	1,076
Total Current Liabilities	11,285	11,329
Long-Term Debt, less current maturities	3,850	3,350
Future Policy Benefits for Life and Annuity Contracts	1,691	1,669
Deferred Income Taxes and Other Liabilities	837	814
Commitments and Contingencies (Note 12)		
Shareholders' Equity		
Common Stock, $0.01 par value — 1,500 shares authorized; 634 and 643 issued and outstanding	6	6
Additional Paid-In Capital	2,244	3,095
Retained Earnings	8,263	7,484
Accumulated Other Comprehensive Income:		
Net Unrealized Gains on Investments, net of tax effects	42	132
Total Shareholders' Equity	10,555	10,717
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ 28,218	$ 27,879

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,	
	2005	**2004**
REVENUES		
Premiums	$ 9,871	$7,264
Services	902	789
Investment and Other Income	114	91
Total Revenues	10,887	8,144
MEDICAL AND OPERATING COSTS		
Medical Costs	7,902	5,869
Operating Costs	1,620	1,317
Depreciation and Amortization	109	82
Total Medical and Operating Costs	9,631	7,268
EARNINGS FROM OPERATIONS	1,256	876
Interest Expense	(49)	(24)
EARNINGS BEFORE INCOME TAXES	1,207	852
Provision for Income Taxes	(428)	(298)
NET EARNINGS	$ 779	$ 554
BASIC NET EARNINGS PER COMMON SHARE	$ 1.22	$ 0.92
DILUTED NET EARNINGS PER COMMON SHARE	$ 1.16	$ 0.88
BASIC WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	639	601
DILUTIVE EFFECT OF OUTSTANDING STOCK OPTIONS	31	29
DILUTED WEIGHTED-AVERAGE NUMBER OF COMMON SHARES OUTSTANDING	670	630

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP

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

	Three Months Ended March 31,	
	2005	**2004**
OPERATING ACTIVITIES		
Net Earnings	$ 779	$ 554
Noncash Items:		
Depreciation and Amortization	109	82
Deferred Income Taxes and Other	16	22
Net Change in Other Operating Items, net of effects from acquisitions and changes in AARP balances:		
Accounts Receivable and Other Current Assets	12	39
Medical Costs Payable	264	173
Accounts Payable and Other Accrued Liabilities	239	136
Unearned Premiums	(213)	(96)
Cash Flows From Operating Activities	1,206	910
INVESTING ACTIVITIES		
Cash Paid for Acquisitions, net of cash assumed and other effects	(19)	(527)
Purchases of Property, Equipment and Capitalized Software	(113)	(83)
Purchases of Investments	(1,857)	(521)
Maturities and Sales of Investments	1,590	738
Cash Flows Used For Investing Activities	(399)	(393)
FINANCING ACTIVITIES		
Proceeds from Common Stock Issuances	132	125
Common Stock Repurchases	(1,100)	(627)
Repayments of Commercial Paper, net	(273)	(79)
Proceeds from Issuance of Long-Term Debt	500	500
Other	16	16
Cash Flows Used For Financing Activities	(725)	(65)
INCREASE IN CASH AND CASH EQUIVALENTS	82	452
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	3,991	2,262
CASH AND CASH EQUIVALENTS, END OF PERIOD	$ 4,073	$ 2,714
Supplemental schedule of noncash investing and financing activities:		
Common stock issued for acquisitions	$ —	$ 1,932

See notes to condensed consolidated financial statements

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

1. Basis of Presentation and Use of Estimates

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

The accompanying unaudited condensed consolidated financial statements reflect all adjustments, consisting solely of normal recurring adjustments, needed to present the financial results for these interim periods fairly. In accordance with the rules and regulations of the Securities and Exchange Commission, we have omitted certain footnote disclosures that would substantially duplicate the disclosures contained in our annual audited financial statements. Read together with the disclosures below, we believe the interim financial statements are presented fairly. However, these unaudited condensed consolidated financial statements should be read together with the consolidated financial statements and the notes included in our Annual Report on Form 10-K for the year ended December 31, 2004.

These consolidated financial statements include certain amounts that are based on our best estimates and judgments. These estimates require us to apply complex assumptions and judgments, often because we must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to medical costs, medical costs payable, contingent liabilities, intangible asset valuations, asset impairments and revenues. 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. Stock-Based Compensation

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

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

	For the Three Months Ended March 31,	
	2005	2004
NET EARNINGS		
As Reported	$ 779	$ 554
Compensation Expense, net of tax effect	(36)	(32)
Pro Forma	$ 743	$ 522
BASIC NET EARNINGS PER COMMON SHARE		
As Reported	$1.22	$ 0.92
Pro Forma	$1.16	$ 0.87
DILUTED NET EARNINGS PER COMMON SHARE		
As Reported	$1.16	$ 0.88
Pro Forma	$1.11	$ 0.83

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

As discussed more fully in Note 13, FAS No. 123 (revised 2004), "Share Based Payment," (FAS No. 123(R)) will be effective during the first quarter of 2006, and will require us to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. We are currently evaluating the effect that FAS No. 123(R) will have on our financial position, results of operations and operating cash flows.

3. Acquisitions

On July 29, 2004, our Health Care Services business segment acquired Oxford Health Plans, Inc. (Oxford). Oxford provides health care and benefit services for individuals and employers, principally in New York City, northern New Jersey and southern Connecticut. This merger strengthened our market position in this region and provided substantial distribution opportunities in this region for our other UnitedHealth Group businesses. Under the terms of the purchase agreement, Oxford shareholders received 0.6357 shares of UnitedHealth Group common stock and $16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately $5.0 billion, comprised of approximately 52.2 million shares of UnitedHealth Group common stock (valued at approximately $3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately $1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of $240 million issued in exchange for Oxford's outstanding vested common stock options. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $4.2 billion. Pending completion of an independent valuation analysis, we have preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of $735 million and associated deferred tax liabilities of $277 million, and goodwill of approximately $3.7 billion. The finite-lived intangible assets consist primarily of member lists and health care physician and hospital networks, with an estimated weighted-average useful life of 15 years. The acquired goodwill is not deductible for income tax purposes. Our preliminary estimate of the fair value of the tangible assets/(liabilities) as of the acquisition date, which is subject to further refinement, is as follows:

(in millions)	
Cash, Cash Equivalents and Investments	$1,674
Accounts Receivable and Other Current Assets	165
Property, Equipment, Capitalized Software and Other Assets	37
Medical Costs Payable	(713)
Other Current Liabilities	(325)
Net Tangible Assets Acquired	$ 838

On February 10, 2004, our Health Care Services business segment acquired Mid Atlantic Medical Services, Inc. (MAMSI). MAMSI offers a broad range of health care coverage and related administrative services for individuals and employers in the mid-Atlantic region of the United States. This merger strengthened UnitedHealthcare's market position in the mid-Atlantic region and provided substantial distribution opportunities for other UnitedHealth Group businesses in this region. Under the terms of the purchase agreement, MAMSI shareholders received 0.82 shares of UnitedHealth Group common stock and $18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately $2.7 billion, comprised of 36.4 million shares of UnitedHealth Group common stock (valued at $1.9 billion based on the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and $800 million in cash. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately $2.1 billion. Based on management's consideration of fair value, which included an independent valuation analysis,

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of approximately $280 million and associated deferred tax liabilities of approximately $100 million, and goodwill of approximately $1.9 billion. The finite-lived intangible assets consist of member lists, health care physician and hospital networks, and trademarks, with an estimated weighted-average useful life of 17 years. The acquired goodwill is not deductible for income tax purposes. Our estimate of the fair value of the tangible assets/(liabilities) as of the acquisition date is as follows:

(in millions)	
Cash, Cash Equivalents and Investments	$ 736
Accounts Receivable and Other Current Assets	228
Property, Equipment, Capitalized Software and Other Assets	57
Medical Costs Payable	(283)
Other Current Liabilities	(140)
Net Tangible Assets Acquired	$ 598

The results of operations and financial condition of Oxford and MAMSI have been included in our consolidated financial statements since the acquisition dates and for the entire three month period ended March 31, 2005. The unaudited pro forma financial information presented below assumes that the acquisitions of Oxford and MAMSI had occurred as of the beginning of the three month period ended March 31, 2004. The pro forma adjustments include the pro forma effect of UnitedHealth Group shares issued in the acquisitions, the amortization of finite-lived intangible assets arising from the purchase price allocations, interest expense related to financing the cash portion of the purchase price and the associated income tax effects of the pro forma adjustments. Because the unaudited pro forma financial information has been prepared based on estimates of fair values, the actual amounts recorded as of the completion of the Oxford purchase price allocation may differ from the information presented below. The following unaudited pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the Oxford and MAMSI acquisitions been consummated at the beginning of the period presented.

Proforma — unaudited	For the Three Months Ended March 31, 2004
(in millions, except per share data)	
Revenues	$ 9,845
Net Earnings	$ 651
Earnings Per Share:	
Basic	$ 0.97
Diluted	$ 0.93

On December 10, 2004, our Uniprise business segment acquired Definity Health Corporation (Definity). Definity is the national market leader in consumer-driven health benefit programs. This acquisition strengthened our position in the emerging consumer-driven health benefits marketplace. We paid $305 million in cash in exchange for all of the outstanding stock of Definity. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately $263 million. Pending completion of an independent valuation analysis, we have preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of $60 million and associated deferred tax liabilities of $21 million, and goodwill of $224 million. The finite-lived intangible assets consist primarily of member lists, with an estimated weighted-average useful life of 15 years. The acquired goodwill is not deductible for income tax purposes. The results of operations and financial condition of Definity have been

included in our consolidated financial statements since the acquisition date. The pro forma effects of the Definity acquisition on our consolidated financial statements were not material. Our preliminary estimate of the acquired net tangible assets of $42 million, which is subject to further refinement, consisted mainly of cash, cash equivalents, accounts receivable, property and equipment and other assets partially offset by current liabilities.

4. Cash, Cash Equivalents and Investments

As of March 31, 2005, 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	$ 4,073	$ —	$ —	$ 4,073
Debt Securities — Available for Sale	8,091	112	(58)	8,145
Equity Securities — Available for Sale	201	13	(2)	212
Debt Securities — Held to Maturity	133	—	—	133
Total Cash and Investments	$ 12,498	$ 125	$ (60)	$12,563

The gross unrealized losses of $60 million were largely due to interest rate increases and relate to debt securities with an aggregate fair value of $4.2 billion. As of March 31, 2005, we had no investments in a continuous unrealized loss position for 12 months or greater.

During the three month periods ended March 31, we recorded realized gains and losses on the sale of investments, excluding the UnitedHealth Capital dispositions described below, as follows (in millions):

	Three Months Ended March, 31,	
	2005	2004
Gross Realized Gains	$ 10	$ 7
Gross Realized Losses	(8)	—
Net Realized Gains	$ 2	$ 7

During the first quarter of 2004, we realized a capital gain of $25 million on the sale of certain UnitedHealth Capital investments. With the gain proceeds from this sale, we made a cash contribution of $25 million to the United Health Foundation in the first quarter of 2004. The realized gain of $25 million and the related contribution expense of $25 million are included in Investment and Other Income in the accompanying Condensed Consolidated Statement of Operations.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

5. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by segment, for the three months ended March 31, 2004 and 2005, were as follows (in millions):

	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Consolidated Total
Balance at December 31, 2003	$1,770	$ 698	$ 409	$ 632	$ 3,509
Acquisitions and Subsequent Payments	1,935	—	—	2	1,937
Balance at March 31, 2004	$3,705	$ 698	$ 409	$ 634	$ 5,446
Balance at December 31, 2004	$7,494	$ 903	$ 409	$ 664	$ 9,470
Acquisitions and Subsequent Payments	8	—	—	11	19
Balance at March 31, 2005	$7,502	$ 903	$ 409	$ 675	$ 9,489

The weighted-average useful life, gross carrying value, accumulated amortization and net carrying value of other intangible assets as of March 31, 2005 and December 31, 2004 were as follows (in millions):

		March 31, 2005			December 31, 2004		
	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	15 years	$ 1,153	$ (66)	$ 1,087	$ 1,153	$ (46)	$ 1,107
Patents, Trademarks and Technology	9 years	91	(41)	50	86	(39)	47
Other	11 years	71	(19)	52	69	(18)	51
Total	14 years	$ 1,315	$ (126)	$ 1,189	$ 1,308	$ (103)	$ 1,205

Amortization expense relating to intangible assets was approximately $23 million and $8 million for the three months ended March 31, 2005 and 2004, respectively. Estimated amortization expense relating to intangible assets for the years ending December 31 are as follows: $99 million in 2005, $97 million in 2006, $89 million in 2007, $84 million in 2008, and $81 million in 2009.

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. Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we increase or decrease the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Our medical costs payable estimates as of December 31, 2004 developed favorably by approximately $190 million in the first quarter of 2005. Our medical costs payable estimates as of December 31, 2003 developed favorably by approximately $90 million in the first quarter of 2004. 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, 2005.

7. Commercial Paper and Debt

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

	March 31, 2005		December 31, 2004	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Commercial Paper	$ —	$ —	$ 273	$ 273
7.5% Senior Unsecured Notes due November 2005	400	409	400	417
5.2% Senior Unsecured Notes due January 2007	400	407	400	413
3.4% Senior Unsecured Notes due August 2007	550	538	550	546
3.3% Senior Unsecured Notes due January 2008	500	485	500	493
3.8% Senior Unsecured Notes due February 2009	250	243	250	247
4.1% Senior Unsecured Notes due August 2009	450	441	450	452
4.9% Senior Unsecured Notes due April 2013	450	445	450	453
4.8% Senior Unsecured Notes due February 2014	250	244	250	248
5.0% Senior Unsecured Notes due August 2014	500	494	500	503
4.9% Senior Unsecured Notes due March 2015	500	487	—	—
Total Commercial Paper and Debt	4,250	4,193	4,023	4,045
Less Current Maturities	(400)	(409)	(673)	(690)
Long-Term Debt, less current maturities	$ 3,850	$3,784	$ 3,350	$3,355

In March 2005, we issued $500 million of 4.9% fixed-rate notes due March 2015. We used the proceeds from this borrowing for general corporate purposes including repayment of commercial paper, working capital and share repurchases.

We have interest rate swap agreements that qualify as fair value hedges to convert the majority of our interest rate exposure from a fixed to a variable rate. The interest rate swap agreements have aggregate notional amounts of $3.4 billion with variable rates that are benchmarked to the London Interbank Offered Rate (LIBOR). At March 31, 2005, the rates used to accrue interest expense on these agreements ranged from 3.4% to 4.1%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Condensed Consolidated Statements of Operations.

We have a $1.0 billion five-year revolving credit facility supporting our commercial paper program that expires in June 2009. As of March 31, 2005, we had no amounts outstanding under this credit facility. Our debt arrangements and credit facility contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

8. AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings are approximately $4.6 billion annually.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member 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 Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

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

	Balance as of	
	March 31, 2005	December 31, 2004
Accounts Receivable	$ 409	$ 389
Assets Under Management	$ 1,816	$ 1,883
Medical Costs Payable	$ 970	$ 899
Other Policy Liabilities	$ 1,042	$ 1,162
Other Current Liabilities	$ 213	$ 211

The effects of changes in balance sheet amounts associated with the AARP 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 AARP. 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. As such, they 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, 2005, 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	$ 115	$ —	$ —	$ 115
Debt Securities — Available for Sale	1,696	19	(14)	1,701
Total Cash and Investments	$ 1,811	$ 19	$ (14)	$1,816

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

9. 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 restrictions on volume, pricing and timing. During the three months ended March 31, 2005, we repurchased 13.2 million shares at an average price of approximately $90 per share and an aggregate cost of approximately $1.2 billion. As of March 31, 2005, we had board of directors' authorization to purchase up to an additional 41.4 million shares of our common stock.

10. 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,	
	2005	2004
Net Earnings	$ 779	$ 554
Change in Net Unrealized Gains on Investments, net of tax effects	(90)	45
Comprehensive Income	$ 689	$ 599

11. Segment Financial Information

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

- *Health Care Services* consists of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare coordinates network-based health and well-being services on behalf of multistate mid-sized and local employers and consumers. Ovations delivers health and well-being services to Americans over the age of 50, including the administration of supplemental health insurance coverage on behalf of AARP. AmeriChoice facilitates and manages health care services for state-sponsored Medicaid programs and their beneficiaries. 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 to large employers and health plans, and provides health-related consumer and financial transaction products and services.
- *Specialized Care Services* offers a comprehensive array of specialized benefits, networks, services and resources to help consumers improve their health and well-being.
- *Ingenix* is a leader in the field of health care data analysis and application, serving pharmaceutical companies, health insurers and other payers, physicians and other health care providers, large employers and governments.

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 best estimate of fair value, as if the services were purchased from or sold to third parties. All

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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. The "Corporate and Eliminations" column also includes eliminations of intersegment transactions.

The following table presents segment financial information for the three month periods ended March 31, 2005 and 2004 (in millions):

Three Months Ended March 31, 2005	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Eliminations	Consolidated
Revenues — External Customers	$9,527	$ 757	$ 382	$ 107	$ —	$ 10,773
Revenues — Intersegment	—	176	260	59	(495)	—
Investment and Other Income	101	8	5	—	—	114
Total Revenues	$9,628	$ 941	$ 647	$ 166	$ (495)	$ 10,887
Earnings from Operations	$ 910	$ 189	$ 133	$ 24	$ —	$ 1,256

Three Months Ended March 31, 2004	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Eliminations	Consolidated
Revenues — External Customers	$6,972	$ 666	$ 324	$ 91	$ —	$ 8,053
Revenues — Intersegment	—	161	225	49	(435)	—
Investment and Other Income	78	8	5	—	—	91
Total Revenues	$7,050	$ 835	$ 554	$ 140	$ (435)	$ 8,144
Earnings from Operations	$ 577	$ 167	$ 113	$ 19	$ —	$ 876

12. Commitments and Contingencies

Legal Matters

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

Beginning in 1999, a series of class action lawsuits were filed against us and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. Through a series of motions and appeals, all direct claims against UnitedHealthcare have been compelled to arbitration. The trial court has denied UnitedHealthcare's further motion to compel the secondary RICO claims to arbitration and

the Eleventh Circuit affirmed that order. A trial date has been set for September 2005. The trial court has ordered that the trial be bifurcated into separate liability and damage proceedings.

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

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

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 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 and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, 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 record liabilities for our estimate of probable costs resulting from these matters. Although the results of pending matters are always uncertain, we do not believe the results of any of the current investigations, audits or reviews, currently threatened or pending, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

Other Contingencies

In 2002, Oxford, which we acquired on July 29, 2004, entered into agreements with two insurance companies that guaranteed cost reduction targets related to certain orthopedic medical services. In 2003, the insurers sought to rescind or terminate the agreements claiming various misrepresentations and material breaches of the agreements by Oxford. Pursuant to the agreements, Oxford filed claims to recover approximately $50 million of costs incurred and expensed in excess of the cost reduction targets for the period from November 2002 to

UNITEDHEALTH GROUP

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

October 2004. An arbitration hearing with the insurance company holding a large majority of the coverage under the policies was held in January 2005, and a decision was issued on February 22, 2005, denying the insurer's ability to rescind or terminate its agreement. As a result of the decision, Oxford was awarded approximately $30 million in net recoveries. The insurer has not yet indicated whether it will appeal this decision. Oxford will not record the net recoveries until all contingencies have been resolved. We believe that the remaining insurer's claims are also without merit, and we will vigorously seek to enforce our rights.

13. Recently Issued Accounting Standards

In December 2004, the FASB issued Statement of Financial Accounting Standards No. 123 (revised 2004), "Share-Based Payment" (FAS No. 123(R)), which amends FASB Statement Nos. 123 and 95. FAS No. 123(R) requires all companies to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. Additionally, excess tax benefits, as defined in FAS No. 123(R), will be recognized as an addition to paid-in capital and will be reclassified from operating cash flows to financing cash flows in the Consolidated Statements of Cash Flows. In April 2005, the effective date of FAS No. 123(R) was delayed until the first quarter of 2006. We are currently evaluating the effect that FAS No. 123(R) will have on our financial position, results of operations and operating cash flows. We have included information regarding the effect on net earnings and net earnings per common share had we applied the fair value expense recognition provisions of the original FAS No. 123 within Note 2.

In March 2004, the FASB issued EITF Issue No. 03-1 (EITF 03-1), "The Meaning of Other-Than-Temporary Impairment and its Application to Certain Investments." EITF 03-1 includes new guidance for evaluating and recording impairment losses on certain debt and equity investments when the fair value of the investment security is less than its carrying value. In September 2004, the FASB delayed the effective date for the measurement and recognition provisions until the issuance of additional implementation guidance. The delay does not suspend the requirement to recognize impairment losses as required by existing authoritative literature. We will evaluate the impact of this new accounting standard on our process for determining other-than-temporary impairments of applicable debt and equity securities upon final issuance.

14. Subsequent Event — Stock Split

On May 3, 2005, our board of directors declared a two-for-one stock split of our common stock. The stock split will occur on May 27, 2005, for shareholders of record on May 20, 2005. As a result of the split, the authorized, issued and outstanding shares will double. The number of shares available for repurchase under our board of directors' share repurchase authorization discussed in Note 9 will also double.

The following table presents pro forma basic and diluted net earnings per common share to reflect the two-for-one common stock split.

	For the Three Months Ended March 31,	
	2005	2004
BASIC NET EARNINGS PER COMMON SHARE		
As Reported	$1.22	$ 0.92
Pro Forma	$0.61	$ 0.46
DILUTED NET EARNINGS PER COMMON SHARE		
As Reported	$1.16	$ 0.88
Pro Forma	$0.58	$ 0.44

We intend to increase our annual cash dividend rate on a post-split basis by maintaining our 3-cent per share annual dividend after the split, effectively doubling the dividend rate from its current level.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have reviewed the accompanying condensed consolidated balance sheet of UnitedHealth Group Incorporated and Subsidiaries (the Company) as of March 31, 2005, and the related condensed consolidated statements of operations and cash flows for the three-month periods ended March 31, 2005 and 2004. These interim condensed consolidated financial statements are the responsibility of the Company's management.

We conducted our reviews in accordance with the standards of the Public Company Accounting Oversight Board (United States). A review of interim financial information consists principally of applying analytical procedures and making inquiries of persons responsible for financial and accounting matters. It is substantially less in scope than an audit conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States), the objective of which is the expression of an opinion regarding the financial statements taken as a whole. Accordingly, we do not express such an opinion.

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

We have previously audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheet of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2004, and the related consolidated statements of operations, shareholders' equity, and cash flows for the year then ended (not presented herein); and in our report dated February 28, 2005, we expressed an unqualified opinion on those consolidated financial statements. In our opinion, the information set forth in the accompanying condensed consolidated balance sheet as of December 31, 2004 is fairly stated, in all material respects, in relation to the consolidated balance sheet from which it has been derived.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
May 5, 2005

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 2005 results include:

- Diluted net earnings per common share of $1.16, an increase of 32% from $0.88 per share reported in the first quarter of 2004 and an increase of 6% from $1.09 per share reported in the fourth quarter of 2004.
- Consolidated revenues of $10.9 billion increased $2.7 billion, or 34%, over the first quarter of 2004. Excluding the impact of acquisitions, consolidated revenues increased by approximately 11% over the prior year.
- Earnings from operations of $1.3 billion, up $380 million, or 43%, over the prior year and up $68 million, or 6%, sequentially over the fourth quarter of 2004.
- Consolidated operating margin of 11.5% improved 70 basis points from 10.8% in the first quarter of 2004.
- Cash flows from operations of $1.2 billion for the three months ended March 31, 2005, an increase of 33% compared to $910 million for the first quarter of 2004.
- The consolidated medical care ratio of 80.1% declined from 80.8% in the first quarter of 2004.
- The operating cost ratio of 14.9% improved from 16.2% during the first quarter of 2004.

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

	Three Months Ended March 31,		
(In millions, except per share data)	**2005**	**2004**	**Percent Change**
Revenues	$10,887	$8,144	34%
Earnings from Operations	$ 1,256	$ 876	43%
Net Earnings	$ 779	$ 554	41%
Diluted Net Earnings Per Common Share	$ 1.16	$ 0.88	32%
Medical Care Ratio	80.1%	80.8%	
Medical Care Ratio, excluding AARP	78.9%	79.5%	
Operating Cost Ratio	14.9%	16.2%	
Return on Equity (annualized)	29.3%	35.9%	
Operating Margin	11.5%	10.8%	

Results of Operations

Consolidated Financial Results

Revenues

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

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

Consolidated revenues increased by $2.7 billion, or 34%, year-over-year in the first quarter of 2005 to $10.9 billion, primarily as a result of revenues from businesses acquired since the beginning of 2004. Excluding the impact of these acquisitions, consolidated revenues increased by approximately 11% as a result of rate increases on premium-based and fee-based services and growth in individuals served across business segments. Following is a discussion of first quarter consolidated revenue trends for each of our three revenue components.

Premium Revenues

Consolidated premium revenues totaled $9.9 billion in the first quarter of 2005, an increase of $2.6 billion, or 36%, over the first quarter of 2004. Excluding the impact of acquisitions, consolidated premium revenues increased by approximately 11% over the prior year.

UnitedHealthcare premium revenues increased by $2.0 billion, or 46%, to $6.3 billion in the first quarter of 2005. Excluding premium revenues from businesses acquired in 2004, UnitedHealthcare premium revenues increased by approximately 10%. This increase is primarily due to average net premium rate increases of approximately 8% to 9% on UnitedHealthcare's renewing commercial risk-based products and an increase in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations premium revenues increased by 26% in the first quarter of 2005. Excluding the impact of acquisitions, Ovations premium revenues increased by 16% driven primarily by an increase in the number of individuals it serves through Medicare Advantage products, as well as rate increases on these products. Premium revenues from AmeriChoice's Medicaid programs increased by $104 million, or 15%, over the first quarter of 2004 primarily driven by an increase in the number of individuals served and rate increases. The remaining premium revenue increase is due mainly to strong growth in the number of individuals served by several Specialized Care Services' businesses.

Service Revenues

Service revenues during the first quarter of 2005 totaled $902 million, an increase of $113 million, or 14%, over the first quarter of 2004. The increase in service revenues was driven primarily by aggregate growth of 7% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements since the first quarter of 2004, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased by 19% due to new business growth in the health information and clinical research businesses.

Investment and Other Income

Investment and other income during the first quarter of 2005 totaled $114 million, representing an increase of $23 million from the comparable period in 2004. Interest income increased by $28 million in 2005, principally due to the impact of increased levels of cash and fixed-income investments from the acquisitions of Oxford and MAMSI and higher yields on fixed-income investments. Net capital gains on sales of investments were $2 million in the first quarter of 2005 compared with $7 million in the first quarter of 2004.

Medical Costs

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

The consolidated medical care ratio decreased from 80.8% in the first quarter of 2004 to 80.1% in the first quarter of 2005. Excluding the AARP business,[1] the medical care ratio decreased 60 basis points from 79.5% in the first quarter of 2004 to 78.9% in the first of quarter of 2005. The medical care ratio decrease resulted primarily from the increase in favorable medical cost development related to prior periods and changes in product, business and customer mix.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior periods, resulting from more complete claim information, are identified in the current period and are included in total medical costs reported for the current period. Medical costs for the first quarter of 2005 include approximately $190 million of favorable medical cost development related to prior fiscal years. Medical costs for the first quarter of 2004 include approximately $90 million of favorable medical cost development related to prior fiscal years. The increase in favorable medical cost development was driven primarily by lower than anticipated medical cost utilization and growth in the size of the medical cost base and related medical payables due to businesses acquired during 2004.

On an absolute dollar basis, first quarter 2005 medical costs increased $2.0 billion, or 35%, over the comparable 2004 period principally due to the impact of businesses acquired during 2004. Excluding the impact of acquisitions, medical costs increased by approximately 9%. This increase was primarily driven by an 8% increase in medical cost trend due to inflation and a slight increase in health care consumption.

Operating Costs

The operating cost ratio (operating costs as a percentage of total revenues) for the first quarter of 2005 was 14.9%, down from 16.2% in the comparable 2004 period. This decrease was primarily driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. Operating costs as a percentage of premium revenues are generally considerably lower than operating costs as a percentage of fee-based revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for the first quarter of 2005 increased $303 million, or 23%, over the first quarter of 2004. Excluding the impact of acquisitions, operating costs increased by approximately 8%. This increase was driven by a 5% increase in the total number of individuals served by Health Care Services and Uniprise in the first quarter of 2005 compared to the first quarter of 2004, excluding the impact of acquisitions, and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

Depreciation and Amortization

Depreciation and amortization was $109 million and $82 million for the three month periods ended March 31, 2005 and 2004, respectively. The $27 million increase is primarily related to intangible assets acquired in business acquisitions in 2004 and higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired in 2004.

Income Taxes

Our effective income tax rate was 35.5% in the first quarter of 2005 and 35.0% in the first quarter of 2004. The increase is mainly driven by changes in business and income mix between states with differing income tax rates.

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

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,		
	2005	2004	Percent Change
Health Care Services	$ 9,628	$7,050	37%
Uniprise	941	835	13%
Specialized Care Services	647	554	17%
Ingenix	166	140	19%
Eliminations	(495)	(435)	n/a
Consolidated Revenues	$10,887	$8,144	34%

Earnings from Operations

	Three Months Ended March 31,		
	2005	2004	Percent Change
Health Care Services	$ 910	$577	58%
Uniprise	189	167	13%
Specialized Care Services	133	113	18%
Ingenix	24	19	26%
Consolidated Earnings from Operations	$1,256	$876	43%

Health Care Services

The Health Care Services segment, comprised of the UnitedHealthcare, Ovations and AmeriChoice businesses, had first quarter 2005 revenues of $9.6 billion, representing an increase of $2.6 billion, or 37%, over the first quarter of 2004. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately 11%.

The increase in revenues primarily resulted from an increase of $2.0 billion in UnitedHealthcare premium revenues due mainly to the premium revenues from businesses acquired during 2004. Excluding the impact of acquisitions, UnitedHealthcare premium revenues increased approximately 10% over the first quarter of 2004 driven by average net premium rate increases of approximately 8% to 9% on UnitedHealthcare's renewing commercial risk-based products and an increase in the number of individuals served by UnitedHealthcare's commercial risk-based products. The remaining increase in Health Care Services revenues is largely attributable to growth in the number of individuals served by Ovations' Medicare Advantage products and growth in the number of individuals served by AmeriChoice's Medicaid programs, as well as rate increases on all of these products.

The Health Care Services segment had first quarter 2005 earnings from operations of $910 million, representing an increase of $333 million, or 58%, over the first quarter of 2004. This increase primarily resulted from revenue growth and improved gross margins on UnitedHealthcare's risk-based products, growth in the number of individuals served by UnitedHealthcare's commercial risk-based and fee-based products, and the acquisitions of

Oxford and MAMSI during 2004. UnitedHealthcare's commercial medical care ratio improved to 78.4% in the first quarter of 2005 from 79.3% in the first quarter of 2004. The decrease is mainly due to the increase in favorable medical cost development related to prior periods and changes in product, business and customer mix. Health Care Services' first quarter 2005 operating margin was 9.5%, an increase of 130 basis points over the first quarter of 2004 driven mainly by the improved commercial medical care ratio and changes in business and customer mix.

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

	2005	2004
Commercial		
Risk-based	7,675	6,200
Fee-based	3,380	3,045
Total Commercial	11,055	9,245
Medicare	345	235
Medicaid	1,260	1,220
Total Health Care Services	12,660	10,700

[1] Excludes individuals served by Ovations' Medicare supplement products provided to AARP members.

The number of individuals served by UnitedHealthcare's commercial business as of March 31, 2005 increased approximately 1.8 million, or 20%, over the first quarter of 2004. Excluding the acquisition of Oxford, UnitedHealthcare's commercial business increased by 400,000, or 4% over the prior year. This included an increase of approximately 300,000 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, in addition to an increase of approximately 100,000 in the number of individuals served with commercial risk-based products driven primarily by new customer relationships.

Excluding the impact of the Oxford acquisition, the number of individuals served by Ovations' Medicare Advantage products increased by 40,000, or 17%, from the first quarter of 2004 and AmeriChoice's Medicaid enrollment increased by 40,000, or 3%, due mainly to new customer relationships since the first quarter of 2004.

Uniprise

Uniprise revenues in the first quarter of 2005 were $941 million, representing an increase of $106 million, or 13%, over the 2004 comparable period. This increase was driven primarily by growth of 6% in the number of individuals served by Uniprise in the first quarter of 2005 over the first quarter of 2004, excluding the impact of the acquisition of Definity Health Corporation (Definity) in December 2004, and annual service fee rate increases for self-insured customers. Uniprise served 10.5 million individuals as of March 31, 2005.

Uniprise first quarter 2005 earnings from operations were $189 million, an increase of $22 million, or 13%, over the first quarter of 2004. Operating margin improved to 20.1% in the first quarter of 2005 from 20.0% in the comparable 2004 period. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

Specialized Care Services

Specialized Care Services had revenues of $647 million in the first quarter of 2005, an increase of $93 million, or 17%, over the comparable 2004 period. This increase was principally driven by an increase in the number of individuals served by several of its specialty benefit businesses and rate increases related to these businesses.

Earnings from operations in the first quarter of 2005 of $133 million increased $20 million, or 18%, over the first quarter of 2004. Specialized Care Services' operating margin increased to 20.6% in the first quarter of 2005, up from 20.4% in the comparable 2004 period. This increase was driven primarily by operational and productivity improvements within Specialized Care Services' businesses and consolidation of the production and service operation infrastructure to enhance productivity and efficiency and to improve the quality and consistency of service, partially offset by a business mix shift toward higher revenue, lower margin products.

Ingenix

Ingenix revenues in the first quarter of 2005 of $166 million increased by $26 million, or 19%, over the comparable 2004 period due primarily to new business growth in the health information and clinical research businesses.

Earnings from operations were $24 million in the first quarter of 2005, up $5 million, or 26%, from the comparable 2004 period. The operating margin was 14.5% in the first quarter of 2005, up from 13.6% in the first quarter of 2004. These increases were driven by growth and improving gross margins in the health information and clinical research businesses. 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, 2005

Liquidity and Capital Resources

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

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

Our non-regulated businesses also generate significant cash from operations for general corporate use. Cash flows generated by these entities, combined with the issuance of commercial paper, long-term debt and the availability of committed credit facilities, further strengthen our operating and financial flexibility. We generally use these cash flows to reinvest in our businesses in the form of capital expenditures, to expand the depth and breadth of our services through business acquisitions, and to repurchase shares of our common stock, depending on market conditions.

Cash flows generated from operating activities, our primary source of liquidity, are principally from net earnings, excluding depreciation and amortization. As a result, any future decline in our profitability may have a negative

impact on our liquidity. The level of profitability of our risk-based business depends in large part on our ability to accurately predict and price for health care and operating cost increases. This risk is partially mitigated by the diversity of our other businesses, the geographic diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs. In 2004, a hypothetical unexpected 1% increase in commercial insured medical costs would have reduced net earnings by approximately $105 million.

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

Cash and Investments

Cash flows from operating activities were $1.2 billion in the first quarter of 2005, representing an increase over the comparable 2004 period of $296 million, or 33%. This increase in operating cash flows resulted primarily from an increase of $246 million in net income excluding depreciation, amortization and other noncash items. Additionally, operating cash flows increased by $50 million due to cash generated by working capital changes, driven largely by increases in medical costs payable. As premium revenues and related medical costs increase, we typically generate incremental operating cash flows because we collect premium revenues in advance of the claim payments for related medical costs.

We maintained a strong financial condition and liquidity position, with cash and investments of $12.6 billion at March 31, 2005. Total cash and investments increased by $310 million since December 31, 2004, primarily due to strong operating cash flows and increased debt levels, partially offset by common stock repurchases, cash paid for business acquisitions and capital expenditures.

As further described under Regulatory Capital and Dividend Restrictions, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At March 31, 2005, approximately $180 million of our $12.6 billion of cash and investments was held by non-regulated subsidiaries and was available for general corporate use, including acquisitions and share repurchases.

Financing and Investing Activities

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of March 31, 2005 and December 31, 2004, we had commercial paper and debt outstanding of approximately $4.3 billion and $4.0 billion, respectively. Our debt-to-total-capital ratio was 28.7% and 27.3% as of March 31, 2005 and December 31, 2004, respectively. We believe the prudent use of debt leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

In March 2005, we issued $500 million of 4.9% fixed-rate notes due March 2015. We used the proceeds from this borrowing for general corporate purposes including repayment of commercial paper, working capital and share repurchases.

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

billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of $240 million issued in exchange for Oxford's outstanding vested common stock options.

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

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

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

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

We entered into interest rate swap agreements to convert our interest exposure on a majority of our borrowings from a fixed to a variable rate. Our interest rate swap agreements have aggregate notional amounts of $3.4 billion. At March 31, 2005, the rate used to accrue interest expense on these agreements ranged from 3.4% to 4.1%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations.

We have a $1.0 billion five-year revolving credit facility supporting our commercial paper program that expires in June 2009. As of March 31, 2005, we had no amounts outstanding under this credit facility. Commercial paper decreased from $273 million at December 31, 2004, to zero at March 31, 2005.

Our debt arrangements and credit facility contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio (calculated as the sum of commercial paper and debt divided by the sum of commercial paper, debt and shareholders' equity) below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

Our senior debt is rated "A" by Standard & Poor's (S&P) and Fitch, and "A2" by Moody's. Our commercial paper is rated "A-1" by S&P, "F-1" by Fitch, and "P-1" by Moody's. During the quarter, our senior debt rating was upgraded from "A3" to "A2" and our commercial paper rating was upgraded from "P-2" to "P-1" by Moody's. Consistent with our intention of maintaining our senior debt ratings in the "A" range, we intend to maintain our debt-to-total-capital ratio at approximately 30% or less. A significant downgrade in our debt or commercial paper ratings could adversely affect our borrowing capacity and costs.

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the three months ended March 31, 2005, we repurchased 13.2 million shares at an average price of approximately $90 per share and an aggregate cost of approximately $1.2 billion. As of March 31, 2005, we had board of directors' authorization to purchase up to an additional 41.4 million shares of our common stock. Our common stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of capital. A decision by the company to discontinue share repurchases would significantly increase our liquidity and financial flexibility.

In March 2005, we filed a $3.0 billion S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities) which was declared effective by the Securities and Exchange Commission in April 2005. This shelf registration statement replaced our $2.0 billion shelf registration statement filed in the first quarter of 2004 which has been fully utilized. We have not yet issued any securities under our new shelf registration statement. We may publicly offer securities from time to time at prices and terms to be determined at the time of offering. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of 24.3 million shares of our common stock in connection with acquisition activities. We filed separate S-4 registration statements for the 36.4 million shares issued in connection with the February 2004 acquisition of MAMSI and for the 52.2 million shares issued in connection with the July 2004 acquisition of Oxford described previously.

Contractual Obligations, Off-Balance Sheet Arrangements And Commitments

A summary of future obligations under our various contractual obligations, off-balance sheet arrangements and commitments was disclosed in our December 31, 2004 Annual Report on Form 10-K. There have not been significant changes to the amounts of these obligations other than those items disclosed under the "Financial Condition and Liquidity at March 31, 2005" section. Additionally, we do not have any other material contractual obligations, off-balance sheet arrangements or commitments that require cash resources; however, we continually evaluate opportunities to expand our operations. This includes internal development of new products, programs and technology applications, and may include acquisitions.

AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings are approximately $4.6 billion annually.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. As further described in Note 8 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 is sufficient to cover potential future underwriting or other risks associated with the contract.

Regulatory Capital And Dividend Restrictions

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

Critical Accounting Policies And Estimates

Critical accounting policies are those policies that require management to make the most challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting policies involve judgments and uncertainties that are sufficiently sensitive to result in materially different results under different assumptions and conditions. 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 Annual Report on Form 10-K for the year ended December 31, 2004.

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, care provider contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to 12 months from the date of service. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

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

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

	Net Favorable Development	Net Impact on Medical Costs(a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted(b)	As Reported	As Adjusted(b)
2001	$ 30	$ (40)	$ 17,644	$ 17,604	$ 1,566	$ 1,606
2002	$ 70	$ (80)	$ 18,192	$ 18,112	$ 2,186	$ 2,266
2003	$ 150	$ (60)	$ 20,714	$ 20,654	$ 2,935	$ 2,995
2004	$ 210	$ 20(c)	$ 27,000	$ 27,020(c)	$ 4,101	$ 4,081(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 2005, the company recorded net favorable development of $190 million pertaining to 2004. The amount of prior period development in 2005 pertaining to 2004 will change as our December 31, 2004 medical costs payable estimate continues to develop throughout 2005.

Our estimate of medical costs payable represents management's best estimate of the company's liability for unpaid medical costs as of March 31, 2005, 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, 2005; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our March 31, 2005 estimates of medical costs payable and actual costs payable, excluding the AARP business, first quarter 2005 earnings from operations would increase or decrease by approximately $49 million and diluted net earnings per common share would increase or decrease by approximately $0.05 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. As of March 31, 2005, there were no significant concentrations of credit risk.

Cautionary Statements

The statements contained in this Quarterly Report on Form 10-Q include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (the "PSLRA"). When used in this Quarterly Report on Form 10-Q and in future filings by us with the Securities and Exchange Commission, in our 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 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. These factors, among others, could cause actual results to differ materially from those contained in forward-looking statements contained in this quarterly report. 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 Quarterly Report of 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. Consequently, no forward-looking statement can be guaranteed. Actual future results may vary materially from expectations expressed in our prior communications.

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 (excluding AARP) have typically comprised approximately 75% to 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to our customers. The profitability of our risk-based products depends in large part on our ability to accurately predict, price for, and effectively manage health care costs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue is typically fixed in price for a 12-month period and is generally priced one to four months before contract commencement. Services are delivered and related costs are incurred when the contract commences. Although we base the premiums we charge on our estimate of future health care costs over the fixed premium period, inflation, regulations and other factors may cause actual 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 as a percentage of premium revenues can result in significant changes in our financial results. If medical costs increased by 1 percent without a proportional change in related revenues for UnitedHealthcare's commercial insured products, our annual net earnings for 2004 would have been reduced by approximately $105 million. In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which we have not received the underlying claims or for which we have received the claims but not yet processed them. 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.

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., PacifiCare Health Systems, Inc., WellChoice, Inc., and WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises concentrated in more limited geographic areas. Our Specialized Care Services and Ingenix segments also compete with a number of businesses. The addition of new competitors for at least the short-term can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. In particular markets, competitors may have capabilities that give them a

competitive advantage. Greater market share, established reputation, superior supplier 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 10-year contract with AARP, which commenced in 1998, we provide Medicare supplement and hospital indemnity health insurance and other products to AARP members. As of March 31, 2005, our portion of AARP's insurance program represented approximately $4.6 billion in annual net premium revenue from approximately 3.8 million AARP members. The AARP contract may be terminated early by us or AARP 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 arrangement depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, and respond effectively to federal and state regulatory changes.

The favorable and unfavorable effects of changes in Medicare are uncertain.

The Medicare changes being implemented as a result of the Medicare Modernization Act of 2003 are complex and wide-ranging. There are numerous changes that will influence our business. We have invested considerable resources analyzing how to best address uncertainties and risks associated with the changes that may arise. In January 2005, the Centers for Medicare and Medicaid Services released detailed regulations on major aspects of the legislation, however, some important requirements related to the implementation of the new product offerings, including the Part D prescription drug benefit and the regional Medicare Advantage Preferred Provider Organizations, have not yet been released by the federal government, thus creating challenges for planning and implementation. We believe the increased funding provided in the legislation will increase the number of competitors in the seniors health services market.

Our business is subject to government scrutiny, and we must respond quickly and appropriately to 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 consummate our acquisitions and dispositions. Delays in obtaining or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

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

State legislatures and Congress continue to focus on health care issues. Legislative and regulatory proposals at state and federal levels may affect certain aspects of our business, including contracting with physicians, hospitals and other health care professionals; physician reimbursement methods and payment rates; coverage determinations; claim payments and processing; 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 binding law or regulation, or, if enacted, what their terms will be, but their enactment could increase our costs, expose us to expanded liability, require us to revise the ways in which we conduct business or put us at risk for loss of business.

We typically have 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 and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, 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. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price.

Important relationships with physicians, hospitals and other health care providers.

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. A number of organizations are advocating for legislation that would exempt certain of these physicians and health care professionals from federal and state antitrust laws. In any particular market, these physicians and health care professionals could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part.

The nature of our business exposes us to litigation risks, and our insurance coverage may not be sufficient to cover some of the costs associated with litigation.

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, management and offerings of our services. These matters include, but are not limited to, claims related to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. In 1999, a number of class action lawsuits were filed against us and virtually all major entities in the health benefits business. The suits are purported class actions on behalf of physicians for alleged breaches of federal statutes, including the Employee Retirement Income Security Act of 1974 ("ERISA") and the Racketeer Influenced Corrupt Organization Act ("RICO"). In March 2000, the American Medical Association filed a lawsuit against us in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. Although the expenses which we have incurred to date in defending the 1999 class action lawsuits and the American Medical Association lawsuit have not been material to our business, we will continue to incur expenses in the defense of these lawsuits and other matters, even if they are without merit.

Following the events of September 11, 2001, the cost of business insurance coverage has increased significantly. As a result, we have increased the amount of risk that we self-insure, particularly with respect to matters incidental to our business. We believe that we are adequately insured for claims in excess of our self-insurance; however, 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 depend on effective information systems and the integrity of the data in our information systems.

Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to accurately report our financial results depends on the integrity of the data in our information systems. As a

result of our acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate and have upgraded and expanded our information systems capabilities. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory problems, have increases in operating expenses or suffer other adverse consequences.

We use or employ independent third parties, such as International Business Machines Corporation (IBM), with whom we have entered into agreements, for significant portions of our data center operations. Even though we have appropriate provisions in our agreements, including provisions with respect to specific performance standards, covenants, warranties, audit rights, indemnification, and other provisions, our dependence on these third parties makes our operations vulnerable to their failure to perform adequately under the contracts, due to internal or external factors. Although there are a limited number of service organizations with the size, scale and capabilities to effectively provide certain of these services, we believe that other organizations could provide similar services on comparable terms. A change in service providers, however, could result in a decline in service quality and effectiveness or less favorable contract terms.

We have intangible assets, whose values 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 $10.7 billion as of March 31, 2005, representing approximately 38% 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.

We must comply with emerging restrictions on patient privacy and information security, including taking steps to ensure compliance by our business associates who obtain access to sensitive patient information when providing services to us.

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 HIPAA. HIPAA also imposes guidelines on our business associates (as this term is defined in the HIPAA regulations). Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Compliance with 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.

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 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.

The effects of the war on terror and future terrorist attacks could impact the health care industry.

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

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 $12.4 billion of our cash equivalents and investments at March 31, 2005 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, 2005, the fair value of our fixed-income investments would decrease or increase by approximately $375 million. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

To mitigate the financial impact of changes in interest rates, we have entered into interest rate swap agreements to more closely match the interest rates of our long-term debt with those of our cash equivalents and short-term investments. Including the impact of our interest rate swap agreements, approximately $3.4 billion of our commercial paper and debt had variable rates of interest and $825 million had fixed rates as of March 31, 2005. 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, 2005, we had $212 million of equity investments, primarily held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

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

Evaluation of Disclosure Controls and Procedures

As of March 31, 2005, an evaluation was carried out under the supervision and with the participation of the company's management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934). Based upon that evaluation, the Chief Executive Officer and the Chief Financial Officer concluded that the design and operation of these disclosure controls and procedures were effective to ensure that information required to be disclosed by the company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in applicable rules and forms.

Changes in Internal Control Over Financial Reporting During the Quarter Ended March 31, 2005

There were no significant changes in our internal control over financial reporting that occurred during the Company's quarter ended March 31, 2005 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 1. *Legal Proceedings*

In Re: Managed Care Litigation: MDL No. 1334. Beginning in 1999, a series of class action lawsuits were filed against us and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. Through a series of motions and appeals, all direct claims against UnitedHealthcare have been compelled to arbitration. The trial court has denied UnitedHealthcare's further motion to compel the secondary RICO claims to arbitration and the Eleventh Circuit affirmed that order. A trial date has been set for September 2005. The trial court has ordered that the trial be bifurcated into separate liability and damage proceedings.

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

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 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 and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, 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 record liabilities for our estimate of probable costs resulting from these matters.

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

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Item 2. ***Issuer Purchases of Equity Securities***

Issuer Purchases of Equity Securities (1)
First Quarter 2005

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, 2005	6,030,000	$ 87.84	6,030,000	48,560,000
February 28, 2005	3,250,000	$ 89.10	3,250,000	45,310,000
March 31, 2005	3,930,000	$ 92.84	3,930,000	41,380,000
TOTAL	13,210,000	$ 89.64	13,210,000	

(1) On November 4, 1997, the Company's Board of Directors adopted a share repurchase program, which the Board evaluates periodically and renews as necessary. The Company announced this program on November 6, 1997, and announced renewals of the program on November 5, 1998, October 27, 1999, February 14, 2002, October 25, 2002, July 30, 2003 and November 4, 2004. On November 4, 2004, the Board renewed the share repurchase program and authorized the Company to repurchase up to 65 million shares of the Company's common stock at prevailing market prices. There is no established expiration date for the program. During the three months ended March 31, 2005, the Company did not repurchase any shares other than through this publicly announced program.

Item 6. ***Exhibits and Reports on Form 8-K***

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

Exhibit Number	Description
Exhibit 15	— Letter Re Unaudited Interim Financial Information
Exhibit 31	— Certifications Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
Exhibit 32	— Certifications Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

The following Current Reports on Form 8-K were filed or furnished, as applicable, during the first quarter of 2005.

8-K dated January 20, 2005, together with a news release, announcing fourth quarter earnings results, under Item 2.02 "Results of Operations and Financial Condition."

8-K/A dated January 20, 2005, together with a news release, amending 8-K dated January 20, 2005, under Item 2.02 "Results of Operations and Financial Condition."

8-K dated February 7, 2005, announcing the Compensation Committee's designation of participants, approval of performance targets and objectives, and related matters under the Company's Executive Incentive Plan, under Item 1.01 "Entry Into a Material Definitive Agreement."

8-K dated February 11, 2005, announcing upcoming meetings with investors and analysts, pursuant to Item 7.01 "Regulation FD Disclosure."

8-K dated March 7, 2005, announcing the issuance of Company Notes, under Item 8.01 "Other Events" and Item 9.01 "Financial Statements and Exhibits."

8-K dated March 10, 2005, announcing upcoming meetings with investors and analysts, pursuant to Item 7.01 "Regulation FD Disclosure."

SIGNATURES

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

UNITEDHEALTH GROUP INCORPORATED

/s/ STEPHEN J. HEMSLEY Stephen J. Hemsley	President and Chief Operating Officer	Dated: May 5, 2005
/s/ PATRICK J. ERLANDSON Patrick J. Erlandson	Chief Financial Officer and Principal Accounting Officer	Dated: May 5, 2005

EXHIBITS

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