

## Financial review

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## Financial Highlights

For the Year Ended December 31,  
(in millions, except per share data)

	2003	2002	2001	2000	1999
<b>CONSOLIDATED OPERATING RESULTS</b>					
Revenues	\$ 28,823	\$ 25,020	\$ 23,454	\$ 21,122	\$ 19,562
Earnings From Operations	\$ 2,935	\$ 2,186	\$ 1,566	\$ 1,200	\$ 943
Net Earnings	\$ 1,825	\$ 1,352	\$ 913	\$ 736 <sup>1</sup>	\$ 568 <sup>2</sup>
Return on Shareholders' Equity	39.0%	33.0%	24.5%	19.8% <sup>1</sup>	14.1%
Basic Net Earnings per Common Share	\$ 3.10	\$ 2.23	\$ 1.46	\$ 1.14	\$ 0.82
Diluted Net Earnings per Common Share	\$ 2.96	\$ 2.13	\$ 1.40	\$ 1.09 <sup>1</sup>	\$ 0.80 <sup>2</sup>
Common Stock Dividends per Share	\$ 0.015	\$ 0.015	\$ 0.015	\$ 0.008	\$ 0.008
<b>CONSOLIDATED CASH FLOWS FROM (USED FOR)</b>					
Operating Activities	\$ 3,003	\$ 2,423	\$ 1,844	\$ 1,521	\$ 1,189
Investing Activities	\$ (745)	\$ (1,391)	\$ (1,138)	\$ (968)	\$ (623)
Financing Activities	\$ (1,126)	\$ (1,442)	\$ (585)	\$ (739)	\$ (605)
<b>CONSOLIDATED FINANCIAL CONDITION</b> (As of December 31)					
Cash and Investments	\$ 9,477	\$ 6,329	\$ 5,698	\$ 5,053	\$ 4,719
Total Assets	\$ 17,634	\$ 14,164	\$ 12,486	\$ 11,053	\$ 10,273
Debt	\$ 1,979	\$ 1,761	\$ 1,584	\$ 1,209	\$ 991
Shareholders' Equity	\$ 5,128	\$ 4,428	\$ 3,891	\$ 3,688	\$ 3,863
Debt-to-Total-Capital Ratio	27.8%	28.5%	28.9%	24.7%	20.4%

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

<sup>1</sup> 2000 results include a \$14 million net permanent tax benefit related to the contribution of UnitedHealth Capital investments to the United Health Foundation and a \$27 million gain (\$17 million after tax) related to a separate disposition of UnitedHealth Capital investments. Excluding these items for comparability purposes, 2000 net earnings and diluted earnings per common share were \$705 million and \$1.05 per share, and return on shareholders' equity was 19.0%.

<sup>2</sup> 1999 results include a net permanent tax benefit primarily related to the contribution of UnitedHealth Capital investments to the United Health Foundation. Excluding this benefit for comparability purposes, net earnings and diluted net earnings per common share were \$563 million and \$0.79 per share.

## Results of Operations

### BUSINESS OVERVIEW

UnitedHealth Group is a leader in the health and well-being industry, serving approximately 52 million Americans. Our primary focus is on improving the American health care system by simplifying the administrative components of health care delivery, promoting evidence-based medicine as the standard for care and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions.

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

### 2003 FINANCIAL PERFORMANCE HIGHLIGHTS

UnitedHealth Group had a very strong year in 2003. The company continued to achieve diversified growth across its business segments and generated net earnings of \$1.8 billion and operating cash flows of \$3.0 billion, representing increases of 35% and 24%, respectively, over 2002. Other financial performance highlights include:

- > Diluted net earnings per common share of \$2.96, representing an increase of 39% over 2002.
- > Revenues of \$28.8 billion, a 15% increase over 2002.
- > Operating earnings of more than \$2.9 billion, up 34% over 2002.
- > Consolidated operating margin of 10.2%, up from 8.7% in 2002 driven primarily by improved margins on risk-based products, a product mix shift from risk-based products to higher-margin, fee-based products, and operational and productivity improvements.
- > Return on shareholders' equity of 39.0%, up from 33.0% in 2002.

### 2003 RESULTS COMPARED TO 2002 RESULTS

#### Consolidated Financial Results

##### *Revenues*

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

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

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

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

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

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

#### **Medical Costs**

The 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 83.0% in 2002 to 81.4% in 2003. Excluding the AARP business,<sup>1</sup> the medical care ratio decreased 140 basis points from 81.4% in 2002 to 80.0% in 2003. Approximately 30 basis points of the decrease in the medical care ratio was driven by favorable development of prior period medical cost estimates as further discussed below. The balance of the medical care ratio decrease resulted primarily from net premium rate increases that exceeded overall medical benefit cost increases and changes in product, business and customer mix.

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

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

<sup>1</sup>Management believes disclosure of the medical care ratio excluding the AARP business is meaningful since underwriting gains or losses related to the AARP business accrue to 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.

### **Operating Costs**

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

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

### **Depreciation and Amortization**

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

### **Income Taxes**

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

### **Business Segments**

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

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

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

nm — not meaningful

## Health Care Services

The Health Care Services segment consists of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare coordinates network-based health and well-being services on behalf of 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 Medicaid programs and their beneficiaries.

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

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

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

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

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

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2003 increased by 510,000, or 7%, over the prior year. This included an increase of 180,000, or 7%, in the number of individuals served with fee-based products, driven by new customer relationships and existing customers converting from risk-based products to fee-based products. In addition, the number of individuals served by risk-based products increased by 330,000. This increase was driven by the acquisition of Golden Rule Financial Corporation (Golden Rule) in November 2003, which resulted in

the addition of 430,000 individuals served, partially offset by customers converting to self-funded, fee-based arrangements and UnitedHealthcare's targeted withdrawal of risk-based offerings from unprofitable arrangements with customers using multiple benefit carriers.

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

### ***Uniprise***

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

Uniprise earnings from operations in 2003 were \$610 million, representing an increase of 18% over 2002. Operating margin for 2003 improved to 19.6% from 19.0% in 2002. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

### ***Specialized Care Services***

Specialized Care Services is a portfolio of health and well-being companies, each serving a specialized market need with a unique offering of benefits, networks, services and resources. Specialized Care Services revenues during 2003 of \$1.9 billion increased by \$369 million, or 24%, over 2002. This increase was principally driven by an increase in the number of individuals served by United Behavioral Health, its mental health benefits business; Dental Benefit Providers, its dental services business; and Spectera, its vision care benefits business; as well as rate increases related to these businesses.

Earnings from operations in 2003 of \$385 million increased \$99 million, or 35%, over 2002. Specialized Care Services' operating margin increased to 20.5% in 2003, up from 19.0% in 2002. This increase was driven primarily by operational and productivity improvements at United Behavioral Health. With the continuing growth of the Specialized Care Services segment, we are consolidating production and service operations to a segmentwide service and production infrastructure to improve service, quality and consistency, and to enhance productivity and efficiency.

### ***Ingenix***

Ingenix is an international leader in the field of health care data analysis and application, serving pharmaceutical companies, health insurers and other payers, physicians and other health care providers, large employers and governments. Ingenix revenues in 2003 of \$574 million increased by \$83 million, or 17%, over 2002. This was driven primarily by new business growth in the health information business.

Earnings from operations in 2003 were \$75 million, up \$20 million, or 36%, from 2002. Operating margin was 13.1% in 2003, up from 11.2% in 2002. The increase in the operating margin was primarily due to growth in the health information business.

## 2002 RESULTS COMPARED TO 2001 RESULTS

### Consolidated Financial Results

#### Revenues

Consolidated revenues increased by approximately \$1.6 billion, or 7%, in 2002 to \$25.0 billion. Strong growth across our business segments was partially offset by the impact of targeted withdrawals from unprofitable risk-based arrangements with customers using multiple health benefit carriers, and withdrawals and benefit design changes in our Medicare+Choice product offering in certain markets. Following is a discussion of 2002 consolidated revenue trends for each revenue component.

**Premium Revenues** Consolidated premium revenues in 2002 totaled \$21.9 billion, an increase of \$1.2 billion, or 6%, compared with 2001. Premium revenues from UnitedHealthcare's commercial risk-based products increased by approximately \$1.2 billion, or 10%, to \$12.9 billion in 2002. Average net premium rate increases exceeded 13% on UnitedHealthcare's renewing commercial risk-based business. This increase was partially offset by the effects of targeted withdrawals from unprofitable risk-based arrangements with customers using multiple health benefit carriers and a shift in product mix from risk-based to fee-based products. During 2002, the number of individuals served by UnitedHealthcare commercial risk-based products decreased by 180,000, or 3%.

Premium revenues from Medicaid and Medicare+Choice programs decreased by \$400 million, or 11%, to \$3.2 billion in 2002. Premium revenues from Medicare+Choice programs decreased by \$850 million to \$1.6 billion because of planned withdrawals and benefit design changes in certain markets undertaken in response to insufficient Medicare program reimbursement rates. Premium revenues from Medicaid programs increased by \$450 million to \$1.6 billion in 2002. More than half of this increase, \$240 million, related to the acquisition of AmeriChoice on September 30, 2002.

The balance of premium revenue growth in 2002 included a \$240 million increase in Health Care Services' premium revenues driven by an increase in the number of individuals served by both Ovations' Medicare supplement products provided to AARP members and by its Evercare business. In addition, Specialized Care Services realized a \$140 million increase in premium revenues in 2002.

**Service Revenues** Service revenues in 2002 totaled \$2.9 billion, an increase of \$404 million, or 16%, over 2001. The increase in service revenues was driven primarily by aggregate growth of 11% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements. Uniprise and UnitedHealthcare service revenues grew by an aggregate of \$230 million during 2002. Additionally, revenues from Ovations' Pharmacy Services business, established in June 2001, increased by approximately \$110 million, as it was in operation for the full year in 2002.

**Investment and Other Income** Investment and other income in 2002 totaled \$220 million, a decrease of \$61 million, or 22%, from 2001. Interest income decreased by \$32 million due to lower interest yields on investments in 2002 compared with 2001, partially offset by the impact of increased levels of cash and fixed-income investments. Net realized capital losses in 2002 were \$18 million, compared to net realized capital gains of \$11 million in 2001. The 2002 net realized capital losses were mainly due to sales of investments in debt securities of certain companies in the telecommunications industry and impairments recorded on certain UnitedHealth Capital equity investments. The losses were partially offset by capital gains on sales of investments in other debt securities.

### **Medical Costs**

The consolidated medical care ratio decreased from 85.3% in 2001 to 83.0% in 2002. Excluding the AARP business, the medical care ratio decreased by 250 basis points from 83.9% in 2001 to 81.4% in 2002. Approximately 90 basis points of the medical care ratio decrease resulted from targeted withdrawals from unprofitable risk-based arrangements with commercial customers using multiple health benefit carriers and a shift in commercial customer mix, with a larger percentage of premium revenues derived from small business customers. These employer groups typically have a lower medical care ratio, but carry higher operating costs than larger customers. Additionally, the medical care ratio decreased approximately 90 basis points because of withdrawals and benefit design changes in certain Medicare markets pertaining to our Medicare+Choice offering. The balance of the decrease in the medical care ratio was primarily driven by changes in product and business mix, care management activities and net premium rate increases that exceeded overall medical benefit cost increases.

On an absolute dollar basis, consolidated medical costs increased by \$548 million, or 3%, over 2001. This increase principally resulted from a rise in medical costs of approximately 12%, or \$2.1 billion, driven by the combination of medical cost inflation and increased health care consumption. Partially offsetting this increase, medical costs decreased by approximately \$1.4 billion due to net reductions in the number of people receiving benefits under our Medicare and commercial risk-based products. The balance of the decrease in medical costs was driven primarily by changes in benefit designs in certain Medicare markets.

### **Operating Costs**

The operating cost ratio was 17.5% in 2002, compared with 17.0% in 2001. During 2002, our fee-based products and services grew at a faster rate than our premium-based products, and fee-based products have much higher operating cost ratios than premium-based products. In addition, our Medicare business, which has relatively low operating costs as a percentage of revenues, decreased in size relative to our overall operations. Using a revenue mix comparable to 2001, the 2002 operating cost ratio would have decreased slightly in 2002. This decrease was principally driven by operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that reduced labor and occupancy costs in our transaction processing and customer service, billing and enrollment functions. The impact of these efficiencies was partially offset by the incremental costs associated with the development, deployment, adoption and maintenance of new technology releases, as well as increased business self-insurance costs during 2002.

On an absolute dollar basis, operating costs increased by \$408 million, or 10%, over 2001. This increase was driven by a 7% increase in the total number of individuals served by Health Care Services and Uniprise during 2002, general operating cost inflation and the additional costs associated with acquired businesses.

### **Depreciation and Amortization**

Depreciation and amortization was \$255 million in 2002 and \$265 million in 2001. This decrease was due to \$93 million of amortization expense in 2001 recorded for goodwill, which was no longer amortized in 2002 pursuant to the adoption of Financial Accounting Standards (FAS) No. 142, "Goodwill and Other Intangible Assets." This decrease was largely offset by \$83 million of additional depreciation and amortization resulting from higher levels of equipment and capitalized software as a result of technology enhancements and business growth.

### **Income Taxes**

Our effective income tax rate was 35.5% in 2002 and 38.0% in 2001. The decrease was primarily due to the impact of non-tax-deductible goodwill amortization that is no longer amortized for financial reporting purposes, as required by FAS No. 142. Assuming FAS No. 142 was effective during 2001, the effective tax rate would have been approximately 36.0% during 2001.

## Business Segments

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

REVENUES				Percent Change
	2002	2001		
Health Care Services	\$ 21,552	\$ 20,403		6%
Uniprise	2,725	2,474		10%
Specialized Care Services	1,509	1,254		20%
Ingenix	491	447		10%
Corporate and Eliminations	(1,257)	(1,124)		nm
Consolidated Revenues	\$ 25,020	\$ 23,454		7%

  

EARNINGS FROM OPERATIONS		2001		Percent Change <sup>1</sup>
	2002	Reported	Adjusted <sup>1</sup>	
Health Care Services	\$ 1,328	\$ 936	\$ 974	36%
Uniprise	517	382	410	26%
Specialized Care Services	286	214	220	30%
Ingenix	55	48	69	(20%)
Corporate	–	(14)	(14)	nm
Consolidated Earnings From Operations	\$ 2,186	\$ 1,566	\$ 1,659	32%

nm — not meaningful

<sup>1</sup> Adjusted to exclude \$93 million of amortization expense associated with goodwill for comparability purposes. Pursuant to FAS No. 142, which we adopted effective January 1, 2002, goodwill is no longer amortized. Where applicable, the percent change is calculated comparing the 2002 results to the 2001 "Adjusted" results.

### Health Care Services

Health Care Services posted record revenues of \$21.6 billion in 2002, an increase of nearly \$1.2 billion, or 6%, over 2001. The increase in revenues primarily resulted from an increase of approximately \$1.2 billion in UnitedHealthcare's commercial premium revenues. This was driven by average net premium rate increases in excess of 13% on renewing commercial risk-based business, partially offset by the effects of targeted withdrawals from unprofitable risk-based arrangements with commercial customers using multiple health benefit carriers. Premium revenues from Medicaid programs increased by \$450 million in 2002, of which \$240 million related to the acquisition of AmeriChoice on September 30, 2002. Offsetting these increases, Medicare+Choice premium revenues decreased by \$850 million as a result of planned withdrawals and benefit design changes in certain markets in response to insufficient Medicare program reimbursement rates. The balance of Health Care Services' revenue growth in 2002 includes a \$240 million increase in Ovations revenues driven by an increase in the number of individuals served by both its Medicare supplement products provided to AARP members and its Evercare business, and a \$140 million increase in revenues from its Pharmacy Services business, established in June 2001.

Health Care Services realized earnings from operations of \$1.3 billion in 2002, an increase of \$392 million, or 42%, over 2001 on a reported basis, and an increase of \$354 million, or 36%, over 2001 on a FAS No. 142 comparable reporting basis. This increase primarily resulted from improved gross margins on UnitedHealthcare's commercial risk-based products, revenue growth and operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that reduced labor and occupancy costs in the transaction processing and customer service, billing and enrollment functions. Health Care Services' operating margin increased to 6.2% in 2002 from 4.6% on a reported basis and from 4.8% on a FAS No. 142 comparable reporting basis in 2001. This increase was driven by a combination of an improved medical care ratio, productivity improvements and a shift in product mix from risk-based products to higher-margin, fee-based products.

UnitedHealthcare's commercial medical care ratio decreased by 230 basis points from 84.1% in 2001 to 81.8% in 2002. Approximately 130 basis points of the commercial medical care ratio decrease resulted from targeted withdrawals from unprofitable risk-based arrangements with commercial customers using multiple carriers and a shift in commercial customer mix, with a larger percentage of premium revenues derived from small business customers. These employer groups typically have a lower medical care ratio, but carry higher operating costs than larger customers. The balance of the decrease in the commercial medical care ratio was primarily driven by changes in product mix, care management activities and net premium rate increases that exceeded overall medical benefit cost increases.

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

(in thousands)	2002	2001
Commercial		
Risk-Based	5,070	5,250
Fee-Based	2,715	2,305
Total Commercial	7,785	7,555
Medicare	225	345
Medicaid	1,030	640
Total Health Care Services	9,040	8,540

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

The number of individuals served by UnitedHealthcare's commercial products increased by 230,000, or 3%, during 2002. This included an increase of 410,000, or 18%, in the number of individuals served with fee-based products, driven by new customer relationships and customers converting from risk-based products during 2002. This increase was partially offset by a decrease of 180,000, or 3%, in the number of individuals served by risk-based products, driven by customers converting to self-funded, fee-based arrangements and UnitedHealthcare's targeted withdrawal of risk-based product offerings from unprofitable arrangements with customers using multiple health benefit carriers.

Ovations' year-over-year Medicare enrollment decreased 35% because of market withdrawals and benefit design changes. These actions were taken in response to insufficient Medicare program reimbursement rates in specific counties and were intended to preserve profit margins and better position the Medicare program for long-term success. Year-over-year Medicaid enrollment increased by 390,000, largely due to the acquisition of AmeriChoice on September 30, 2002, which served approximately 360,000 individuals as of the acquisition date.

### **Uniprise**

Uniprise revenues were \$2.7 billion in 2002, up \$251 million, or 10%, over 2001. This increase was driven primarily by an 8% increase in Uniprise's customer base. Uniprise served 8.6 million individuals as of December 31, 2002, and 8.0 million individuals as of December 31, 2001.

Uniprise earnings from operations grew by \$135 million, or 35%, over 2001 on a reported basis, and by \$107 million, or 26%, over 2001 on a FAS No. 142 comparable reporting basis. Operating margin improved to 19.0% in 2002 from 15.4% on a reported basis and from 16.6% on a FAS No. 142 comparable reporting basis in 2001. Uniprise expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that reduced labor and occupancy costs supporting its transaction processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

### ***Specialized Care Services***

Specialized Care Services had revenues of \$1.5 billion in 2002, an increase of \$255 million, or 20%, over 2001. This increase was principally driven by \$140 million of revenue growth from Spectera, its vision care benefits business acquired in October 2001, and an increase in the number of individuals served by United Behavioral Health, its mental health benefits business, and Dental Benefit Providers, its dental services business.

Earnings from operations reached \$286 million in 2002, an increase over 2001 of \$72 million, or 34%, on a reported basis and \$66 million, or 30%, on a FAS No. 142 comparable reporting basis. Specialized Care Services' operating margin increased to 19.0% in 2002, up from 17.1% on a reported basis and from 17.5% on a FAS No. 142 comparable reporting basis in 2001. This increase was driven by operational and productivity improvements, partially offset by a shifting business mix toward higher revenue, lower margin products. With the growth of this segment, we began consolidating production and service operations to a segmentwide service and production infrastructure to improve service quality and consistency and enhance productivity and efficiency.

### ***Ingenix***

Revenues were \$491 million in 2002, an increase of \$44 million, or 10%, over 2001. This was the result of strong new business growth in the health information business and revenues from acquired businesses, partially offset by reduced revenues in the pharmaceutical services business.

Earnings from operations were \$55 million, up \$7 million, or 15%, over 2001 on a reported basis, and down \$14 million, or 20%, from 2001 on a FAS No. 142 comparable reporting basis. Operating margin was 11.2% in 2002, up from 10.7% in 2001 on a reported basis, and down from 15.4% on a FAS No. 142 comparable reporting basis. The reduction in earnings from operations and operating margin on a FAS No. 142 comparable reporting basis was due to cancellations and delays of certain clinical research trials by pharmaceutical clients, which were affected by weak industry-specific conditions. This reduction was partially offset by strong business growth and slightly expanding margins in the health information business.

### ***Corporate***

Corporate includes costs for certain companywide process improvement initiatives, net expenses from charitable contributions to the United Health Foundation and eliminations of intersegment transactions. The decrease in corporate expenses of \$14 million from 2001 to 2002 reflects the completion during 2001 of certain companywide process improvement initiatives.

## FINANCIAL CONDITION AND LIQUIDITY AT DECEMBER 31, 2003

### Liquidity

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

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 monies 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. Monies in excess of the capital needs of our regulated entities are paid to their non-regulated parent companies, typically in the form of dividends, for general corporate use, when and as permitted by applicable regulations.

Our non-regulated businesses also generate significant cash from operations 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 generated from operating activities, our primary source of liquidity, is principally from net earnings, excluding depreciation and amortization. As a result, any future decline in our profitability may have a negative impact on our liquidity. The level of profitability of our risk-based business depends in large part on our ability to accurately predict and price for health care 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 2003, a hypothetical 1% increase in commercial insured medical costs would have reduced net earnings by approximately \$75 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, 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 was \$3.0 billion in 2003, representing an increase over 2002 of \$580 million, or 24%. This increase in operating cash flows resulted primarily from an increase of \$454 million in net income excluding depreciation, amortization and other noncash items. Additionally, operating cash flows increased by \$126 million due to cash generated by working capital changes, driven primarily by an increase in medical costs payable. As premium revenues and related medical costs increase, we generate incremental operating cash flows because we collect premium revenues in advance of the claim payments for related medical costs.

We maintained a strong financial condition and liquidity position, with cash and investments of \$9.5 billion at December 31, 2003. Total cash and investments increased by \$3.1 billion since December 31, 2002, primarily due to \$2.2 billion in cash and investments acquired in the Golden Rule acquisition in November 2003 and strong operating cash flows, partially offset by capital expenditures, businesses acquired for cash and common stock repurchases.

As further described under "Regulatory Capital and Dividend Restrictions," many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At December 31, 2003, approximately \$385 million of our \$9.5 billion of cash and investments was held by non-regulated subsidiaries. Of this amount, approximately \$45 million was segregated for future regulatory capital needs and the remainder was available for general corporate use, including acquisitions and share repurchases.

## Financing and Investing Activities

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of December 31, 2003 and 2002, we had commercial paper and debt outstanding of approximately \$2.0 billion and \$1.8 billion, respectively. Our debt-to-total-capital ratio was 27.8% and 28.5% as of December 31, 2003 and December 31, 2002, respectively. We believe the prudent use of debt leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

In December and March 2003, we issued \$500 million of four-year, fixed-rate notes and \$450 million of 10-year, fixed-rate notes with interest rates of 3.3% and 4.9%, respectively. We entered into interest rate swap agreements to convert our interest exposure on \$725 million of the 2003 borrowings from a fixed to a variable rate. At December 31, 2003, the rate used to accrue interest expense on these agreements ranged from 1.2% to 1.6%. 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 used the proceeds from these borrowings to repay commercial paper and term debt maturing in 2003, and for general corporate purposes, including working capital, capital expenditures, business acquisitions and share repurchases. Commercial paper and current maturities of long-term debt decreased from \$811 million as of December 31, 2002, to \$229 million as of December 31, 2003, as a result of these actions.

We have credit arrangements for \$900 million that support our commercial paper program. These credit arrangements include a \$450 million revolving facility that expires in July 2005, and a \$450 million, 364-day facility that expires in July 2004. As of December 31, 2003, we had no amounts outstanding under our credit facilities.

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

Our senior debt is rated “A” by Standard & Poor’s (S&P) and Fitch, and “A3” with a positive outlook by Moody’s. Our commercial paper is rated “A-1” by S&P, “F-1” by Fitch, and “P-2” with a positive outlook by Moody’s. Consistent with our intention of maintaining our senior debt ratings in the “A” range, we intend to maintain our debt-to-total-capital ratio at 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 2003, we repurchased 33 million shares at an average price of approximately \$47 per share and an aggregate cost of approximately \$1.6 billion. As of December 31, 2003, we had board of directors’ authorization to purchase up to an additional 45 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 May 2003, our board of directors declared a two-for-one split of the company’s common stock in the form of a 100% common stock dividend. The stock dividend was issued on June 18, 2003, to shareholders of record as of June 2, 2003. All share and per share amounts have been restated to reflect the stock split.

On November 13, 2003, our Health Care Services business segment acquired Golden Rule Financial Corporation and subsidiaries. We paid \$495 million in cash in exchange for all of the outstanding stock of Golden Rule.

On February 10, 2004, our Health Care Services business segment acquired Mid Atlantic Medical Services, Inc. (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.

We financed the cash portion of the MAMSI purchase price primarily through commercial paper issuances and a total of \$500 million of five- and 10-year fixed-rate notes issued on February 10, 2004. We have entered into interest rate swap agreements to convert our interest exposure on these notes from a fixed to a variable rate. Following the closing of this acquisition and the debt issuances, our debt-to-total-capital ratio remained below 30%.

Under our S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities), the remaining issuing capacity of all covered securities, after consideration of the notes issued in connection with the MAMSI acquisition described above, is \$250 million. We may publicly offer securities from time to time at prices and terms to be determined at the time of offering. We plan to file an amendment to increase the issuing capacity under our S-3 shelf registration statement to \$2.0 billion during the first half of 2004. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of approximately 24.3 million shares of our common stock in connection with acquisition activities. We filed a separate S-4 registration statement for the 36.4 million shares issued in connection with the acquisition of MAMSI described above.

## Contractual Obligations, Off-Balance Sheet Arrangements And Commitments

The following table summarizes future obligations due by period as of December 31, 2003, under our various contractual obligations, off-balance sheet arrangements and commitments (in millions):

	2004	2005 to 2006	2007 to 2008	Thereafter	Total
Debt and Commercial Paper <sup>1</sup>	\$ 229	\$ 400	\$ 900	\$ 450	\$ 1,979
Operating Leases	103	185	144	191	623
Purchase Obligations <sup>2</sup>	83	99	14	–	196
Future Policy Benefits <sup>3</sup>	160	290	265	962	1,677
Other Long-Term Obligations <sup>4</sup>	–	–	65	173	238
Total Contractual Obligations	\$ 575	\$ 974	\$ 1,388	\$ 1,776	\$ 4,713

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

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

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

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

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

## REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the "A" range, we maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require. As of December 31, 2003, our regulated subsidiaries had aggregate statutory capital of approximately \$3.1 billion, which is significantly more than the aggregate minimum regulatory requirements.

## **CRITICAL ACCOUNTING POLICIES AND ESTIMATES**

Critical accounting policies are those policies that require management to make the most challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting policies involve judgments and uncertainties that are sufficiently sensitive to result in materially different results under different assumptions and conditions. We believe our most critical accounting policies are those described below. For a detailed discussion of these and other accounting policies, see Note 2 to the Consolidated Financial Statements.

### **Revenues**

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

### **Medical Costs**

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical care services incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, seasonal variances in medical care consumption, provider contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, benefit plan changes, and business mix changes related to products, customers and geography. Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to 12 months from the date of service. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

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

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

	Favorable Development	Net Impact on Medical Costs (a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted (b)	As Reported	As Adjusted (b)
2000	\$ 15	\$ (15)	\$ 16,155	\$ 16,140	\$ 1,200	\$ 1,215
2001	\$ 30	\$ (40)	\$ 17,644	\$ 17,604	\$ 1,566	\$ 1,606
2002	\$ 70	\$ (80)	\$ 18,192	\$ 18,112	\$ 2,186	\$ 2,266
2003	\$ 150	(c)	\$ 20,714	(c)	\$ 2,935	(c)

- a) The amount of favorable development recorded in the current year pertaining to the prior year less the amount of favorable development recorded in the subsequent year pertaining to the current year.  
b) Represents reported amounts adjusted to reflect the net impact of medical cost development.  
c) Not yet determinable as the amount of prior period development recorded in 2004 will change as our December 31, 2003 medical costs payable estimate develops throughout 2004.

Our estimate of medical costs payable represents management's best estimate of the company's liability for unpaid medical costs as of December 31, 2003, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover the company's liability for unpaid claims as of December 31, 2003; however, actual claim payments may differ from established estimates. Assuming a hypothetical 1% difference between our December 31, 2003 estimates of medical costs payable and actual costs payable, excluding the AARP business, 2003 earnings from operations would increase or decrease by approximately \$33 million and diluted net earnings per common share would increase or decrease by approximately \$0.03 per share.

## Investments

As of December 31, 2003, we had approximately \$7.2 billion of investments, primarily held in marketable debt securities. Our investments are principally classified as available for sale and are recorded at fair value. We exclude unrealized gains and losses on investments available for sale from earnings and report them together, net of income tax effects, as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2003, our investments had gross unrealized gains of \$238 million and gross unrealized losses of \$7 million. If any of our investments experience a decline in fair value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in our Consolidated Statement of Operations. Management judgment is involved in evaluating whether a decline in an investment's fair value is other than temporary. New information and the passage of time can change these judgments. We revise impairment judgments when new information becomes known and record any resulting impairment charges at that time. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

## Long-Lived Assets

As of December 31, 2003 and 2002, we had long-lived assets, including goodwill, other intangible assets, and property, equipment and capitalized software, of \$4.7 billion and \$4.4 billion, respectively. We review these assets for events and changes in circumstances that would indicate we might not recover their carrying value. In assessing the recoverability of our long-lived assets, we must make assumptions regarding estimated future utility, cash flows and other internal and external factors to determine the fair value of the respective assets. If these estimates or their related assumptions change in the future, we may be required to record impairment charges for these assets.

## **Contingent Liabilities**

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

## **INFLATION**

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

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

## **LEGAL MATTERS**

Because of the nature of our businesses, we are routinely 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. Generally, the health care provider plaintiffs allege violations of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Racketeer Influenced Corrupt Organization Act (RICO), as well as several state law claims. The suit seeks injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. We are engaged in discovery in this matter. A trial date has been set for September 13, 2004.

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

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

## **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 and 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 \$7.0 billion of our investments at December 31, 2003 were fixed-income securities. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed-income investment portfolio at December 31, 2003, the fair value of our fixed-income investments would decrease or increase by approximately \$340 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 \$1.2 billion of our commercial paper and debt had variable rates of interest and \$825 million had fixed rates as of December 31, 2003. A hypothetical 1% increase or decrease in interest rates would not be material to the fair value of our commercial paper and debt.

At December 31, 2003, we had \$181 million of equity investments, primarily held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

## **CONCENTRATIONS OF CREDIT RISK**

Investments in financial instruments such as marketable securities and accounts receivable may subject UnitedHealth Group to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our board of directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. Government and Agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups that constitute our customer base. As of December 31, 2003, there were no significant concentrations of credit risk.

## CAUTIONARY STATEMENT REGARDING “FORWARD-LOOKING” STATEMENTS

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

Many factors will be important in determining future results. Consequently, no forward-looking statement can be guaranteed. Actual future results may vary materially from those expressed in our prior communications. Factors that could cause results and developments to differ materially from expectations include, without limitation, (a) increases in medical costs that are higher than we anticipated in establishing our premium rates, including increased consumption of or costs of medical services; (b) increases in costs associated with increased litigation, legislative activity and government regulation and review of our industry; (c) heightened competition as a result of new entrants into our market, mergers and acquisitions of health care companies and suppliers, and expansion of physician or practice management companies; (d) failure to maintain effective and efficient information systems, which could result in the loss of existing customers, difficulties in attracting new customers, difficulties in determining medical costs estimates and establishing appropriate pricing, customer and physician and health care provider disputes, regulatory violations, increases in operating costs or other adverse consequences; (e) events that may negatively affect our contract with AARP, including any failure on our part to service AARP customers in an effective manner and any adverse events that directly affect AARP or its business partners; (f) significant deterioration in customer retention; (g) our ability to execute contracts on favorable terms with physicians, hospitals and other service providers, and (h) significant deterioration in economic conditions, including the effects of acts of terrorism, particularly bioterrorism, or major epidemics. A further list and description of these risks, uncertainties and other matters can be found in our annual report on Form 10-K for the year ended December 31, 2003, and in our reports on Forms 10-Q and 8-K.