UNITEDHEALTH GROUP INC
Form 10-K
March 06, 2007
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# UNITED STATES

# SECURITIES AND EXCHANGE COMMISSION

**Washington, D.C. 20549**

# FORM 10-K

**(Mark One)**

**x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2006**

**OR**

**¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
**Commission file number: 1-10864**

# UNITEDHEALTH GROUP INCORPORATED

**(Exact name of registrant as specified in its charter)**

| **MINNESOTA** | **41-1321939** |
|---|---|
| **(State or other jurisdiction of incorporation or organization)** | **(I.R.S. Employer Identification No.)** |
| **UNITEDHEALTH GROUP CENTER 9900 BREN ROAD EAST MINNETONKA, MINNESOTA** | **55343** |
| **(Address of principal executive offices)** | **(Zip Code)** |

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

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

| **COMMON STOCK, $.01 PAR VALUE** | **NEW YORK STOCK EXCHANGE, INC.** |
|---|---|
| **(Title of each class)** | **(Name of each exchange on which registered)** |

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

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

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

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 x No ¨

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

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

| Large accelerated filer x | Accelerated filer ¨ | Non-accelerated filer ¨ |
|---|---|---|

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

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2006, was approximately $55,976,249,541 (based on the last reported sale price of $44.78 per share on June 30, 2006, on the New York Stock Exchange).*

As of February 15, 2007, there were 1,354,320,209 shares of the registrant s Common Stock, $.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we incorporate by reference certain information from our Definitive Proxy Statement for the Annual Meeting of Shareholders to be held on May 29, 2007. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

* Only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the Company have been excluded in determining this number.

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**EXPLANATORY NOTE**

In this Form 10-K, UnitedHealth Group Incorporated ( UnitedHealth Group or the Company ) is restating its Consolidated Balance Sheet as of December 31, 2005, and the related Consolidated Statements of Operations, Changes in Shareholders Equity and Cash Flows for each of the fiscal years ended December 31, 2005 and December 31, 2004 and quarterly financial data for the quarter ended December 31, 2005.

This Form 10-K also reflects the restatement of Selected Financial Data in Item 6 for the fiscal years ended December 31, 2005, 2004, 2003 and 2002, and the amendment of Management s Discussion and Analysis of Financial Condition and Results of Operations presented in the Company s Form 10-K for the fiscal year ended December 31, 2005 as it related to the fiscal years ended December 31, 2005 and December 31, 2004.

Immediately prior to the filing of this Form 10-K, the Company filed an amended quarterly report on Form 10-Q/A for the quarter ended March 31, 2006 and quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006. These Forms 10-Q/A and 10-Q contain restated financial information for the first three fiscal quarters of 2005 and the quarter ended March 31, 2006.

Previously filed annual reports on Form 10-K and quarterly reports on Form 10-Q (other than for the quarter ended March 31, 2006, which has been amended by the Form 10-Q/A) have not been amended and should not be relied upon.

**Background of the Restatement**

In March 2006, media reports questioned whether a number of companies, including UnitedHealth Group, had engaged in backdating stock option grants. Shortly thereafter, the Company was notified that the Securities and Exchange Commission (the SEC ) had commenced an inquiry into the Company s historic practices concerning stock option grants.

On April 4, 2006, the Company s Board of Directors (the Board ) created an independent committee comprised of three independent directors to review the Company s option grant practices over the period from 1994 through 2005 (the Independent Review Period ). The independent committee engaged the law firm of Wilmer Cutler Pickering Hale and Dorr LLP ( WilmerHale ) as counsel for its independent review, and WilmerHale retained independent accounting advisors. WilmerHale has advised that, in the course of its review, it examined physical and electronic documents comprising more than 26 million pages of material and conducted over 80 interviews.

WilmerHale s report of its findings (the WilmerHale Report ) was furnished to the Board and publicly issued on October 15, 2006. The complete text of the WilmerHale Report is available on the Company s Web site, www.unitedhealthgroup.com, and is included as an exhibit to the Company s Current Report on Form 8-K filed with the SEC on October 16, 2006.

After substantially completing its analysis of the accounting adjustments necessary to reflect the findings of the WilmerHale Report, on November 8, 2006, the Company filed with the SEC a Current Report on Form 8-K reporting management s conclusion, which the Audit Committee of the Board had approved, that due solely to the Company s historic stock option practices the Company s financial statements for the fiscal years ended December 31, 1994 through 2005, the interim periods contained therein, the quarter ended March 31, 2006 and all earnings and press releases, including for the quarters ended June 30, 2006 and September 30, 2006, and similar communications issued by the Company for such periods, and the related reports of the Company s independent registered public accounting firm, should no longer be relied upon. The Form 8-K also reported that management had re-evaluated its assessment of the Company s internal controls over financial reporting and had concluded that, as of December 31, 2005, the Company had a material weakness solely relating to stock option plan administration and accounting for and disclosure of stock option grants.

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The Form 8-K also disclosed that certain of the Company s current and former senior executives had agreed to increase the exercise price of all stock options granted to that executive with stated grant dates between 1994 and 2002 to eliminate any financial benefit resulting from what the WilmerHale Report concluded was the likely backdating of grants that they received.

After completing its internal review of the accounting treatment for all option grants, and following consultation on certain interpretive accounting issues with the Office of the Chief Accountant of the SEC, management has concluded, and the Audit Committee of the Board has approved the conclusion, that the Company used incorrect measurement dates and made other errors described below in accounting for stock option grants and, accordingly, that the Company s previously issued financial statements should be restated in this Form 10-K.

**Summary of the Restatement Adjustments**

As of January 1, 2006, the Company adopted Statement of Financial Accounting Standards No. 123 (revised 2004), Share-Based Payment (FAS 123R), using the modified retrospective transition method. Under this method, all prior period financial statements are required to be restated to recognize compensation cost in the amounts historically disclosed in our consolidated financial statements under Statement of Financial Accounting Standards No. 123, Accounting for Stock-Based Compensation (FAS 123). Prior to January 1, 2006, the Company accounted for share-based compensation granted under its stock option plans using the recognition and measurement provisions of Accounting Principles Board Opinion No. 25, Accounting for Stock Issued to Employees (APB 25). Under APB 25, a company was not required to recognize compensation expense for stock options issued to employees if the exercise price of the stock options was at least equal to the quoted market price of the company s common stock on the measurement date. APB 25 defined the measurement date as the first date on which both the number of shares an individual employee was entitled to receive and the option or purchase price, if any, were known.

The restatement in this Form 10-K principally reflects additional stock-based compensation expense and related tax effects under both FAS 123R, the Company s current accounting method, and APB 25, the Company s historical accounting method, relating to the Company s historic stock option practices. The restatement also reflects certain other accounting adjustments, including adjustments unrelated to historic stock option practices, which are not material either individually or in the aggregate to the current or prior periods.

The principal components of the restatement are as follows:

***Revised Measurement Dates.*** Based on all available evidence, the Company applied the methodologies described below to determine the appropriate measurement dates under both FAS 123 and APB 25 for grants in the following categories: (1) grants of approximately 80 million shares on a split-adjusted basis to Section 16 officers ( Section 16 Grants ); (2) grants of approximately 260 million shares on a split-adjusted basis to middle management and senior management employees ( Broad-Based Grants ); and (3) grants of approximately 50 million shares on a split-adjusted basis in connection with the hiring or promotion of employees ( New Hire and Promotion Grants ). As a result of this analysis, the Company has determined that, in most cases, the stated grant date was not the correct measurement date.

*Section 16 Grants* Section 16 Grants, generally made to eight to twelve officers, required approval by the Compensation and Human Resources Committee of the Board (the Compensation Committee ).

For the majority of Section 16 Grants, Compensation Committee approval was reflected in written actions. The WilmerHale Report concluded that the written actions were generally executed subsequent to the stated grant dates. (Under Minnesota corporate law, it is permissible to make a Written Action effective as of a date other than the date on which the last of the required signers affixes his or her signature, even if that effective date is before the last signature affixed.) Based on the available evidence, the Company has determined that the appropriate measurement date for each of these Section 16 Grants is the earlier of (a) the date on which a Form 4 (or other statement of changes in beneficial ownership) was filed with the SEC with respect to a

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particular officer s grant or (b) the date on which the written action with respect to that grant was likely executed by a majority of the members of the Compensation Committee.

As to certain other Section 16 Grants, Compensation Committee approval occurred at a meeting or there was general Compensation Committee approval of the Section 16 Grant together with a delegation to the Chairman of the Compensation Committee to determine the final amount of stock options, grant date and exercise price for each Section 16 officer receiving options. The Company has determined, based on all available evidence, that the appropriate measurement date for these Section 16 Grants is the earlier of (a) the date on which a Form 4 (or other statement of changes in beneficial ownership) was filed with the SEC with respect to a particular officer s grant or (b) the date on which a resolution with respect to that grant was adopted at a meeting of the Compensation Committee or a decision was made by the Chairman of the Compensation Committee, if so delegated.

For option grants with stated grant dates in October 1999 that were made in connection with the entry of employment agreements for our former chief executive officer and our current chief executive officer (both of whom had been employed by the Company prior to that date), the Company has determined that the appropriate measurement date is the date on which the employment agreements were executed on behalf of the Company. With respect to stock option grants with a stated grant date in October 1999 that represented the number of additional stock options necessary to equal the minimum annual stock option grant provided for pursuant to each such employment agreement, the Company has determined that the appropriate measurement date is the last day of 1999, the calendar year in which the Company was contractually obligated to make the grants.

*Broad-Based Grants* Between 1,500 and 4,000 middle and senior management employees periodically and customarily received options. As described in the WilmerHale Report, our former chief executive officer, acting pursuant to authority delegated to him by the Compensation Committee, chose the grant dates and overall amounts for Broad-Based Grants and ultimately reflected the Broad-Based Grants in CEO Certificates.

The Company followed separate allocation processes to determine the particular recipients and individual option amounts of grants to middle management employees and senior management employees. In the majority of Broad-Based Grants, the process of allocating stock option grants among individual employees in both middle management and senior management continued beyond the stated grant date. After the date on which substantially all granting activities were completed, there was an insignificant number of changes to option awards attributable to circumstances such as the effective cancellation of a grant because of an employee s termination, administrative error corrections, promotion or individual performance reassessment.

Based on all available evidence, the Company has determined that the appropriate measurement date for Broad-Based Grants was the later of the following two dates: (a) the date on which the evidence identified by the Company indicated that a communication to or from our former chief executive officer refers to a particular grant, or the grant was presented to the Compensation Committee or (b) the date on which the allocation of the options to individual employees and grant process associated with the Broad-Based Grant was substantially complete. Where information is not available to evidence either (a) or (b) above, the Company has determined the appropriate measurement date to be the date on which the Company determined, based upon all available evidence, that the CEO Certificate for such grant was likely executed. Where option award amounts changed subsequent to the date the allocation process was substantially complete, the Company has determined that each award that was changed is a separate grant with its own measurement date and should not be considered indicative that the granting process was not complete.

*New Hire and Promotion Grants* During the Independent Review Period, the Company granted stock options to approximately 2,500 employees in connection with their hire or promotion ( New Hire and Promotion Grants ).

For New Hire and Promotion Grants made prior to 2002, the Company typically chose grant dates by determining the lowest closing price of the Company s common stock between the date of an event in

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the recruitment of the newly hired employee (e.g., date of first contact, date of an offer letter) or promotion of the employee and the end of the quarter in which the employee started work or was promoted. As a result of this practice, some employees received stock options with grant dates that were earlier than that employee s start date. In 2002, the Company changed to a practice of determining grant dates for new hires and promotions to be the date of the lowest closing price of the Company s common stock between the start date of employment or date of promotion and the end of the quarter in which the employee started work or was promoted. The Company historically used these stated grant dates as the measurement dates for accounting purposes.

The Company has concluded that the measurement dates used with respect to nearly all of the New Hire and Promotion Grants during the Independent Review Period were not correct because the Company s practice was to determine grant dates with the benefit of hindsight. The Company has determined that the appropriate measurement date for each New Hire and Promotion Grant was the date on which the Company set the terms of the award or, if the Company could not identify such date based on all available evidence, the last date of the fiscal quarter in which a particular New Hire or Promotion Grant was made.

***1999 Grant of Supplemental Options.*** In the fourth quarter of 1999, following a decline in its stock price, the Company granted supplemental stock options to acquire 2.2 million shares of Company common stock (17.6 million shares on a split-adjusted basis) to a broad group of employees, including our former chief executive officer and other Section 16 officers. The supplemental options were granted in connection with the suspension of the vesting and exercisability of an equal number of options with exercise prices above $46.50 ($5.8125 on a split-adjusted basis) that had previously been granted to those employees (the Suspended Options ). The supplemental options had a stated grant date of October 13, 1999 and an exercise price equal to $40.125 ($5.0156 on a split-adjusted basis).

After taking into account all available evidence regarding the Suspended Options, the Company has concluded that, under APB 25, the grant of the supplemental options constituted an effective re-pricing subject to variable accounting for each option until exercise, forfeiture or expiration. Additionally, the Company has determined that, under FAS 123, the grant of the supplemental options was a modification that required an incremental fair value charge to be recognized over the related vesting period.

***2000 Reactivation of Suspended Options.*** In 2000, the Company reactivated the vesting and exercisability of the Suspended Options. The Company has determined that, under APB 25 and FAS 123, the reactivation of the vesting and exercisability of the Suspended Options was a new stock option grant that should have had a new measurement date, and the Company has determined that the appropriate measurement date is the date grantees were again permitted to exercise their previously vested awards.

***Cliff Vesting Options.*** Prior to April 2000, the Company granted to employees certain stock options that vested 100% on the sixth or ninth anniversary of the date of grant (the Cliff Vesting Options ). Under the terms of the options, the Company could elect to accelerate the vesting of all or a portion of the Cliff Vesting Options at its discretion. The Company followed a policy of accelerating the vesting of a consistent percentage of the Cliff Vesting Options, unless the option holder was subject to disciplinary action or performing at a less than satisfactory level. This resulted in nearly all option holders having their Cliff Vesting Options accelerated so they actually vested as if they had a 20% or 25% per year time-based vesting schedule (i.e., a four-year or five-year vesting period).

*Grant of Cliff Vesting Options.* Under APB 25, an award should be accounted for as a performance award if its cliff vesting terms are not considered to be substantive. Based on numerous factors, including evaluation of employee turnover rates, the Company has determined that the nine-year vesting term was not substantive in grants after January 1995 to middle management employees. Accordingly, these options should have been subject to variable accounting until each of their vesting dates. With respect to substantially all other Cliff Vesting Options, the Company has concluded that the cliff vesting term is substantive.

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*Acceleration of Cliff Vesting Options.* In accordance with the provisions of Financial Accounting Standards Board Interpretation No. 44, Accounting for Certain Transactions Involving Stock Compensation (An Interpretation of APB Opinion No. 25) ( FIN 44 ), subsequent to July 1, 2000, the acceleration of the six- or nine-year cliff vesting term of a stock option constituted a modification. Accordingly, the Company should have measured the intrinsic value of the award at the date of the modification and recognized this amount as compensation cost on the termination of employment if, absent the acceleration, the award would have been forfeited pursuant to its original terms. Under FAS 123, the performance targets were taken into consideration when determining the expected term of the award and therefore the acceleration of vesting was not considered to be a modification of the terms.

***Other Modifications of Option Terms.*** The Company has also determined that certain other actions were taken that resulted in the modification of option terms, as follows:

*Options Modified Upon Terminations.* On approximately 75 occasions from 1998 to 2005, the Company entered into amended employment or separation agreements with employees that resulted in the modification of vesting or cancellation terms of their stock option agreements. Under APB 25, the potential compensation expense of the modification should have been measured at the date of the modification and recognized if the employee ultimately received a benefit on the termination date. Under FAS 123, the modification should have been recognized at the date of the modification based upon the incremental fair value provided to the employee.

*1999 Cancellation and Reissuance of Options.* In the fourth quarter of 1999, the Company issued stock options to acquire an aggregate of 400,000 shares of Company common stock (3.2 million shares on a split-adjusted basis) to approximately 65 employees in exchange for the cancellation of an equal number of stock options that had previously been granted to those employees at various times earlier in 1999. The reissued stock options had a stated grant date of October 13, 1999 and an exercise price equal to $40.125 ($5.0156 on a split-adjusted basis), which was lower than the exercise price of the cancelled options. The Company has determined that, under APB 25, this constituted a re-pricing, resulting in variable accounting for each option until exercise, forfeiture or expiration. Additionally, the Company has concluded that, under FAS 123, this would also be viewed as a modification to the award and the incremental fair value in addition to the originally measured fair value should have been recognized over the remaining vesting period.

***Related Tax Adjustments.*** The restatement in this Form 10-K also reflects the estimated loss of certain tax deductions and additional interest expense related to the exercise of stock options granted to certain of the Company s executive officers that as a result of the revision of measurement dates no longer qualify as deductible performance-based compensation in accordance with Internal Revenue Code section 162(m).

**Additional Information**

Note 3 of the Notes to Consolidated Financial Statements in this Form 10-K sets forth, on a year-by-year basis, the impact under FAS 123R and APB 25 of recognizing additional stock-based compensation expense and related tax effects as a result of historic stock option practices.

The Company also conducted a sensitivity analysis to assess how the restatement adjustments described in this Form 10-K would have changed under two alternative methodologies for determining measurement dates for stock option grants made during the Independent Review Period. See Management s Discussion and Analysis of Financial Condition and Results of Operations, presented in Item 7 of this Form 10-K, for information regarding the incremental stock-based compensation cost that would result from using alternate measurement date determination methodologies. See Cautionary Statements in Item 7 for a discussion of certain risk factors related to the Company s historic stock option practices.

Item 9A of this Form 10-K describes management s conclusion, in light of the findings of the WilmerHale Report and the restatement reflected in this Form 10-K and as reported in a Current Report on Form 8-K filed

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with the SEC on November 8, 2006, that the Company had a material weakness in internal control over financial reporting solely relating to stock option plan administration and accounting for and disclosure of stock option grants as of December 31, 2005 and that, solely for this reason, its internal control over financial reporting and its disclosure controls and procedures were not effective as of that date. Item 9A of this Form 10-K further describes the conclusion of the Company s Chief Executive Officer and Chief Financial Officer, based upon management s evaluation of the effectiveness of the design and operation of the Company s disclosure controls and procedures as of December 31, 2006, that the Company has remediated the material weakness in internal control over financial reporting relating to stock option plan administration and accounting for and disclosure of stock option grants and that the Company s disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2006.

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**PART I**

**ITEM 1. BUSINESS**

**INTRODUCTION**

**Overview**

UnitedHealth Group ( we, our, or the Company ) is a diversified health and well-being company, serving approximately 70 million Americans. We are focused on improving the American health care system and how it works for multiple, distinct constituencies. We provide individuals with access to quality, cost-effective health care services and resources through more than 520,000 physicians and other care providers and 4,700 hospitals across the United States.

During 2006, we managed approximately $92 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our primary focus is on improving health care systems 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 information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

Our revenues are derived from premium revenues on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. In 2006, we conducted our business primarily through operating divisions in the following business segments:

- Uniprise;
- Health Care Services, which includes our UnitedHealthcare, Ovations and AmeriChoice businesses;
- Specialized Care Services; and
- Ingenix.

For a discussion of our financial results by segment, see Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations.

**Recent Developments**

*Key Business Developments*

The results of PacifiCare Health Systems, Inc. ( PacifiCare ), which we acquired in December 2005 for total cash and stock consideration of approximately $8.8 billion, were included for the full year 2006. This acquisition significantly strengthened our resources by enhancing our capabilities on the Pacific Coast and in other Western states and broadening the scope of our product offerings for a host of specialized services.

On January 1, 2006, we began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with the Centers for Medicare & Medicaid Services (CMS). As of December 31, 2006**,** we had enrolled approximately 5.7 million members in the Part D program, including approximately 4.5 million in the stand-alone prescription drug plans and approximately 1.2 million in Medicare Advantage plans incorporating Part D coverage.

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*Senior Leadership Changes*

During 2006, we made significant changes in our senior management personnel and in the structure and responsibilities of senior management positions, including the following:

Stephen J. Hemsley, who had been our President and Chief Operating Officer (COO), became our President and Chief Executive Officer (CEO) on November 30, 2006. Although it had not been planned that Mr. Hemsley would succeed our former CEO in 2006, the decision by our Board of Directors to select Mr. Hemsley to become CEO was consistent with our CEO succession plan, which is reviewed annually by the Board of Directors.

Our Board of Directors appointed George L. Mikan III (G. Mike Mikan) to serve as our new Executive Vice President and Chief Financial Officer (CFO) on November 7, 2006, and appointed Eric S. Rangen to serve as our new Senior Vice President and Chief Accounting Officer on December 15, 2006.

On December 1, 2006, we announced changes to the structure of the Company s executive management. Richard H. Anderson, Lois E. Quam and David S. Wichmann were each promoted to the position of President of one of our three new business groups: Commercial Services Group; Public and Senior Markets Group; and Individual and Employer Markets Group. Each of these executive officers was also assigned enterprise-wide functional responsibilities at the corporate level. The purpose of these changes is to focus greater attention and resources on critical areas of the Company, facilitate communication and coordination across the various businesses, and increase executive visibility of and input into the corporate decision-making process.

New senior management positions of Chief Legal Officer, Chief Administrative Officer, Chief Ethics Officer, Chief Accounting Officer, and Secretary to the Board of Directors were created to strengthen the Company s overall management oversight, control, depth and expertise. Eric Rangen was appointed as our Chief Accounting Officer, Forrest Burke was appointed Acting General Counsel, William Bojan was appointed Chief Ethics Officer and searches are underway to fill the remaining new positions.

*Business Organization Changes*

Consistent with the structural changes to the Company s executive management, we began transitioning our operating structure into the following three new market groups in 2007:

Commercial Services Group, which will include Specialized Care Services, Ingenix and Exante Financial Services;

Individual and Employer Markets Group, which will include UnitedHealthcare and Uniprise; and

Public and Senior Markets Group, which will include Ovations and AmeriChoice.

This initial operating structure will continue to evolve as we add new executive positions and realign enterprise-wide functions to strengthen our capabilities and performance. We have not currently realigned assets or changed the way our senior executives evaluate financial performance. Therefore, until we have completed the transition of our operating structure into the new market groups, we will continue to describe and report our results of operations in our earnings releases and SEC filings (including this Form 10-K) using the four business segments described in Overview above.

*Executive Compensation and Corporate Governance*

In addition to the senior leadership and business organization changes, our Board of Directors implemented a number of significant changes in the areas of executive compensation (including controls over equity awards) and corporate governance. The Compensation Discussion and

Analysis and Corporate Governance sections of our Definitive Proxy Statement for the Annual Meeting of Shareholders to be held on May 29, 2007 will contain a detailed description of these changes. See also Item 9A of this Form 10-K for a discussion of the remediation of our internal control over financial reporting solely relating to stock option plan administration and accounting for and disclosure of stock option grants.

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**Additional Information**

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. The terms we, our or the Company refer to UnitedHealth Group Incorporated and our subsidiaries. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our Web site at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to those reports. You can also download from our Web site our Articles of Incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our Web site free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

Our transfer agent, Wells Fargo, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email *stocktransfer@wellsfargo.com*, or telephone (800) 468-9716 or (651) 450-4064.

## DESCRIPTION OF BUSINESS SEGMENTS

**UNIPRISE**

Uniprise delivers health care and well-being services nationwide to large national employers, individual consumers and other health care organizations through three related business units: Uniprise Strategic Solutions (USS), Definity Health and Exante Financial Services (Exante). Each business unit works with other UnitedHealth Group businesses to deliver a complementary and integrated array of services. USS delivers strategic health and well-being solutions to large national employers. Definity Health provides consumer-driven health plans and consumer activation services to employers and their employees. As of December 31, 2006, USS and Definity Health served approximately eleven million individuals. Exante delivers health-care-focused financial services for consumers, employers and providers. Uniprise also offers transactional processing services to various intermediaries and health care entities. Most Uniprise products and services are delivered through its affiliates. Uniprise provides administrative and customer care services for certain other businesses of UnitedHealth Group.

Uniprise specializes in large-volume transaction management, large-scale benefit design and innovative technology solutions that simplify complex administrative processes and promote improved health outcomes. Uniprise processes approximately 270 million medical benefit claims each year and responds to approximately 50 million service calls annually. Uniprise provides comprehensive operational services for independent health plans and third-party administrators, as well as the majority of the commercial health plan consumers served by UnitedHealthcare. Uniprise maintains Internet-based administrative and financial applications for physician inquiries and transactions, for customer-specific data analysis for employers, and for consumer access to personal health care information and services.

**USS**

USS provides comprehensive and customized administrative, benefits and service solutions for large employers and other organizations with more than 5,000 employees in multiple locations. USS customers generally retain the risk of financing the medical benefits of their employees and their dependents and USS provides coordination and facilitation of medical services; transaction processing; consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals for a fixed service fee per individual served. As of December 31, 2006, USS served approximately 405 employers, including approximately 180 of the *Fortune 500* companies.

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**Definity Health**

Definity Health provides innovative consumer health care solutions that enable consumers to take ownership and control of their health care benefits. Definity Health s products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs) or health savings accounts (HSAs), and are offered on a self-funded and fully insured basis. Definity Health is a national leader in consumer-driven health benefit programs and as of December 31, 2006, its products were provided to more than 18,000 group health plans across the UnitedHealth Group enterprise, including approximately 150 employers in the large group USS self-funded market.

**Exante**

Exante Financial Services provides health-based financial services for consumers, employers and providers. These financial services are delivered through Exante Bank, a Utah-chartered industrial bank. These financial services include HSAs that consumers can access using a debit card. Exante s health benefit card programs include electronic systems for verification of benefit coverage and eligibility and administration of Flexible Spending Accounts (FSAs), HRAs and HSAs. Exante also provides extensive electronic payment and statement services for health care providers and payers.

**HEALTH CARE SERVICES**

Our Health Care Services segment consists of our UnitedHealthcare, Ovations and AmeriChoice businesses.

*UnitedHealthcare*

UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for public sector, small and mid-sized employers, and individuals nationwide. UnitedHealthcare facilitates access to health care services on behalf of nearly 15 million Americans as of December 31, 2006. With its risk-based product offerings, UnitedHealthcare assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate for a one-year period. UnitedHealthcare also provides administrative and other management services to customers that self-insure the medical costs of their employees and their dependents, for which UnitedHealthcare receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and their dependents, while UnitedHealthcare provides coordination and facilitation of medical services, customer and care provider services and access to a contracted network of physicians, hospitals and other health care professionals. Small employer groups are more likely to purchase risk-based products because they are generally unable or unwilling to bear a greater potential liability for health care expenditures. UnitedHealthcare also offers a variety of non-employer based insurance options for purchase by individuals, which are designed to meet the health coverage needs of consumers and their families.

UnitedHealthcare offers its products through affiliates that are usually licensed as insurance companies or as health maintenance organizations, depending upon a variety of factors, including state regulations. UnitedHealthcare s product strategy centers on several principles: consumer choice, broad access to health professionals, use of data and science to promote better outcomes, quality service and greater affordability. Integrated wellness programs and services help individuals make informed decisions, maintain a healthy lifestyle and optimize health outcomes by coordinating access to care services and providing personalized, targeted education and information services.

UnitedHealthcare arranges for discounted access to care through more than 520,000 physicians and other care providers, and 4,700 hospitals across the United States. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare to contract for cost-effective access to a large number of conveniently located care providers. Directly or through UnitedHealth Group s family of companies, UnitedHealthcare offers:

- A comprehensive range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;

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Affordability across a wide product line from essential needs to comprehensive benefit plans, all of which offer access to our broad-based proprietary network with economic benefits reflective of the aggregate purchasing capacity of our organization;

Innovative clinical programs built around an extensive longitudinal clinical data set and the principles of evidence-based medicine;

Access to quality and cost information for physicians and hospitals through the UnitedHealth Premium program;

Care facilitation services that use several identification tools including proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risks for potential health problems and then facilitate appropriate interventions;

Disease and condition management programs to help individuals address significant, complex disease states;

Convenient self-service tools for health transactions and information; and

Clinical information that physicians can use to better serve their patients as well as improve their practices.

UnitedHealthcare s regional and national access to broad, affordable and quality networks of health care providers has advanced over the past three years, with significant increases in access to services in California, Connecticut, Delaware, Florida, Central Illinois, Northern Indiana, Iowa, Maryland, Massachusetts, Western Michigan, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Eastern Tennessee, Virginia, Washington, West Virginia, Wisconsin, and Washington DC. UnitedHealthcare has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

We believe that UnitedHealthcare s innovation distinguishes its product offerings from the competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. Data-driven networks and clinical management are organized around clinical lines of service such as behavioral health; cardiology; congenital heart disease; kidney disease; oncology; neuroscience; orthopedics; spine; women s health; primary care and transplantation to provide consumers with the necessary resources and information to make more informed choices when managing their health. UnitedHealthcare also offers comprehensive and integrated pharmaceutical management services that achieve lower costs by using formulary programs that drive better unit costs for drugs, benefit designs that encourage consumers to use drugs that offer the best value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare s distribution system consists primarily of insurance producers and direct and Internet marketing sales in the individual market; insurance producers in the small employer group market; and producers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare s direct distribution efforts are generally limited to the individual market, portions of the large employer group and public sector markets, and cross-selling of specialty products to existing customers.

*Ovations*

Ovations provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations, through its affiliates, is one of few enterprises fully dedicated to this market segment, providing products and services in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the Northern Mariana Islands. Ovations participates nationally in the Medicare program, offering a wide-ranging spectrum of Medicare products, including Medigap products that

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supplement traditional fee-for-service coverage, more traditional health-plan-type programs under Medicare Advantage, Medicare Part D prescription drug coverage and discount card offerings, and special offerings for chronically ill and Medicare and Medicaid dual-eligible beneficiaries.

Ovations has extensive capabilities and experience with distribution, including direct marketing to consumers on behalf of its key clients AARP, the nation s largest membership organization dedicated to the needs of people age 50 and over, state and U.S. government agencies and employer groups. Ovations also has distinct pricing, underwriting and clinical program management, and marketing capabilities dedicated to risk-based health products and services in the senior and geriatric markets.

CMS is overseeing a multi-year implementation of the 2003 Medicare Modernization Act, including the introduction of the Medicare Part D prescription drug benefit in 2006 and a greater diversity in Medicare s product offerings. We believe that these changes create and expand opportunities for well-organized and focused companies to better serve older Americans. We believe that Ovations is well-positioned to respond to these opportunities.

We currently have a number of contracts with CMS, which primarily relate to the Medicare health benefit program authorized under the Medicare Modernization Act. Beginning January 1, 2006, we began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage. As a result of this contract and the December 2005 acquisition of PacifiCare, premium revenues from CMS approximated 26% of our total consolidated revenues as of December 31, 2006, a majority of which were generated by Ovations.

**Insurance Solutions**

Ovations offers a range of health insurance products and services to AARP members, and has expanded the scope of services and programs offered over the past several years. Ovations provides Medicare Supplement and hospital indemnity insurance from its insurance company affiliates to approximately 3.8 million AARP members. Additional Ovations services include a nurse healthline service, a lower cost Medicare Supplement offering that provides consumers with a hospital network and 24-hour access to health care information. Ovations also offers an AARP-branded health insurance program focused on persons between 50 and 64 years of age.

**Medicare Prescription Drug Benefit (Part D)**

Effective January 1, 2006, Ovations provides the Medicare prescription drug benefit (Part D) to beneficiaries throughout the United States and its territories. Among the several Part D plans it offers, Ovations provides a Medicare prescription drug coverage plan branded by AARP. Ovations also provides Part D drug coverage through its Medicare Advantage program, Special Needs Plans and stand-alone prescription drug plans. As of December 31, 2006**,** including PacifiCare, Ovations had enrolled approximately 5.7 million members in the Part D program, including approximately 4.5 million in the stand-alone prescription drug plans and approximately 1.2 million in Medicare Advantage plans incorporating Part D coverage.

**Secure Horizons**

The Ovations Secure Horizons division provides health care coverage for the seniors market primarily through the Medicare Advantage program administered by CMS. Ovations offers Medicare Advantage HMO, preferred provider organization (PPO), Special Needs Plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, Ovations provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside. Most products are offered under the Secure Horizons by UnitedHealthcare brand name. In 2006, Ovations Secure Horizons expanded its program and now offers Medicare Advantage products in all 50 states. As of December 31, 2006, Ovations had approximately 1.4 million enrolled individuals in its Medicare Advantage products, of whom more than 1.2 million will receive their Part D coverage through Secure Horizons. Ovations began offering a regional PPO Medicare Advantage plan in three markets on January 1, 2006.

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**Evercare**

Through its Evercare division, Ovations is one of the nation s leaders in offering complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. Evercare serves approximately 124,000 people (including 53,000 with Medicare Advantage) across the nation in long-term care settings including nursing homes, community-based settings and private homes, as well as through hospice and palliative care. Evercare offers services through innovative care management and clinical programs.

Evercare integrates federal, state and private funding through a continuum of products from Special Needs Plans and long-term care Medicaid programs to hospice care, and serves people in 35 markets in home, community and nursing home settings. These services are provided primarily through nurse practitioners, nurses and care managers. Evercare operated Special Needs Plans in 34 states as of December 31, 2006.

Evercare Solutions for Caregivers is a comprehensive eldercare service program providing service coordination, consultation, claim management and information resources nationwide. Proprietary, automated medical record software enables the Evercare clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of coherent care information that bridges across home, hospital and nursing home care settings for high-risk populations. Evercare also operates hospice and palliative care programs in nine states and intends to expand these products into at least five new markets in 2007.

**Prescription Solutions®**

Prescription Solutions offers integrated pharmacy benefit management (PBM) services (including mail order pharmacy services) to approximately 6.6 million people, as of December 31, 2006. Prescription Solutions offers a broad range of innovative programs, products and services designed to enhance clinical outcomes with appropriate financial results for employers and members. The fulfillment capabilities of Prescription Solutions are an important strategic component in serving PacifiCare s legacy commercial and senior business, as well as PacifiCare s Part D enrollees. Effective January 1, 2007, Prescription Solutions began providing PBM services to an additional four million Ovations Medicare Advantage and stand-alone Part D members.

*AmeriChoice*

AmeriChoice, through its affiliates, provides network-based health and well-being services to beneficiaries of state Medicaid, Children s Health Insurance Programs (CHIP), and other government-sponsored health care programs. AmeriChoice provides health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state. AmeriChoice provides services to approximately 1.4 million individuals in 13 states. AmeriChoice also offers government agencies a broad menu of separate management services including clinical care, consulting and management, pharmacy benefit services and administrative and technology services to help them effectively administer their distinct health care delivery systems and benefits for individuals in their programs. AmeriChoice also contracts with CMS for the provision of Special Needs Plans serving individuals dually eligible for Medicaid and Medicare services. These programs are primarily organized toward enrolling individuals who dually qualify for Medicaid and Medicare coverage in states where AmeriChoice operates its Medicaid health plans.

AmeriChoice s approach is grounded in its belief that health care cannot be provided effectively without considering all of the factors social, economic, environmental, and physical that affect a person s life. AmeriChoice coordinates resources among family members, physicians, other health care providers and government and community-based agencies and organizations to provide continuous and effective care. For members, this means that the AmeriChoice Personal Care Model offers them a holistic approach to health care, emphasizing practical programs to improve their living circumstances as well as quality medical care and treatment in accessible, culturally sensitive, community-oriented settings. For example, AmeriChoice s disease management and outreach programs focus on high-prevalence and debilitating illnesses such as hypertension and

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cardiovascular disease, asthma, sickle cell disease, diabetes, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), cancer and high-risk pregnancy. Several of these programs have been developed by AmeriChoice with the help of leading researchers and clinicians at academic medical centers and medical schools.

For physicians, the AmeriChoice Personal Care Model means assistance with coordination of their patients care. AmeriChoice utilizes sophisticated technology to monitor preventive care interventions and evidence-based treatment protocols to support care management. AmeriChoice utilizes advanced and unique pharmacy services including benefit design, generic drug programs, drug utilization review and preferred drug list development to help optimize the use of appropriate quality pharmaceuticals and concurrently manage pharmacy expenditures to levels appropriate to the specific clinical situations. For state customers, the AmeriChoice Personal Care Model means increased access to care and improved quality for their beneficiaries, in a measurable system that reduces their administrative burden and lowers their costs.

AmeriChoice considers a variety of factors in determining in which state programs to participate and on what basis, including the state s experience and consistency of support for its Medicaid program in terms of service innovation and funding, the population base in the state, the willingness of the physician/provider community to participate with the AmeriChoice Personal Care Model, and the presence of community-based organizations that can partner with AmeriChoice to meet the needs of its members. Using these criteria, AmeriChoice entered three new markets in 2006, signed an agreement to expand in one existing market in 2007, and is examining several others. Conversely, in recent years, AmeriChoice has exited several markets because of, among other reasons, the lack of consistent direction and support from the sponsoring states.

**SPECIALIZED CARE SERVICES**

The Specialized Care Services (SCS) companies offer a comprehensive platform of specialty health and wellness and ancillary benefits, services and resources to specific customer markets nationwide. These products and services include employee benefit offerings, provider networks and related resources focusing on behavioral health and substance abuse, dental, vision, disease management, complex and chronic illness and care facilitation. The SCS companies also offer solutions in the areas of complementary and alternative care, employee assistance, short-term disability, life insurance, work/life balance and health-related information. These services are designed to simplify the consumer health care experience and facilitate efficient health care delivery.

SCS s products are marketed under several different brands through three strategic markets we serve: the employer market for both UnitedHealth Group customers and unaffiliated parties; the payer market for UnitedHealth Group health plans, independent health plans, third-party administrators and reinsurers; and the public sector segment for Medicare and state Medicaid offerings through partnerships with Ovations, AmeriChoice and other intermediaries. SCS offers its products both on an administrative fee basis, where it manages and administers benefit claims for self-insured customers in exchange for a fixed service fee per individual served, and on a risk basis, where SCS assumes responsibility for health care and income replacement costs in exchange for a fixed monthly premium per individual served. The simple, modular service designs offered by SCS can be easily integrated to meet varying health plan, employer and consumer needs at a wide range of price points. Approximately 53% of the 56 million unique consumers served by SCS receive their major medical health benefits from a source other than a UnitedHealth Group affiliate.

For most of 2006, SCS consisted of three operating groups: Specialized Health Solutions; Dental and Vision; and Group Insurance Services. In December 2006, Group Insurance Services and Dental and Vision were combined into the Group Benefits Solutions operating group.

**Specialized Health Solutions**

The Specialized Health Solutions operating group provides services and products for benefits commonly found in comprehensive medical benefit plans, as well as a continuum of individualized specialty health and wellness

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solutions from health information to case and disease management for complex, chronic and rare medical conditions.

United Behavioral Health (UBH) and its subsidiaries provide employee assistance programs, work/life, behavioral health care, substance abuse programs and psychiatric disability benefit management services to employers, health plans, labor groups and public payers. UBH s programs assist individuals in managing personal challenges and behavioral health issues while seeking to increase overall health, wellness and productivity. UBH s customers buy care management services and access to UBH s large national network of 78,000 clinicians and counselors through standard and highly customized behavioral programs. UBH serves 33 million individuals.

ACN Group (ACN) and its affiliates provide benefit administration, and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services. ACN serves more than 24 million consumers through its national network of contracted health professionals.

Through Optum, SCS delivers personalized care and condition management, health assessments, longitudinal care management, disease management, health information assistance, support and related services including wellness services. Utilizing evidence-based medicine, technology and specially trained nurses, Optum facilitates effective and efficient health care delivery by helping its 32 million consumers address daily living concerns, make informed health care decisions, and become more effective health care consumers.

United Resource Networks (URN) provides support services and access to Centers of Excellence networks for individuals in need of organ transplantation and those diagnosed with complex cancer, congenital heart disease, kidney disease, infertility and neonatal care issues. URN provides these services to approximately 50 million individuals through 2,800 payers. URN negotiates competitive rates with medical centers that have been designated as Centers of Excellence based on their satisfaction of clinical standards, including patient volumes and outcomes, medical team credentials and experience, and patient and family support services.

**Group Benefits Solutions**

Group Benefits Solutions provides vision, dental, life, critical illness, and short-term disability benefits along with cost management products and services for governments, health plans and employers through its affiliates and other intermediaries.

Spectera provides vision benefits for more than eleven million people enrolled in employer-sponsored and government benefit plans. Spectera works to build productive relationships with vision care professionals, retailers, employer groups and benefit consultants. Spectera s national network includes more than 24,000 vision professionals.

Through UnitedHealthcare Dental and other brands (UHD), we provide dental benefit management and related services to six million individuals through a network of approximately 80,000 dentists. UHD s products are distributed to commercial and government markets, both directly and through unaffiliated insurers and its UnitedHealth Group affiliates.

Unimerica Workplace Benefits provides integrated short-term disability, critical illness and group life insurance products to employer s benefit programs.

National Benefit Resources (NBR) distributes and administers medical stop-loss insurance covering self-funded employer benefit plans. Through a network of third-party administrators, brokers and consultants, NBR markets stop-loss insurance throughout the United States. NBR also distributes products and services on behalf of its SCS affiliates, URN and Optum.

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**INGENIX**

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a nationwide and international basis. Ingenix s customers include more than 5,000 hospitals, 250,000 physicians, 1,500 payers and intermediaries, more than 200 *Fortune 500* companies, and more than 150 life sciences companies, as well as other UnitedHealth Group businesses. Ingenix is engaged in the simplification of health care administration with information and technology that helps customers accurately and efficiently document, code and bill for the delivery of care services. Ingenix is a leader in contract research services, medical education services, publications, and pharmacoeconomics, outcomes, safety and epidemiology research through its i3 businesses.

Ingenix s products and services are sold primarily through a direct sales force focused on specific customers and market segments across the pharmaceutical, biotechnology, employer, government, hospital, physician and payer market segments. Ingenix s products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

The Ingenix companies are divided into two operating groups: information services and pharmaceutical services.

**Information Services**

Ingenix s diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trend management, decision-support portals for evaluation of health benefits and treatment options, and claims management tools for administrative error and cost reduction. Ingenix uses proprietary software applications that manage clinical and administrative data across diverse information technology environments. Ingenix also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets. Ingenix offers complete Electronic Data Interchange (EDI) services helping health care providers and payers decrease costs of claims transmission, payment and reimbursement through both networked and direct connection services.

Ingenix provides other services on an outsourced basis, such as verification of physician credentials, provider directories, HEDIS reporting, and fraud and abuse detection and prevention services. Ingenix also offers consulting services, including actuarial and financial advisory work through its Reden & Anders division, as well as product development, provider contracting and medical policy management. Ingenix publishes print and electronic media products that provide customers with information regarding medical claims coding, reimbursement, billing and compliance issues.

**Pharmaceutical Services**

Ingenix s i3 division helps to coordinate and manage clinical trials for products in development for pharmaceutical, biotechnology and medical device manufacturers. Ingenix s focus is to help pharmaceutical and biotechnology customers effectively and efficiently get drug and medical device data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. Ingenix s capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology, safety and outcomes research, and medical education. Ingenix s services include global contract research services, protocol development, investigator identification and training, regulatory assistance, project management, data management, biostatistical analysis, quality assurance, medical writing and staffing resource services. Ingenix s pharmaceutical contract research operations are in more than 50 countries and are therapeutically focused on oncology, the central nervous system, respiratory and infectious diseases, and endocrinology. Ingenix uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical, biotechnology and medical device development. Ingenix also helps educate providers about pharmaceutical products through medical symposia, product communications and scientific publications.

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## GOVERNMENT REGULATION

Most of our health and well-being services are regulated by federal and state regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. This regulation can vary significantly from jurisdiction to jurisdiction. Changes in applicable laws and regulations are continually being considered, and the interpretation of existing laws and rules also may change periodically. Complying with new laws and rules, or changes in the interpretation of existing laws and rules, could negatively impact our business. We believe we are in compliance in all material respects with the applicable laws, rules and regulations.

### Federal Regulation

We are subject to federal regulation. Ovations Medicare business and AmeriChoice s Medicaid business are regulated by CMS. CMS has the right to audit performance to determine compliance with CMS contracts and regulations and the quality of care being given to Medicare beneficiaries. Our Health Care Services segment, through AmeriChoice, also has Medicaid and State Children s Health Insurance Program contracts that are subject to federal and state regulations regarding services to be provided to Medicaid enrollees, payment for those services, and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance. In addition, the portion of Ingenix s business that includes clinical research is subject to regulation by the U.S. Food and Drug Administration.

### State Regulation

AmeriChoice is subject to regulation by state Medicaid agencies that oversee the provision of benefits by AmeriChoice to its beneficiaries. In addition, all of the states in which our subsidiaries offer insurance and health maintenance organization products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state Departments of Insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends. In addition, some of our business and related activities may be subject to PPO, managed care organization (MCO), utilization review (UR) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, fraud prevention, protection of consumer health information and covered benefits and services. Our pharmacy activities are generally regulated at the state level and may require registration or licensure with certain state boards of pharmacy. Additionally, different approaches to state and federal privacy and insurance regulation and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines.

In connection with the PacifiCare acquisition, which closed on December 20, 2005, as typically occurs in connection with a transaction of this size, certain of our subsidiaries entered into various commitments with state regulatory departments, principally in California. We believe that none of these commitments will materially affect our operations.

### HIPAA

The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. HIPAA requires guaranteed health care coverage for small employers and certain eligible individuals. It also requires guaranteed renewability for most employers and individuals and limits exclusions based on preexisting conditions. Federal regulations promulgated pursuant to HIPAA include

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minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. New standards for national provider identifiers are currently being implemented by regulators.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the U.S. Department of Labor as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. Regulations established by the U.S. Department of Labor provide additional rules for claims payment and member appeals under health care plans governed by ERISA. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

**Audits and Investigations**

We typically have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. We also are subject to a formal investigation of our historic stock option practices by the SEC, Internal Revenue Service, U.S. Attorney for the Southern District of New York, Minnesota Attorney General, and a related review by the Special Litigation Committee of the Company, and we have received requests for documents from U.S. Congressional committees, as described in Item 7 Legal Matters. With the exception of the Civil Investigative Demand from the Minnesota Attorney General, we generally have cooperated and will continue to cooperate with the regulatory authorities. At the conclusion of these regulatory inquiries, we could be subject to regulatory or criminal fines or penalties as well as other sanctions or other contingent liabilities, which could be material.

**International Regulation**

Some of our business units, including Ingenix s i3 business, have international operations. These international operations are subject to different legal and regulatory requirements in different jurisdictions, including various tax, tariff and trade regulations, as well as employment, intellectual property and investment rules and laws.

## COMPETITION

As a diversified health and well-being services company, we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, third-party administrators and business services outsourcing companies, health care providers that have formed networks to directly contract with employers, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our Uniprise and Health Care Services businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., Kaiser Permanente, 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 business segments also compete with a number of other businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales, marketing and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation.

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## EMPLOYEES

As of December 31, 2006, we employed approximately 58,000 individuals. We believe our employee relations are generally positive.

## EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 15, 2007, including the business experience of each executive officer during the past five years:

| Name | Age | Position | First Elected as Executive Officer |
|---|---|---|---|
| Stephen J. Hemsley | 54 | President and Chief Executive Officer | 1997 |
| G. Mike Mikan | 35 | Executive Vice President and Chief Financial Officer | 2006 |
| Richard H. Anderson | 51 | Executive Vice President of UnitedHealth Group and President of Commercial Services Group | 2005 |
| Forrest G. Burke | 45 | Acting General Counsel | 2006 |
| Lois E. Quam | 45 | Executive Vice President of UnitedHealth Group and President of Public and Senior Markets Group | 1998 |
| Eric S. Rangen | 50 | Senior Vice President and Chief Accounting Officer | 2006 |
| David S. Wichmann | 44 | Executive Vice President of UnitedHealth Group and President of Individual and Employer Markets Group | 2004 |

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified.

*Mr. Hemsley* is the President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. Mr. Hemsley served as President and Chief Operating Officer from 2002 to November 2006. He joined UnitedHealth Group in 1997.

*Mr. Mikan* is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since November 2006. Mr. Mikan served as Senior Vice President of Finance of UnitedHealth Group from February 2006 to November 2006. From June 2004 to February 2006, Mr. Mikan served as Chief Financial Officer of UnitedHealthcare and as President of UnitedHealth Networks. Mr. Mikan was Chief Financial Officer of Specialized Care Services from 2002 to June 2004. Mr. Mikan joined UnitedHealth Group in 1998.

*Mr. Anderson* is Executive Vice President of UnitedHealth Group and President of the Commercial Services Group and has served in that capacity since December 2006. From January 2005 to December 2006, Mr. Anderson was Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ingenix. From November 2004 to January 2005, Mr. Anderson was Executive Vice President of UnitedHealth Group. Mr. Anderson joined UnitedHealth Group in 2004. Prior to joining UnitedHealth Group, Mr. Anderson served as Chief Executive Officer of Northwest Airlines Corporation from 2002 until November 2004.

*Mr. Burke* is the Acting General Counsel of UnitedHealth Group and has served in that capacity since October 2006. Mr. Burke has served as General Counsel of Uniprise, UnitedHealthcare and Specialized Care Services since March 2006. He served as General Counsel of Uniprise from January 2005 to March 2006. Mr. Burke joined UnitedHealth Group in 2005. From 2002 to 2005, Mr. Burke was a partner at the law firm Dorsey & Whitney, LLP, where he served on the Management Committee and chaired the Business Services group.

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*Ms. Quam* is Executive Vice President of UnitedHealth Group and President of the Public and Senior Markets Group and has served in that capacity since December 2006. From 2002 to December 2006, Ms. Quam served as Chief Executive Officer of Ovations. Ms. Quam joined UnitedHealth Group in 1989.

*Mr. Rangen* is the Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006. From November 2006 to December 2006, Mr. Rangen was Senior Vice President of UnitedHealth Group. Mr. Rangen joined UnitedHealth Group in November 2006. Prior to joining UnitedHealth Group, Mr. Rangen served as Executive Vice President and Chief Financial Officer of Alliant Techsystems Inc. from April 2004 to March 2006 and as Vice President and Chief Financial Officer of Alliant Techsystems, Inc. from 2002 to April 2004.

*Mr. Wichmann* is Executive Vice President of UnitedHealth Group and President of the Individual and Employer Markets Group and has served in that capacity since December 2006. From July 2004 to December 2006, Mr. Wichmann served as President and Chief Operating Officer of UnitedHeathcare. From June 2003 to July 2004, Mr. Wichmann served as Chief Executive Officer of Specialized Care Services. He also served as President and Chief Operating Officer of Specialized Care Services from 2002 to June 2003. Mr. Wichmann joined UnitedHealth Group in 1998.

**ITEM 1A. RISK FACTORS**

See Item 7 Cautionary Statements, which is incorporated by reference herein.

**ITEM 1B. UNRESOLVED STAFF COMMENTS**

None.

**ITEM 2. PROPERTIES**

As of December 31, 2006, we owned and/or leased real properties totaling 12.4 million square feet to support our business operations in the United States and other countries (net of approximately 0.7 million square feet of space subleased to third parties). Of this total, we leased approximately 11.6 million aggregate square feet of space and owned approximately 1.5 million aggregate square feet of space. Our leases expire at various dates through May 31, 2025. Our facilities are primarily located in the United States. Our various segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

**ITEM 3. LEGAL PROCEEDINGS**

See Item 7 Legal Matters, which is incorporated by reference herein.

**ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS**

None.

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## PART II

### ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

**Market Prices**

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On February 15, 2007, there were 15,069 registered holders of record of our common stock. The per share high and low common stock closing prices reported by the NYSE were as follows:

| | High | Low |
|---|---|---|
| *2007* | | |
| First quarter (through February 15, 2007) | $ 56.29 | $ 50.51 |
| *2006* | | |
| First quarter | $ 62.93 | $ 53.20 |
| Second quarter | $ 56.60 | $ 41.44 |
| Third quarter | $ 52.84 | $ 44.29 |
| Fourth quarter | $ 54.46 | $ 45.12 |
| *2005* | | |
| First quarter | $ 48.33 | $ 42.63 |
| Second quarter | $ 53.64 | $ 44.30 |
| Third quarter | $ 56.66 | $ 47.75 |
| Fourth quarter | $ 64.61 | $ 53.84 |

**Dividend Policy**

Our Board of Directors established our dividend policy in August 1990. Pursuant to our dividend policy, the Board reviews our financial statements following the end of each fiscal year and decides whether to declare a dividend on the outstanding shares of common stock. Shareholders of record on April 3, 2006 received an annual dividend for 2006 of $0.03 per share and shareholders of record on April 1, 2005 received an annual dividend for 2005 of $0.015 per share. On January 30, 2007, our Board of Directors approved an annual dividend of $0.03 per share, which will be paid on April 16, 2007 to shareholders of record on April 2, 2007.

**Issuer Purchases of Equity Securities**

**Issuer Purchases of Equity Securities (1)**

**Fourth Quarter 2006**

| For the Month Ended | Total Number of Shares Purchased | Average Price Paid per Share | Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs | Maximum Number of Shares that may yet be purchased under the Plans or Programs |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| October 31, 2006 | | | | 136,650,000 |
| November 30, 2006 | 10,328(2) | $ | 48.30 | 136,650,000 |
| December 31, 2006 | 205,923(2) | $ | 53.60 | 136,650,000 |
| TOTAL | 216,251 | $ | 53.35 | |

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

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we would not purchase shares under this stock repurchase program until we had completed our restatement (which is reflected in this Form 10-K) and become current in our periodic SEC filings. As a result, we did not repurchase any shares through this publicly announced program for the quarter ended December 31, 2006.

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

**Performance Graphs**

The following two performance graphs compare the Company s total return to shareholders with indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on UnitedHealth Group s common stock relative to the cumulative total returns of the S&P 500 index, and a customized peer group (the *Fortune 50* Group ), an index of certain *Fortune 50* companies. The second graph compares our cumulative total return to shareholders with the S&P 500 Index and an index of a group of peer companies selected by us for the five-year period ended December 31, 2006. The Company is not included in either the *Fortune 50* Group index in the first graph or the peer group index in the second graph. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies in the first graph and the peer group companies in the second graph are weighted according to the stock market capitalizations of the companies at January 1 of each year. The comparisons assume the investment of $100 on December 31, 2001 in company common stock and in each index, and that dividends were reinvested when paid.

***Fortune 50 Group***

The *Fortune 50* Group consists of the following companies: American International Group Inc, Berkshire Hathaway Inc, Cardinal Health Inc, Citigroup Inc, General Electric Company, International Business Machine Corp. and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy. These companies have also distinguished themselves by the consistency of their growth and performance, in many cases over multiple decades.

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| | 12/01 | 12/02 | 12/03 | 12/04 | 12/05 | 12/06 |
|---|---|---|---|---|---|---|
| **UnitedHealth Group** | **100.00** | **118.03** | **164.54** | **249.08** | **351.75** | **304.31** |
| **S & P 500** | **100.00** | **77.90** | **100.24** | **111.15** | **116.61** | **135.03** |
| **Fortune 50 Group** | **100.00** | **73.79** | **89.64** | **99.03** | **98.09** | **111.23** |

*The stock price performance included in this graph is not necessarily indicative of future stock price performance.*

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***Peer Group***

The companies included in our peer group are Aetna Inc, Cigna Corp., Coventry Health Care Inc., Humana Inc. and WellPoint Inc. We believe that this peer group accurately reflects our peers in the health care industry.

| | 12/01 | 12/02 | 12/03 | 12/04 | 12/05 | 12/06 |
|---|---|---|---|---|---|---|
| **UnitedHealth Group** | **100.00** | **118.03** | **164.54** | **249.08** | **351.75** | **304.31** |
| **S & P 500** | **100.00** | **77.90** | **100.24** | **111.15** | **116.61** | **135.03** |
| **Peer Group** | **100.00** | **83.05** | **125.88** | **194.28** | **283.66** | **280.08** |

*The stock price performance included in this graph is not necessarily indicative of future stock price performance.*

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**ITEM 6. SELECTED FINANCIAL DATA**

**Financial Highlights**

We derived the selected consolidated financial data for 2005 and 2004 from our audited restated consolidated financial statements and notes thereto appearing in Item 8 of this Form 10-K. The consolidated statement of operations data for 2003 and 2002 and the consolidated balance sheet data as of the years ended 2004, 2003 and 2002 have been restated to conform to the restated consolidated financial statements included in this Form 10-K and are presented herein on an unaudited basis. We have presented these selected financial data on both a FAS 123R basis, which we adopted on January 1, 2006, and on an APB 25 basis, our historical accounting method for periods prior to January 1, 2006.

| | FAS 123R (1) | Current Accounting Method | | | |
|---|---|---|---|---|---|
| | For the Year Ended December 31, | | | | |
| (in millions, except per share data) | 2006 (2,3) | 2005 (2,4) (As Restated) | 2004 (2,4) (As Restated) | 2003 (4) (As Restated) | 2002 (4) (As Restated) |
| **Consolidated Operating Results** | | | | | |
| Revenues | $ 71,542 | $ 46,425 | $ 38,217 | $ 29,696 | $ 25,861 |
| Earnings From Operations | $ 6,984 | $ 5,080 | $ 3,858 | $ 2,671 | $ 1,969 |
| Net Earnings | $ 4,159 | $ 3,083 | $ 2,411 | $ 1,655 | $ 1,206 |
| Return on Shareholders Equity | 22.2% | 25.2% | 29.0% | 34.6% | 28.8% |
| Basic Net Earnings per Common Share | $ 3.09 | $ 2.44 | $ 1.93 | $ 1.40 | $ 0.99 |
| Diluted Net Earnings per Common Share | $ 2.97 | $ 2.31 | $ 1.83 | $ 1.34 | $ 0.95 |
| Common Stock Dividends per Share | $ 0.030 | $ 0.015 | $ 0.015 | $ 0.008 | $ 0.008 |
| **Consolidated Cash Flows From (Used For)** | | | | | |
| Operating Activities | $ 6,526 | $ 4,083 | $ 3,923 | $ 2,913 | $ 2,348 |
| Investing Activities | $ (2,101) | $ (3,489) | $ (1,644) | $ (745) | $ (1,391) |
| Financing Activities | $ 474 | $ 836 | $ (550) | $ (1,036) | $ (1,367) |
| **Consolidated Financial Condition** | | | | | |
| (As of December 31) | | | | | |
| Cash and Investments | $ 20,582 | $ 14,982 | $ 12,253 | $ 9,477 | $ 6,329 |
| Total Assets | $ 48,320 | $ 41,288 | $ 27,862 | $ 17,668 | $ 14,187 |
| Debt | $ 7,456 | $ 7,095 | $ 4,011 | $ 1,979 | $ 1,761 |
| Shareholders Equity | $ 20,810 | $ 17,815 | $ 10,772 | $ 5,236 | $ 4,551 |
| Debt-to-Total-Capital Ratio | 26.4% | 28.5% | 27.1% | 27.4% | 27.9% |

Financial Highlights and Management s Discussion and Analysis of Financial Condition and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

(1) UnitedHealth Group adopted FAS 123R on a modified retrospective basis on January 1, 2006. This method of adoption requires all prior periods to be restated by the amounts previously disclosed on a pro-forma basis under FAS 123.

(2) UnitedHealth Group acquired PacifiCare in December 2005 for total consideration of approximately $8.8 billion, Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately $5.0 billion and Mid-Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately $2.7 billion. These acquisitions affect the comparability of 2006, 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group s Consolidated Financial Statements since the respective acquisition dates.

(3) On January 1, 2006, the Company began serving as a plan sponsor offering Medicare Part D drug insurance coverage under a contract with CMS. Total revenues generated under this program were $5.7 billion for the

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year ended December 31, 2006. This program affects the comparability of 2006 financial information with prior years. See Note 4 of the Notes to Consolidated Financial Statements for a detailed discussion of this program.

(4) The unaudited Consolidated Statements of Operations and Cash Flows data for 2003 and 2002, and the unaudited consolidated balance sheet data as of December 31, 2004, 2003 and 2002 have been revised to reflect adjustments related to the restatement described under Management s Discussion and Analysis of Financial Condition and Results of Operations and Note 3 of the Notes to Consolidated Financial Statements. Pre-tax adjustments related to 2003 and 2002 include non-cash stock-based compensation expense totaling $54 million and $62 million, respectively under FAS 123R, our current accounting method. The cumulative after tax impact of all restatement adjustments related to years prior to 2002 totaled $220 million under FAS 123R, our current accounting method, and has been reflected as an adjustment to retained earnings at December 31, 2001. The tables following the financial highlights presented under APB 25, our historical accounting method, reflect the detailed unaudited 2003 and 2002 Statements of Operations adjustments under APB 25 and FAS 123R.

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**Financial Highlights**

| (in millions, except per share data) | 2005 (2,3) (As Restated) | APB 25 (1) Historical Accounting Method For the Year Ended December 31, 2004 (2,3) (As Restated) | 2003 (3) (As Restated) | 2002 (3) (As Restated) |
|---|---|---|---|---|
| **Consolidated Operating Results** | | | | |
| Revenues | $ 46,425 | $ 38,217 | $ 29,696 | $ 25,861 |
| Earnings From Operations | $ 5,069 | $ 3,901 | $ 2,743 | $ 2,043 |
| Net Earnings | $ 3,062 | $ 2,429 | $ 1,695 | $ 1,251 |
| Return on Shareholders Equity | 25.1% | 29.5% | 36.0% | 30.3% |
| Basic Net Earnings per Common Share | $ 2.42 | $ 1.94 | $ 1.44 | $ 1.03 |
| Diluted Net Earnings per Common Share | $ 2.31 | $ 1.86 | $ 1.37 | $ 0.99 |
| Common Stock Dividends per Share | $ 0.015 | $ 0.015 | $ 0.008 | $ 0.008 |
| **Consolidated Cash Flows From (Used For)** | | | | |
| Operating Activities | $ 4,326 | $ 4,147 | $ 3,003 | $ 2,423 |
| Investing Activities | $ (3,489) | $ (1,644) | $ (745) | $ (1,391) |
| Financing Activities | $ 593 | $ (774) | $ (1,126) | $ (1,442) |
| **Consolidated Financial Condition** | | | | |
| (As of December 31) | | | | |
| Cash and Investments | $ 14,982 | $ 12,253 | $ 9,477 | $ 6,329 |
| Total Assets | $ 41,288 | $ 27,862 | $ 17,668 | $ 14,187 |
| Debt | $ 7,095 | $ 4,011 | $ 1,979 | $ 1,761 |
| Shareholders Equity | $ 17,788 | $ 10,725 | $ 5,174 | $ 4,495 |
| Debt-to-Total-Capital Ratio | 28.5% | 27.2% | 27.7% | 28.1% |

Financial Highlights and Management s Discussion and Analysis of Financial Condition and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

(1) UnitedHealth Group s historical accounting policy for stock-based compensation followed the recognition and measurement principles of APB 25. Furthermore, UnitedHealth Group complied with the disclosure provisions of FAS 123.

(2) UnitedHealth Group acquired PacifiCare in December 2005 for total consideration of approximately $8.8 billion, Oxford in July 2004 for total consideration of approximately $5.0 billion and MAMSI in February 2004 for total consideration of approximately $2.7 billion. These acquisitions affect the comparability of 2006, 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group s Consolidated Financial Statements since the respective acquisition dates. See Note 5 of the Notes to Consolidated Financial Statements for a detailed discussion of these acquisitions.

(3) The unaudited Consolidated Statements of Operations and Cash Flows data for 2003 and 2002, and the unaudited Consolidated Balance Sheets data as of December 31, 2004, 2003 and 2002 have been revised to reflect adjustments related to the restatement described under

Management s Discussion and Analysis of Financial Condition and Results of Operations and Note 3 of the Notes to Consolidated Financial Statements. Pre-tax adjustments related to 2003 and 2002 include non-cash stock-based compensation expense totaling $172 million and $144 million, respectively under APB 25, our historical accounting method. The cumulative after tax impact of all restatement adjustments related to years prior to 2002 totaled $507 million under APB 25, our historical accounting method, and has been reflected as an adjustment to retained earnings at December 31, 2001. The following tables reflect the detailed unaudited 2003 and 2002 Statement of Operations adjustments under APB 25 and FAS 123R.

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**CONSOLIDATED STATEMENTS OF OPERATIONS UNAUDITED**

| (in millions, except per share data) | For the Year Ended December 31, 2003 | | | | | |
|---|---|---|---|---|---|---|
| | APB 25 | Historical Accounting Method | | FAS 123R | Current Accounting Method | |
| | As Reported | Adjustments (1) | As Restated | Adoption (2) | Adjustments (3) | As Restated |
| **Revenues** | | | | | | |
| Premiums | $ 25,448 | $ 835 | $ 26,283 | $ | $ | $ 26,283 |
| Services | 3,118 | (225) | 2,893 | | | 2,893 |
| Products | | 263 | 263 | | | 263 |
| Investment and Other Income | 257 | | 257 | | | 257 |
| Total Revenues | 28,823 | 873 | 29,696 | | | 29,696 |
| **Operating Costs** | | | | | | |
| Medical Costs | 20,714 | 768 | 21,482 | | | 21,482 |
| Operating Costs | 4,875 | 128 | 5,003 | 18 | 54 | 5,075 |
| Cost of Products Sold | | 169 | 169 | | | 169 |
| Depreciation and Amortization | 299 | | 299 | | | 299 |
| Total Operating Costs | 25,888 | 1,065 | 26,953 | 18 | 54 | 27,025 |
| **Earnings From Operations** | 2,935 | (192) | 2,743 | (18) | (54) | 2,671 |
| Interest Expense | (95) | | (95) | | | (95) |
| **Earnings Before Income Taxes** | 2,840 | (192) | 2,648 | (18) | (54) | 2,576 |
| Provision for Income Taxes | (1,015) | 62 | (953) | 19 | 13 | (921) |
| **Net Earnings** | $ 1,825 | $ (130) | $ 1,695 | $ 1 | $ (41) | $ 1,655 |
| **Basic Net Earnings per Common Share** | $ 1.55 | $ (0.11) | $ 1.44 | $ | $ (0.04) | $ 1.40 |
| **Diluted Net Earnings per Common Share** | $ 1.48 | $ (0.11) | $ 1.37 | $ | $ (0.03) | $ 1.34 |
| **Basic Weighted-Average Number of Common Shares Outstanding** | 1,178 | | 1,178 | | | 1,178 |
| **Dilutive Effect of Common Stock Equivalents** | 56 | (1) | 55 | 1 | 3 | 59 |
| **Diluted Weighted-Average Number of Common Shares Outstanding** | 1,234 | (1) | 1,233 | 1 | 3 | 1,237 |

Financial Highlights and Management s Discussion and Analysis of Financial Condition and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

(1) Includes $172 million of stock-based compensation expense and $49 million of deferred tax benefit associated with the restatement of our historical APB 25 Consolidated Statement of Operations as well as an adjustment to premium revenue of $927 million, medical costs of $848 million and operating costs of $79 million to reflect a reinsurance contract on a gross basis. In order to conform to our current presentation, we have also reclassified certain service revenues and operating costs to product revenues and cost of products sold, respectively, primarily related to our pharmacy benefit management business acquired as part of the PacifiCare acquisition in December 2005.

(2) Reflects $190 million of stock-based compensation expense and $68 million of deferred tax benefit as recorded under the modified retrospective method of adoption of FAS 123R, net of the restatement adjustments under APB 25.

(3) Represents adjustments made to restate our Consolidated Statement of Operations subsequent to the adoption of FAS 123R under the modified retrospective method of adoption and includes $54 million of additional stock-based compensation expense and $13 million of related deferred tax benefit.

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**CONSOLIDATED STATEMENTS OF OPERATIONS UNAUDITED**

| (in millions, except per share data) | For the Year Ended December 31, 2002 | | | | | |
|---|---|---|---|---|---|---|
| | APB 25 | Historical Accounting Method | | FAS 123R | Current Accounting Method | |
| | As Reported | Adjustments (1) | As Restated | Adoption (2) | Adjustments (3) | As Restated |
| **Revenues** | | | | | | |
| Premiums | $ 21,906 | $ 808 | $ 22,714 | $ | $ | $ 22,714 |
| Services | 2,894 | (310) | 2,584 | | | 2,584 |
| Products | | 345 | 345 | | | 345 |
| Investment and Other Income | 220 | (2) | 218 | | | 218 |
| Total Revenues | 25,020 | 841 | 25,861 | | | 25,861 |
| **Operating Costs** | | | | | | |
| Medical Costs | 18,192 | 746 | 18,938 | | | 18,938 |
| Operating Costs | 4,387 | (11) | 4,376 | 12 | 62 | 4,450 |
| Cost of Products Sold | | 249 | 249 | | | 249 |
| Depreciation and Amortization | 255 | | 255 | | | 255 |
| Total Operating Costs | 22,834 | 984 | 23,818 | 12 | 62 | 23,892 |
| **Earnings From Operations** | 2,186 | (143) | 2,043 | (12) | (62) | 1,969 |
| Interest Expense | (90) | | (90) | | | (90) |
| **Earnings Before Income Taxes** | 2,096 | (143) | 1,953 | (12) | (62) | 1,879 |
| Provision for Income Taxes | (744) | 42 | (702) | 11 | 18 | (673) |
| **Net Earnings** | $ 1,352 | $ (101) | $ 1,251 | $ (1) | $ (44) | $ 1,206 |
| **Basic Net Earnings per Common Share** | $ 1.12 | $ (0.09) | $ 1.03 | $ | $ (0.04) | $ 0.99 |
| **Diluted Net Earnings per Common Share** | $ 1.06 | $ (0.07) | $ 0.99 | $ | $ (0.04) | $ 0.95 |
| **Basic Weighted-Average Number of Common Shares Outstanding** | 1,214 | | 1,214 | | | 1,214 |
| **Dilutive Effect of Common Stock Equivalents** | 58 | (2) | 56 | 2 | | 58 |
| **Diluted Weighted-Average Number of Common Shares Outstanding** | 1,272 | (2) | 1,270 | 2 | | 1,272 |

Financial Highlights and Management s Discussion and Analysis of Financial Condition and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes.

(1) Includes $144 million of stock-based compensation and $44 million of deferred tax benefit associated with the restatement of our historical APB 25 Consolidated Statement of Operations as well as an adjustment to premium revenue of $897 million, medical costs of $825 million and operating costs of $72 million to reflect a reinsurance contract on a gross basis. In order to conform to our current presentation, we have also reclassified certain service revenues and operating costs to product revenues and costs of products sold, respectively, primarily related to our pharmacy benefit management business acquired as part of the PacifiCare acquisition in December 2005.

(2) Reflects $156 million of stock-based compensation and $55 million of deferred tax benefit as recorded under the modified retrospective method of adoption of FAS 123R, net of the restatement adjustments under APB 25.

(3) Represents adjustments made to restate our Consolidated Statement of Operations subsequent to the adoption of FAS 123R under the modified retrospective method of adoption and includes $62 million of additional stock-based compensation expense and $18 million of related deferred tax benefit.

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**ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS**

**Business Overview**

UnitedHealth Group is a diversified health and well-being company, serving approximately 70 million Americans. Our focus is on improving the American health care system by simplifying the administrative components of health care delivery; promoting evidence-based medicine as the standard for care; and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and informatics; and health care resource organization and care facilitation to make health care work better. We provide individuals with access to quality, cost-effective health care services and resources. We provide employers and consumers 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.

**Financial Restatements**

All of the financial information presented in this Item 7 has been adjusted to reflect the restatement of the Company s financial results, which is more fully described in the Explanatory Note immediately preceding Part I, Item 1 and in Note 3, Restatement of Consolidated Financial Statements of the Notes to Consolidated Financial Statements in this Form 10-K. The impact under FAS 123R of recognizing additional stock-based compensation expense and related tax effects as a result of historic stock option practices as well as immaterial adjustments unrelated to historic stock option practices that were identified through a review of the Company s accounting practices is $43 million ($57 million net of tax) in 2005, $40 million ($44 million net of tax) in 2004, and an aggregate of $453 million ($313 million net of tax) for 2003 and all prior years. The impact under APB 25 of all errors is $304 million ($238 million net of tax) in 2005, $200 million ($158 million net of tax) in 2004, and an aggregate of $1,056 million ($738 million net of tax) for 2003 and all prior years. The Company also conducted a sensitivity analysis to assess how the restatement adjustment would have changed under two alternative methodologies for determining measurement dates. See Critical Accounting Policies and Estimates Stock Option Measurement Dates for details.

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The following tables illustrate the effect of the restatement adjustments on our pro forma net earnings and pro forma net earnings per share if we had recorded compensation expense based on the estimated grant date fair value accounting method as defined by FAS 123 for all stock-based awards granted from 1995 to 2003. Refer to Note 3 for an illustration of the effect of the FAS 123R restatement adjustments relating to 2004 and 2005.

| (in millions, except per share data)-Unaudited | 2003 | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 |
|---|---|---|---|---|---|---|---|---|---|
| Net Earnings | | | | | | | | | |
| *APB 25* | | | | | | | | | |
| As Reported APB 25 | $ 1,825 | $ 1,352 | $ 913 | $ 736 | $ 568 | $ (214) | $ 431 | $ 327 | $ 279 |
| Restatement Adjustments APB 25: | | | | | | | | | |
| Compensation Expense, net of tax effects | (123) | (100) | (172) | (177) | (27) | (40) | (16) | (20) | (17) |
| Other Adjustments, net of tax effects | (7) | (1) | (5) | (3) | (3) | (2) | (3) | (2) | (3) |
| As Restated APB 25 | $ 1,695 | $ 1,251 | $ 736 | $ 556 | $ 538 | $ (256) | $ 412 | $ 305 | $ 259 |
| *FAS 123 Pro Forma* | | | | | | | | | |
| As Restated-APB 25 | $ 1,695 | $ 1,251 | $ 736 | $ 556 | $ 538 | $ (256) | $ 412 | $ 305 | $ 259 |
| Less: APB 25 Compensation Expense, net of tax effects | 123 | 100 | 172 | 177 | 27 | 40 | 16 | 20 | 17 |
| FAS 123 Historical Compensation Expense, net of tax effects | (122) | (101) | (82) | (76) | (37) | (40) | (30) | (24) | (20) |
| Restatement Adjustments | | | | | | | | | |
| FAS 123 Compensation Expense, net of tax effects | (41) | (44) | (53) | (94) | (14) | (22) | (8) | (4) | (4) |
| As Restated FAS 123 Pro Forma | $ 1,655 | $ 1,206 | $ 773 | $ 563 | $ 514 | $ (278) | $ 390 | $ 297 | $ 252 |
| Basic Net Earnings Per Common Share: | | | | | | | | | |
| As Reported APB 25 | $ 1.55 | $ 1.11 | $ 0.73 | $ 0.57 | $ 0.41 | $ (0.14) | $ 0.29 | $ 0.23 | $ 0.20 |
| As Restated APB 25 | $ 1.44 | $ 1.03 | $ 0.59 | $ 0.43 | $ 0.39 | $ (0.17) | $ 0.28 | $ 0.21 | $ 0.19 |
| As Restated FAS 123 Pro Forma | $ 1.40 | $ 0.99 | $ 0.62 | $ 0.43 | $ 0.37 | $ (0.18) | $ 0.26 | $ 0.20 | $ 0.18 |
| Diluted Net Earnings Per Common Share: | | | | | | | | | |
| As Reported APB 25 | $ 1.48 | $ 1.06 | $ 0.70 | $ 0.55 | $ 0.40 | $ (0.14) | $ 0.28 | $ 0.22 | $ 0.20 |
| As Restated APB 25 | $ 1.37 | $ 0.99 | $ 0.56 | $ 0.41 | $ 0.38 | $ (0.17) | $ 0.27 | $ 0.20 | $ 0.18 |
| As Restated FAS 123 Pro Forma | $ 1.34 | $ 0.95 | $ 0.59 | $ 0.42 | $ 0.36 | $ (0.18) | $ 0.25 | $ 0.20 | $ 0.18 |

**2006 Financial Performance Highlights**

UnitedHealth Group had very strong results in 2006. The Company achieved diversified growth across its business segments and generated net earnings of $4.2 billion, representing an increase of 35% over 2005. Other financial performance highlights include:

Diluted net earnings per common share of $2.97, an increase of 29% over 2005.

Consolidated revenues of $71.5 billion, an increase of 54% over 2005, with revenues advancing in each business segment. Excluding the impact of acquisitions, revenues increased 21% over 2005.

Earnings from operations of $7.0 billion, up $1.9 billion, or 37%, over 2005.

Operating margin of 9.8%, down from 10.9% in 2005, primarily due to changes in business mix related to the PacifiCare acquisition and the launch of the Medicare Part D program.

Cash flows from operations of $6.5 billion, up from $4.1 billion in 2005.

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**2006 Results Compared to 2005 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; product revenues; and investment and other income.

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

Consolidated revenues in 2006 of $71.5 billion increased by $25.1 billion, or 54%, over 2005. Excluding the impact of businesses acquired since the beginning of 2005, consolidated revenues increased by approximately 21% in 2006 principally driven by the successful launch of the Medicare Part D program on January 1, 2006, rate increases on premium-based and fee-based services and growth in individuals served across our business segments. Following is a discussion of 2006 consolidated revenue trends for each of our revenue components.

***Premium Revenues*** Consolidated premium revenues totaled $65.7 billion in 2006, an increase of $23.6 billion, or 56%, over 2005. Excluding the impact of acquisitions, consolidated premium revenues increased by $8.8 billion, or 21%, over 2005. This increase was primarily driven by premium rate increases and the successful launch of the Medicare Part D program, partially offset by a slight decrease in the number of individuals served by our commercial risk-based products.

UnitedHealthcare premium revenues in 2006 totaled $33.5 billion, an increase of $7.6 billion, or 29%, over 2005. Excluding premium revenues from businesses acquired since the beginning of 2005, UnitedHealthcare premium revenues were essentially flat compared to 2005. This was primarily due to average net premium rate increases of approximately 8% or above on UnitedHealthcare s renewing commercial risk-based products, offset by lower premium yields from new business due primarily to a larger portion of new customer sales generated from high-deductible lower-premium products (with correspondingly lower medical costs), and a 5% decrease in the number of individuals served by UnitedHealthcare s commercial risk-based products due primarily to the Company s internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of certain groups to fee-based products. Ovations premium revenues in 2006 totaled $24.4 billion, an increase of $15.2 billion, or 165%, over 2005. Excluding the impact of acquisitions, Ovations premium revenues increased by approximately $8.3 billion, or 92%, over 2005. The increase was driven primarily by the successful launch of the Medicare Part D program, which had premium revenues of $5.7 billion for 2006, and an increase in the number of individuals served by Medicare Advantage and Medicare supplement products, as well as rate increases on these products. Specialized Care Services premium revenues increased by approximately $1.0 billion over 2005. This was primarily due to the PacifiCare acquisition and strong growth in the number of individuals served by several Specialized Care Services businesses under premium-based arrangements. The remaining premium revenue increase resulted primarily from membership growth and premium revenue rate increases in AmeriChoice s Medicaid programs, which contributed premium revenue increases of approximately $278 million, or 8%, over 2005 excluding the impact of acquisitions.

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***Service Revenues*** Service revenues in 2006 totaled $4.3 billion, an increase of $602 million, or 16%, over 2005. Excluding the impact of acquisitions, service revenues increased by approximately 12% over 2005. The increase in service revenues was driven primarily by aggregate growth of 8% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2006, as well as annual rate increases. In addition, Ingenix service revenues increased by approximately 23% due to new business growth in the health information and contract research businesses and from businesses acquired since the beginning of 2005.

***Product Revenues*** Product revenues in 2006 totaled $737 million, an increase of $579 million over 2005. This was primarily due to pharmacy revenues at our PBM business, which was acquired in December 2005 with the purchase of PacifiCare.

***Investment and Other Income*** Investment and other income during 2006 totaled $871 million, representing an increase of $366 million over 2005. Interest income increased by $372 million in 2006, principally due to the impact of increased levels of cash and fixed-income investments during the year, due in part to the acquisition of PacifiCare, as well as higher yields on fixed-income investments. Net capital gains on sales of investments were $4 million in 2006, compared with net capital gains of $10 million in 2005.

**Medical Costs**

The combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts is reflected in the medical care ratio (medical costs as a percentage of premium revenues). The consolidated medical care ratio increased from 80.0% in 2005 to 81.2% in 2006. This medical care ratio increase resulted primarily from the impact of the acquisition of PacifiCare and launch of the Medicare Part D program, both of which carry a higher medical care ratio than the historic UnitedHealth Group businesses.

For each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior fiscal years, resulting from more complete claim information and other facts and circumstances, that are identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for 2006 include approximately $430 million of favorable medical cost development related to prior fiscal years. Medical costs for 2005 include approximately $400 million of favorable medical cost development related to prior fiscal years. The increase in favorable medical cost development in 2006 was driven by an increase in medical payables due to organic growth and businesses acquired since the beginning of 2005.

Medical costs for 2006 increased $19.6 billion, or 58%, to $53.3 billion, due to the impact of businesses acquired since the beginning of 2005, medical costs associated with the new Medicare Part D program and a medical cost trend of 7% to 8% on commercial risk-based business. Medical costs associated with the new Medicare Part D program for 2006 were $4.9 billion. Medical trend was due to both medical inflation and increases in health care consumption.

**Operating Costs**

The operating cost ratio (operating costs as a percentage of total revenues) for 2006 of 14.0%, improved from 15.4% in 2005. This decrease was primarily driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues primarily due to the new Medicare Part D program and the PacifiCare acquisition. Operating costs as a percentage of premium revenues are generally considerably lower than operating costs as a percentage of fee-based revenues. The decrease in the operating cost ratio reflected productivity gains from technology deployment and other cost management initiatives, including cost savings associated with the PacifiCare acquisition integration, and an insurance recovery of $43 million. These items were partially offset by a $22 million charitable contribution to the United Health Foundation and approximately $44 million of additional cash expenses related to the stock option review, exclusive of the FAS 123R compensation expense.

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Operating costs in 2006 totaled $10.0 billion, an increase of $2.8 billion, or 40%, over 2005. Excluding the impact of acquisitions, operating costs increased by approximately 13% over 2005. This increase was primarily due to the new Medicare Part D program as well as a 4% increase in the total number of individuals served by Health Care Services and Uniprise during 2006 (excluding the impact of acquisitions), growth in Specialized Care Services and Ingenix, general operating cost inflation, and the specific items discussed above, partially offset by productivity gains from technology deployment, cost savings associated with acquisition integrations and other cost management initiatives.

**Cost of Products Sold**

Cost of products sold in 2006 totaled $599 million, an increase of $510 million over 2005. This increase was primarily due to pharmacy sales at our PBM business, which was acquired in December 2005 with the purchase of PacifiCare.

**Depreciation and Amortization**

Depreciation and amortization in 2006 was $670 million, an increase of $217 million, or 48%, over 2005. Approximately $85 million of this increase was related to intangible assets from PacifiCare and other businesses acquired since the beginning of 2005. The remaining increase was primarily 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 2005.

**Income Taxes**

Our effective income tax rate was 36.3% in 2006 and in 2005.

**Business Segments**

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

| Revenues | 2006 | 2005 (As Restated) | Percent Change (As Restated) |
|---|---|---|---|
| Health Care Services | $ 64,180 | $ 40,023 | 60% |
| Uniprise | 5,451 | 4,893 | 11% |
| Specialized Care Services | 3,989 | 2,806 | 42% |
| Ingenix | 976 | 807 | 21% |
| Intersegment Eliminations | (3,054) | (2,104) | nm |
| Consolidated Revenues | $ 71,542 | $ 46,425 | 54% |

| Earnings From Operations | 2006 | 2005 (As Restated) | Percent Change (As Restated) |
|---|---|---|---|
| Health Care Services | $ 5,128 | $ 3,664 | 40% |
| Uniprise | 897 | 740 | 21% |
| Specialized Care Services | 769 | 541 | 42% |
| Ingenix | 190 | 135 | 41% |
| Consolidated Earnings From Operations | $ 6,984 | $ 5,080 | 37% |

nm - not meaningful

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**Health Care Services**

The Health Care Services segment is composed of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for local, small and mid-sized employers and individuals nationwide. Ovations provides health and well-being services to individuals age 50 and older, including the administration of supplemental health insurance coverage on behalf of AARP and the delivery of the new Medicare Part D prescription drug benefit to beneficiaries throughout the United States. AmeriChoice provides network-based health and well-being services to state Medicaid, Children s Health Insurance Programs and other government-sponsored health care programs and the beneficiaries of those programs. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been combined in the Health Care Services segment column in the tables presented below because these businesses have similar economic characteristics and have similar products and services, types of customers, distribution methods and operational processes, and operate in a similar regulatory environment, typically within the same legal entity.

Health Care Services had revenues of $64.2 billion in 2006, representing an increase of $24.2 billion, or 60%, over 2005. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately $8.9 billion, or 23%, over 2005. UnitedHealthcare revenues of $35.2 billion in 2006 increased by $8.0 billion, or 29%, over 2005. Excluding the impact of acquisitions, UnitedHealthcare revenues increased by approximately 1% over 2005 due to an increase in the number of individuals served with commercial fee-based products as well as average premium rate increases of approximately 8% or above on UnitedHealthcare s renewing commercial risk-based products, offset by lower premium yields from a larger portion of new customer sales generated from high-deductible lower-premium products (with correspondingly lower medical costs) and a 5% decrease in the number of individuals served by UnitedHealthcare s commercial risk-based products due primarily to the Company s internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of certain groups to fee-based products. Ovations revenues of $25.3 billion in 2006 increased by approximately $15.9 billion, or 168% over 2005. Excluding the impact of acquisitions, Ovations revenues increased by $8.4 billion, or 91%, over 2005. The increase was driven primarily by the successful launch of the Medicare Part D program, which had premium revenues of $5.7 billion for 2006, and an increase in the number of individuals served by Medicare Advantage and Medicare supplement products, as well as rate increases on these products. The remaining increase in Health Care Services revenues is attributable to an 8% increase in AmeriChoice revenues, excluding the impact of acquisitions, driven primarily by membership growth and premium revenue rate increases on Medicaid products.

Health Care Services earnings from operations in 2006 were $5.1 billion, representing an increase of $1.5 billion, or 40%, over 2005. This increase was principally driven by acquisitions and increases in the number of individuals served by Ovations Medicare and Part D products and UnitedHealthcare s fee-based products. The segment also benefited by productivity gains from technology deployment and other cost management initiatives, including cost savings associated with the PacifiCare acquisition integration. UnitedHealthcare s commercial medical care ratio increased to 79.8% in 2006 from 78.6% in 2005, mainly due to the impact of the PacifiCare acquisition and changes in product, business and customer mix. Health Care Services operating margin for 2006 was 8.0%, a decrease from 9.2% in 2005. This decrease was driven mainly by the acquisition of PacifiCare and the new Medicare Part D program, which have lower operating margins than historic UnitedHealth Group businesses.

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

| (in thousands) | 2006 | 2005 |
|---|---|---|
| Commercial | | |
| Risk-based | 10,040 | 10,105 |
| Fee-based | 4,735 | 3,990 |
| Total Commercial | 14,775 | 14,095 |
| Medicare Advantage | 1,410 | 1,150 |
| Medicare Part D Stand-alone | 4,500 | |
| Medicaid | 1,425 | 1,250 |
| Total Health Care Services | 22,110 | 16,495 |

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

The number of individuals served by UnitedHealthcare s commercial business as of December 31, 2006 increased by approximately 680,000, or 5%, over the prior year. Excluding the impact of acquisitions, commercial business individuals served increased by 185,000, or 1%, over the prior year. This included an increase of approximately 660,000 in the number of individuals served with commercial fee-based products, driven by new customer relationships and customers converting from risk-based products to fee-based products, offset by a decrease of approximately 475,000 in the number of individuals served with commercial risk-based products due primarily to the Company s internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of certain groups to fee-based products.

Excluding acquisitions, the number of individuals served by Ovations Medicare Advantage products increased by 230,000, or 20%, from 2005 due primarily to new customer relationships. Excluding the impact of acquisitions, AmeriChoice s Medicaid enrollment increased 65,000, or 5%, primarily due to new customer gains.

**Uniprise**

Uniprise provides network-based health and well-being services, business-to-business transaction processing services, consumer connectivity and technology support services nationwide to large employers and health plans, and provides health-related consumer and financial transaction products and services. Uniprise revenues in 2006 were $5.5 billion, representing an increase of $558 million, or 11%, over 2005. Excluding the impact of acquisitions, Uniprise revenues increased 7% over 2005. This increase was driven primarily by growth of 4% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 10.9 million individuals and 10.5 million individuals as of December 31, 2006 and 2005, respectively.

Uniprise earnings from operations for 2006 were $897 million, representing an increase of $157 million, or 21%, over 2005. Operating margin for 2006 improved to 16.5% for 2006 from 15.1% in 2005. 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 offers a comprehensive platform of specialty health, wellness and ancillary benefits, networks, services and resources to specific customer markets nationwide. Specialized Care Services revenues of

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$4.0 billion increased by $1.2 billion, or 42%, over 2005. Excluding the impact of acquisitions, revenues increased by 22% over the prior periods. 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 2006 of $769 million increased $228 million, or 42%, over 2005. Specialized Care Services operating margin was 19.3% in 2006 and 2005. Realized improvements in operating cost structure and benefits from the integration of PacifiCare specialty operations in 2006 were offset by a business mix shift toward higher revenue, lower margin products.

**Ingenix**

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a national and international basis. Ingenix revenues for 2006 of $976 million increased by $169 million, or 21%, over 2005. This was driven primarily by new business growth in the health information and contract research businesses, as well as businesses acquired since the beginning of 2005.

Earnings from operations in 2006 were $190 million, up $55 million, or 41%, from 2005. Operating margin was 19.5% in 2006, up from 16.7% in 2005. These increases in earnings from operations and operating margin were primarily due to growth in the health information and pharmaceutical services businesses, improving gross margins due to effective cost management and businesses acquired since the beginning of 2005.

**2005 Results Compared to 2004 Results**

**Consolidated Financial Results**

**Revenues**

Consolidated revenues in 2005 increased by $8.2 billion, or 21%, to $46.4 billion. Excluding the impact of businesses acquired since the beginning of 2004, consolidated revenues increased by approximately 11% in 2005 primarily 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 2005 consolidated revenue trends for each of our revenue components.

***Premium Revenues*** Consolidated premium revenues totaled $42.1 billion in 2005, an increase of $7.7 billion, or 22%, over 2004. Excluding the impact of acquisitions, consolidated premium revenues increased by approximately 11% over 2004. This increase was primarily driven by premium rate increases and a modest increase in the number of individuals served by our risk-based products.

UnitedHealthcare premium revenues in 2005 totaled $25.9 billion, an increase of $5.1 billion, or 24%, over 2004. Excluding premium revenues from businesses acquired since the beginning of 2004, UnitedHealthcare premium revenues increased by approximately 9% over 2004. This increase was primarily due to average net premium rate increases of approximately 8% to 9% on UnitedHealthcare s renewing commercial risk-based products. In addition, Ovations premium revenues in 2005 totaled $9.2 billion, an increase of $1.8 billion, or 24%, over 2004. Excluding the impact of acquisitions, Ovations premium revenues increased by approximately 20% over 2004, driven primarily by an increase in the number of individuals served by Medicare Advantage products and by Medicare supplement products provided to AARP members, as well as rate increases on these products. Premium revenues from AmeriChoice s Medicaid programs in 2005 totaled $3.3 billion, an increase of $270 million, or 9%, over 2004 driven primarily by premium 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 under premium-based arrangements.

***Service Revenues*** Service revenues in 2005 totaled $3.7 billion, an increase of $423 million, or 13%, over 2004. The increase in service revenues was driven primarily by aggregate growth of 8% in the number of individuals

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served by Uniprise and UnitedHealthcare under fee-based arrangements during 2005, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased by 16% due to growth in the health information and contract research businesses as well as businesses acquired since the beginning of 2004.

***Product Revenues*** Product revenues in 2005 totaled $158 million, an increase of $36 million over 2004. This was primarily due to pharmacy revenues at our PBM business, which was acquired in December 2005 with the purchase of PacifiCare, and increased revenues associated with the interim government-sponsored drug card program.

***Investment and Other Income*** Investment and other income totaled $505 million, representing an increase of $92 million over 2004. Interest income increased by $126 million in 2005, principally due to the impact of increased levels of cash and fixed-income investments during the year due to the acquisitions of Oxford and MAMSI as well as higher yields on fixed-income investments. Net capital gains on sales of investments were $10 million in 2005, a decrease of $34 million from 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. The consolidated medical care ratio decreased from 80.9% in 2004 to 80.0% in 2005. This medical care ratio decrease resulted primarily from changes in product, business and customer mix and an increase in favorable medical cost development related to prior periods.

For each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior fiscal years, resulting from more complete claim information, that are identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for 2005 include approximately $400 million of favorable medical cost development related to prior fiscal years. Medical costs for 2004 include approximately $210 million of favorable medical cost development related to prior fiscal years. The increase in favorable medical cost development in 2005 was driven primarily by growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004.

On an absolute dollar basis, 2005 medical costs totaled $33.7 billion, an increase of $5.8 billion, or 21%, over 2004. Excluding the impact of acquisitions, medical costs increased by approximately 9% driven primarily by a medical cost trend of 7% to 8% due to both inflation and an increase in health care consumption as well as organic growth.

**Operating Costs**

The operating cost ratio for 2005 was 15.4%, down from 15.9% in 2004. 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 2005 totaled $7.1 billion, an increase of $1.1 billion, or 17%, over 2004. Excluding the impact of acquisitions, operating costs increased by approximately 11%. This increase was driven by an 8% increase in total individuals served by Health Care Services and Uniprise during 2005 (excluding the impact of acquisitions), growth in Specialized Care Services and Ingenix and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

**Cost of Products Sold**

Cost of products sold in 2005 totaled $89 million, an increase of $35 million over 2004. This was primarily due to pharmacy sales at our PBM business, which was acquired in December 2005 with the purchase of PacifiCare, and increased costs associated with sales under the interim government-sponsored drug card program.

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**Depreciation and Amortization**

Depreciation and amortization in 2005 was $453 million, an increase of $79 million, or 21%, over 2004. Approximately $32 million of this increase was related to intangible assets from business acquisitions since the beginning of 2004. The remaining increase was primarily due to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements and business growth.

**Income Taxes**

Our effective income tax rate was 36.3% in 2005, compared to 35.4% in 2004. The increase was mainly driven by favorable settlements of prior year tax returns during 2004 and an increase in 2005 state taxes.

**Business Segments**

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

| Revenues | 2005 (As Restated) | 2004 (As Restated) | Percent Change (As Restated) |
|---|---|---|---|
| Health Care Services | $ 40,023 | $ 32,681 | 22% |
| Uniprise | 4,893 | 4,318 | 13% |
| Specialized Care Services | 2,806 | 2,296 | 22% |
| Ingenix | 807 | 707 | 14% |
| Intersegment Eliminations | (2,104) | (1,785) | nm |
| Consolidated Revenues | $ 46,425 | $ 38,217 | 21% |

| Earnings From Operations | 2005 (As Restated) | 2004 (As Restated) | Percent Change (As Restated) |
|---|---|---|---|
| Health Care Services | $ 3,664 | $ 2,688 | 36% |
| Uniprise | 740 | 624 | 19% |
| Specialized Care Services | 541 | 445 | 22% |
| Ingenix | 135 | 101 | 34% |
| Consolidated Earnings From Operations | $ 5,080 | $ 3,858 | 32% |

nm - not meaningful

**Health Care Services**

Health Care Services had revenues of $40.0 billion in 2005, representing an increase of $7.3 billion, or 22%, over 2004. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately $3.0 billion, or 11%, over 2004. UnitedHealthcare accounted for approximately $1.6 billion of this increase, driven by average premium rate increases of approximately 8% to 9% on UnitedHealthcare s renewing commercial risk-based products. Ovations contributed approximately $1.2 billion to the revenue advance over 2004 largely attributable to growth in the number of individuals served by Ovations Medicare supplement products provided to AARP members and by its Medicare Advantage products as well as rate increases on these products. The remaining increase in Health Care Services revenues is attributable to an 8% increase in AmeriChoice s revenues, excluding the impact of acquisitions, driven primarily by premium revenue rate increases on Medicaid products.

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Health Care Services earnings from operations in 2005 were $3.7 billion, representing an increase of $976 million, or 36%, over 2004. This increase primarily resulted from revenue growth and improved gross margins on UnitedHealthcare s risk-based products, increases in the number of individuals served by UnitedHealthcare s commercial fee-based products, and the acquisitions of Oxford and MAMSI during 2004. UnitedHealthcare s commercial medical care ratio decreased to 78.6% in 2005 from 79.3% in 2004 mainly due to changes in product, business and customer mix. Health Care Services 2005 operating margin was 9.2%, an increase from 8.2% in 2004. This increase was driven mainly by the lower commercial medical care ratio as well as changes in business and customer mix.

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

| (in thousands) | 2005 (2) | 2004 |
|---|---|---|
| Commercial | | |
| Risk-based | 10,105 | 7,655 |
| Fee-based | 3,990 | 3,305 |
| Total Commercial | 14,095 | 10,960 |
| Medicare Advantage | 1,150 | 330 |
| Medicaid | 1,250 | 1,260 |
| Total Health Care Services | 16,495 | 12,550 |

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

(2) Includes commercial risk-based membership of 2.34 million, commercial fee-based membership of 95,000 and Medicare membership of 755,000 related to the December 2005 acquisition of PacifiCare.

The number of individuals served by UnitedHealthcare s commercial business as of December 31, 2005, excluding the PacifiCare acquisition, increased by approximately 700,000 over the prior year. This included an increase of 590,000 in the number of individuals served with fee-based products driven by the addition of approximately 335,000 individuals served resulting from new customer relationships and customers converting from risk-based products to fee-based products as well as approximately 255,000 individuals served by a benefits administrative services company acquired in December 2005. In addition, the number of individuals served with commercial risk-based products increased by 110,000 driven primarily by the addition of approximately 130,000 individuals served by Neighborhood Health Partnership, acquired in September 2005, and a slight increase in net new customer relationships more than offset by customers converting from risk-based products to fee-based products.

Excluding the PacifiCare acquisition, the number of individuals served by Ovations Medicare Advantage products increased by 65,000, or 20%, over 2004 due primarily to new customer relationships. AmeriChoice s Medicaid enrollment decreased by 10,000 from 2004 due primarily to the withdrawal of participation in one market during the third quarter of 2005 partially offset by new customer relationships since 2004.

**Uniprise**

Uniprise revenues in 2005 were $4.9 billion, representing an increase of $575 million, or 13%, over 2004. Excluding the impact of acquisitions, Uniprise revenues increased approximately 11% over 2004. This increase was driven primarily by growth of 7% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 10.5 million individuals and 9.9 million individuals as of December 31, 2005 and 2004, respectively.

Uniprise earnings from operations in 2005 were $740 million, representing an increase of $116 million, or 19%, over 2004. Operating margin for 2005 improved to 15.1% from 14.5% in 2004. Uniprise has expanded its

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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 revenues of $2.8 billion increased by $510 million, or 22%, over 2004. This increase was principally driven by an 11% increase in the number of individuals served by its specialty benefit businesses, excluding the impact of acquisitions, and rate increases related to these businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 of $541 million increased $96 million, or 22%, over 2004. Specialized Care Services operating margin was 19.3% in 2005, down from 19.4% in 2004. This decrease was due to a business mix shift toward higher revenue, lower margin products, partially offset by continued gains in quality initiatives and operating cost efficiencies.

**Ingenix**

Ingenix 2005 revenues of $807 million increased by $100 million, or 14%, over 2004. This was driven primarily by growth in the health information and contract research businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 were $135 million, up $34 million, or 34%, from 2004. Ingenix s operating margin was 16.7% in 2005, up from 14.3% in 2004. The increase in earnings from operations and operating margin was primarily due to growth in the health information and contract research businesses, improving gross margins due to effective cost management and businesses acquired since the beginning of 2004.

**Financial Condition, Liquidity and Capital Resources at December 31, 2006**

**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 is 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

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on market conditions. In August 2006, we announced that we would not purchase shares under our stock repurchase program until we had completed our restatement (which is reflected in this Form 10-K) and become current in our periodic SEC filings. As a result, we did not repurchase any shares through this publicly announced program for the quarter ended December 31, 2006.

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

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, debt ratings, debt covenants and other contractual restrictions, regulatory requirements and market conditions. We believe that our strategies and actions toward maintaining financial flexibility mitigate much of this risk. However, a significant downgrade in ratings may increase the cost of borrowing for the Company or limit the Company s access to capital. See Cautionary Statements Relating to Our Historic Stock Option Practices Credit Ratings for additional information.

**Cash and Investments**

Cash flows from operating activities were $6.5 billion in 2006, an increase over $4.1 billion in 2005. The increase in operating cash flows resulted primarily from an increase of $1.3 billion in net income prior to

depreciation, amortization and other noncash items as well as an increase of approximately $1.1 billion in cash flows generated from working capital changes. We generated operating cash flows from working capital changes of $1.6 billion in 2006 and $412 million in 2005. The year-over-year increase primarily resulted from the Company receiving twelve monthly Medicare premium payments during 2006 from CMS rather than the eleven monthly payments received in 2005, positively impacting the change in reported operating cash flows by $275 million, along with growth in medical payables during 2006 compared to 2005 primarily driven by overall growth of the insured business. Additionally, there was an increase in accrued taxes payable due largely to an increase in pre-tax earnings.

We maintained a strong financial condition and liquidity position, with cash and investments of $20.6 billion at December 31, 2006. Total cash and investments increased by $5.6 billion since December 31, 2005, primarily due to strong operating cash flows, cash received from debt and common stock issuances, and cash and investments acquired through businesses acquired since the beginning of 2006, partially offset by common stock repurchases, cash paid for business acquisitions and capital expenditures.

As further described under Regulatory Capital and Dividend Restrictions, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At December 31, 2006, approximately $1.9 billion of our $20.6 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 long-term debt to maintain adequate operating and financial flexibility. As of December 31, 2006 and 2005, we had commercial paper and long-term debt outstanding of approximately $7.5 billion and $7.1 billion, respectively. Our debt-to-total-capital ratio was 26.4% and 28.5% as of December 31, 2006 and December 31, 2005,

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respectively. We believe the prudent use of debt optimizes our cost of capital and return on shareholders equity, while maintaining appropriate liquidity.

As of December 31, 2006, our outstanding commercial paper had interest rates of approximately 5.3% to 5.5%.

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

On February 24, 2006, our Health Care Services business segment acquired John Deere Health Care, Inc. (JDHC). Under the terms of the purchase agreement, we paid approximately $515 million in cash, including transaction costs, in exchange for all of the outstanding equity of JDHC. We issued commercial paper to finance the JDHC purchase price. JDHC has been renamed UnitedHealthcare Services Company of the River Valley, Inc.

On December 20, 2005, the Company acquired PacifiCare. Under the terms of the agreement, PacifiCare shareholders received 1.1 shares of UnitedHealth Group common stock and $21.50 in cash for each share of PacifiCare common stock they owned. Total consideration issued for the transaction was approximately $8.8 billion, composed of approximately 99.2 million shares of UnitedHealth Group common stock (valued at approximately $5.3 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 July 6, 2005), approximately $2.1 billion in cash, $960 million in cash paid to retire PacifiCare s existing debt and UnitedHealth Group vested common stock options with an estimated fair value of approximately $420 million issued in exchange for PacifiCare s outstanding vested common stock options.

On September 19, 2005, our Health Care Services business segment acquired Neighborhood Health Partnership (NHP). Under the terms of the purchase agreement, we paid approximately $185 million in cash in exchange for all of the outstanding equity of NHP. We issued commercial paper to finance the NHP purchase price.

On October 16, 2006, we executed a $7.5 billion 364-day revolving credit facility in order to ensure the Company s immediate and continued access to additional liquidity, if necessary. The credit facility is available for working capital purposes as well as to pay or repay any outstanding borrowings of the Company. We have entered into amendments to this credit facility to provide us with additional time to deliver to the lenders this 10-K and our quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006 and our annual report on Form 10-K for the year ended December 31, 2006. As of December 31, 2006, we had no amounts outstanding under our $7.5 billion credit facility.

In March 2006, we refinanced outstanding commercial paper by issuing $650 million of floating-rate notes due March 2009, $750 million of 5.3% fixed-rate notes due March 2011, $750 million of 5.4% fixed-rate notes due March 2016 and $850 million of 5.8% fixed-rate notes due March 2036. The floating-rate notes due March 2009 are benchmarked to the London Interbank Offered Rate (LIBOR) and had an interest rate of 5.5% at December 31, 2006.

In December 2005, we amended and restated our $1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the credit facility to $1.3 billion and extended the maturity date to December 2010. We entered into amendments to our $1.3 billion credit facility to provide us with additional time to deliver to the lenders our quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006 and our annual report on Form 10-K for the year ended December 31, 2006, to obtain our lenders agreement and acknowledgement that the delivery of a notice of default or notice of acceleration under any indenture or credit agreement that is being contested by the Company in good faith does not cause a default or event of default under the credit agreement, and to obtain a waiver of any potential default that may arise as a result of our determination that our historical financial information should not be relied upon and as a result of

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our restatement of our historical financial statements. As of December 31, 2006, we had no amounts outstanding under our $1.3 billion credit facility.

In November and December 2005, we issued $2.6 billion of commercial paper primarily to finance the cash portion of the purchase price of the PacifiCare acquisition described above and to retire a portion of the PacifiCare debt at the closing of the acquisition, as well as to refinance current maturities of long-term debt.

In October 2005, we executed a $3.0 billion 364-day revolving credit facility to support a $3.0 billion increase in our commercial paper program in order to finance the cash portion of the PacifiCare acquisition. We terminated the 364-day revolving credit facility in March 2006.

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, capital expenditures, working capital and share repurchases.

To more closely align interest costs with the floating interest rate received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from a fixed rate to a variable rate. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of $4.9 billion as of December 31, 2006 with variable rates that are benchmarked to LIBOR, and are recorded on our Consolidated Balance Sheets. As of December 31, 2006, the aggregate liability, recorded at fair value, for all existing interest rate swaps was approximately $73 million. These fair value hedges are accounted for using the short-cut method under Statement of Financial Accounting Standards No. 133, Accounting for Derivative Instruments and Hedging Activities (FAS 133), whereby the hedges are reported on our Consolidated Balance Sheets at fair value, and the carrying value of the long-term debt is adjusted for an offsetting amount representing changes in fair value attributable to the hedged risk. Since these amounts completely offset, we have reported both the swap liability and the debt liability within debt on our Consolidated Balance Sheets and there have been no net gains or losses recognized in our Consolidated Statements of Operations. At December 31, 2006, the rates used to accrue interest expense on these agreements ranged from 4.9% to 5.7%.

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

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

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

Our senior debt is rated A with a negative outlook by Standard & Poor s (S&P), A with a negative watch by Fitch, and A3 with a negative outlook by Moody s. Our commercial paper is rated A-1 with a negative outlook by S&P, F-1 with a negative watch by Fitch, and P-2 with a negative outlook by Moody s. Moody s downgraded our rating in October 2006 citing concerns about corporate governance following the release of the WilmerHale Report (See Note 3 of the Notes to Consolidated Financial Statements). We do not expect this Moody s downgrade to significantly affect our borrowing capacity or costs. A significant downgrade in our debt or commercial paper ratings could adversely affect our borrowing capacity and costs. See Cautionary Statements Relating to Our Historic Stock Option Practices Credit Ratings for additional information.

Under our Board of Directors authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. There is no established expiration date for the program. During the year ended December 31, 2006, we repurchased 40.2 million shares at an average price of approximately $56 per share and an aggregate cost of approximately $2.2 billion. As of December 31, 2006, we had Board of Directors authorization to purchase up to an additional 136.7 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. The Company suspended purchases under its stock repurchase program in the third quarter of 2006 pending completion of our restatement (which is reflected in this Form 10-K) and becoming current in our periodic SEC filings. The Company intends to resume its stock repurchase program in 2007.

We currently have $1.0 billion remaining under our universal S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities), although we will be unable to issue securities on Form S-3 on a primary basis until we have timely filed all reports required to be filed with the SEC for a twelve-month period. We may offer securities from time to time at prices and terms to be determined at the time of offering. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of 48.6 million shares of our common stock in connection with acquisition activities. We filed a separate S-4 registration statement for the 99.2 million shares issued in connection with the December 2005 acquisition of PacifiCare described previously.

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

The following table summarizes future obligations due by period as of December 31, 2006, under our various contractual obligations, off-balance sheet arrangements and commitments (in millions):

| | 2007 | 2008 to 2009 | 2010 to 2011 | Thereafter | Total |
|---|---|---|---|---|---|
| Debt and Commercial Paper (1) | $ 1,483 | $ 1,850 | $ 750 | $ 3,373 | $ 7,456 |
| Interest on Debt and Commercial Paper (2) | 366 | 581 | 438 | 1,660 | 3,045 |
| Operating Leases | 156 | 273 | 167 | 370 | 966 |
| Purchase Obligations (3) | 182 | 144 | 30 | 5 | 361 |
| Future Policy Benefits (4) | 121 | 339 | 325 | 1,186 | 1,971 |
| Other Long-Term Obligations (5) | | 74 | 12 | 325 | 399 |
| Total Contractual Obligations | $ 2,308 | $ 3,261 | $ 1,722 | $ 6,919 | $ 14,210 |

(1) Debt payments could be accelerated upon violation of debt covenants. We believe the likelihood of acceleration is remote.

(2) Calculated using stated rates from the debt agreements and related interest rate swap agreements and assuming amounts are outstanding through their contractual term. For variable-rate obligations, we used the rates in place as of December 31, 2006 to estimate all remaining contractual payments.

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(3) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements which are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and also excludes liabilities to the extent recorded on the Consolidated Balance Sheets at December 31, 2006.

(4) Estimated payments required under life and annuity contracts held by a divested entity. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica, but we remain primarily liable to the policyholders if they are unable to pay (See Note 5 of the Notes to Consolidated Financial Statements). The payable is offset by a corresponding reinsurance receivable from OneAmerica.

(5) Includes obligations associated with certain employee benefit programs and minority interest purchase commitments.

The table above includes a facility lease agreement that we signed in 2006. Lease payments are expected to commence under this agreement in March 2009, at the time we occupy the facility, and extend over a 20 year period with total estimated lease payments of $229 million.

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

Due to the financial restatements previously discussed, the Company has determined that certain options exercised by nonexecutive officer employees in 2006 were discount options subject to Section 409A of the Internal Revenue Code. The Company notified the Internal Revenue Service (IRS) on February 28, 2007 that it would participate in the IRS s resolution program which allows the Company to pay its employees additional tax costs under Section 409A. As such, the Company will take a charge, net of tax benefit, of approximately $55 million in the first quarter of 2007.

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.

**Medicare Part D Pharmacy Benefits Contract**

Beginning January 1, 2006, the Company began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage under a contract with CMS. The Company contracts with CMS on an annual basis. Under Medicare Part D, members have access to a standard drug benefit that features a monthly premium, typically with an initial annual deductible, coinsurance of 25% for the member and 75% for the Company up to an initial coverage limit of $2,250 of annual drug costs, no insurance coverage between $2,250 and $5,100 (except the member gets the benefit of the Company s significant drug discounts), and catastrophic coverage for annual drug costs in excess of $5,100 covered approximately 80% by CMS, 15% by the Company and 5% by the member up to an annual out-of-pocket maximum of $3,600.

The Company s contract with CMS includes risk-sharing provisions, wherein CMS retains approximately 75% to 80% of the losses or profits outside a pre-defined risk corridor. The risk-sharing provisions take effect if actual pharmacy benefit costs are more than 2.5% above or below expected cost levels as submitted by the Company in its initial contract application.

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During 2006, members were permitted to enroll or disenroll in a Medicare Part D plan until May 15, 2006. Once enrolled, most members were allowed to switch plans once before May 15, 2006 (although low-income members eligible for both Medicare and Medicaid are allowed to change plans monthly). Contracts are generally non-cancelable by enrollees after May 15, 2006. After that date, enrollees may change plans once every year between November 15 and December 31 to take effect January 1 of the following year.

As a result of the Medicare Part D benefit design, the Company incurs benefit costs unevenly during the annual contract year. While the Company is responsible for a majority of a Medicare member s drug costs up to $2,250, the member is responsible for their drug costs from $2,250 up to $5,100 (at the Company s discounted purchase price). As such, the Company incurs disproportionately higher benefit claims in the first half of the contract year as compared with last half of the contract year, when comparatively more members will be incurring claims above the $2,250 initial coverage limit. Although the Company also incurs costs for individuals with annual pharmacy claims in excess of $5,100, these costs represent a much smaller portion of total contract costs, and will be incurred primarily in the second half of the year. The uneven timing of Medicare Part D pharmacy benefit claims results in losses in the first half of year that entitle the Company to risk-share adjustment payments from CMS. Accordingly, during the interim periods within the contract year we record a net risk-share receivable from CMS in other current assets in the Consolidated Balance Sheets and a corresponding retrospective premium adjustment in premium revenues in the Consolidated Statements of Operations. This represents the estimated amount payable by CMS to the Company under the risk-share contract provisions if the program were terminated based on estimated costs incurred through that interim period. Those losses reverse in the second half of the year and final risk-share amounts due to or from CMS, if any, are settled approximately six months after the contract year-end. The projected net risk-share payable to be paid to CMS as of December 31, 2006 was approximately $350 million.

**AARP**

In January 1998, we entered into a ten-year contract with AARP to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare (Medicare Supplement insurance), hospital indemnity insurance, health insurance focused on persons between 50 to 64 years of age, and other products. Under the terms of this Medicare Supplement insurance contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from these AARP Supplemental Health Insurance offerings were approximately $5.0 billion in 2006, $4.9 billion in 2005 and $4.5 billion in 2004.

The underwriting gains or losses related to the AARP Medicare Supplement Insurance business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. As further described in Note 13 to the Consolidated Financial Statements, the RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance at December 31, 2006 is currently sufficient to cover potential future underwriting and other risks associated with the contract.

Under a separate license agreement with AARP, we sell Medicare Prescription Drug benefit plans under the AARP brand name. We assume all operational and underwriting risks and losses for these plans.

**Regulatory Capital and Dividend Restrictions**

We conduct a significant portion of our operations through subsidiaries that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require

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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. We maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require.

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

The inability of the Company s regulated subsidiaries to pay dividends to their parent companies would impact the scale to which we could reinvest in our business through capital expenditures, business acquisitions and the repurchase of shares of our common stock. In addition, the inability to pay regulated dividends could impact our ability to repay our debt; however, our cash flows from operating activities generated from our non-regulated businesses greatly mitigate this risk. As of December 31, 2006, approximately $1.9 billion of our $20.6 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use.

**Critical Accounting Policies and Estimates**

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

***Medical Costs***

Each reporting period, we estimate our obligations for medical care services that have been rendered on behalf of insured consumers 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. Depending on the health care provider and type of service, the typical billing lag for services can range from two to 90 days from the date of service. Substantially all claims related to medical care services are known and settled within nine to twelve months from the date of service. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies.

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Historically, the net impact of estimate developments has represented less than 1% of annual medical costs, less than 5% of annual earnings from operations and less than 4% of medical costs payable.

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In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience, of the percentage of incurred claims during a given period that have been adjudicated by the Company as of the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date in order to estimate the expected amount of ultimate incurred claims for those months. We do not believe that completion factors are a reliable basis for estimating claims incurred for the most recent three months as there is typically insufficient claim data available for those months to calculate credible completion factors. Accordingly, for the most recent three months, we estimate claim costs incurred primarily by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months for which more complete claim data is available and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider completion factors in developing medical cost estimates for the most recent months. This approach is consistently applied from period to period.

Completion factors are the most significant factors we use in developing our medical costs payable estimates for older periods, generally periods prior to the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2006:

| Completion Factor<br>Increase (Decrease) in Factor | Increase (Decrease) in Medical Costs Payable (1) (in millions) |
|---|---|
| (0.75)% | $ 126 |
| (0.50)% | $ 84 |
| (0.25)% | $ 42 |
| 0.25% | $ (42) |
| 0.50% | $ (84) |
| 0.75% | $ (126) |

Medical cost PMPM trend factors are the most significant factors we use in estimating our medical costs payable for the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2006:

| Medical Cost PMPM Trend<br>Increase (Decrease) in Factor | Increase (Decrease) in Medical Costs Payable (2) (in millions) |
|---|---|
| 3% | $ 247 |
| 2% | $ 165 |
| 1% | $ 82 |
| (1)% | $ (82) |
| (2)% | $ (165) |
| (3)% | $ (247) |

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

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

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

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

| | Increase (Decrease) | Medical Costs | | Earnings from Operations | |
|---|---|---|---|---|---|
| | Favorable Development | to Medical Costs(a) | As Restated (b) | As Adjusted (c) | As Restated (b) | As Adjusted |
| 2002 | $ 70 | $ (80) | $ 18,938 | $ 18,858 | $ 1,969 | $ 2,049 |
| 2003 | $ 150 | $ (60) | $ 21,482 | $ 21,422 | $ 2,671 | $ 2,731 |
| 2004 | $ 210 | $ (190) | $ 27,858 | $ 27,668 | $ 3,858 | $ 4,048 |
| 2005 | $ 400 | $ (30) | $ 33,669 | $ 33,639 | $ 5,080 | $ 5,110 |
| 2006 | $ 430 | (d) | $ 53,308 | (d) | $ 6,984 | (d) |

(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) Restated to include the impact of FAS 123R, which we adopted effective January 1, 2006, as well as impacts associated with the restatement described in Note 3 Restatement of Consolidated Financial Statements.

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

(d) Not yet determinable as the amount of prior period development recorded in 2007 will change as our December 31, 2006 medical costs payable estimate develops throughout 2007.

Our estimate of medical costs payable represents management s best estimate of the Company s liability for unpaid medical costs as of December 31, 2006, 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, 2006; however, actual claim payments may differ from established estimates. The increase in favorable medical cost development in 2006 was driven primarily by growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2005. As our medical costs payable estimate increases in amount due to increases in the fully insured consumer base and inflationary increases in medical costs, the absolute dollar amount of subsequent changes to that estimate will increase even if the accuracy of our medical costs payable estimate remains consistent as a percentage of the original estimate. Assuming a hypothetical 1% difference between our December 31, 2006 estimates of medical costs payable and actual medical costs payable, excluding the AARP business, 2006 earnings from operations would increase or decrease by $71 million and diluted net earnings per common share would increase or decrease by $0.03 per share.

***Historic Stock Option Measurement Dates***

The selection by the Company of the methodologies described in Note 3 of the Notes to Consolidated Financial Statements to determine the measurement dates of historic stock option grants involved judgment and careful evaluation of all relevant facts and circumstances for each historical grant. The Company believes it has used the most appropriate methodologies. However, the Company also conducted a sensitivity analysis to assess how the restatement adjustments would have changed under two alternative methodologies for determining measurement dates. The following table sets forth the incremental effect on earnings before income taxes that would result from using the alternate measurement date determination methodologies described below:

*Communication Date.* This methodology would select as the measurement date the date on which stock option grants were communicated to employees, assuming that the communication date is readily

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identifiable. This was generally the date on which stock option awards became viewable by all optionees on the Company s intranet portal for employee benefits. In the event the communication date was not readily available, with respect to Section 16 officers, this alternative methodology would select as the measurement date the date on which a Section 16 officer filed a Form 4 (or other statement of changes in beneficial ownership) with respect to a specific grant and, for employees who are not Section 16 officers, the date on which the Company has determined that the CEO Certificate was likely executed by the former CEO of the Company.

*Legal Execution Date.* This methodology would select as the measurement date the date on which the Company has determined that the legal documentation approving a grant was likely executed, based on evaluation of all available information. For Section 16 Officers, this date is typically the date on which the Company has determined that the Written Action of the Compensation Committee was likely executed by a majority of the members of the Compensation Committee and, for all other employees, this date is typically the date on which the Company has determined that the CEO Certificate was likely executed by the former CEO of the Company.

| | Decrease to Earnings Before Income Taxes | | | |
|---|---|---|---|---|
| | FAS 123R - Current Accounting Method | | APB 25 - Historical Accounting Method | |
| (in millions) | | | | |
| Year | Communication Measurement Dates | Legal Execution Measurement Dates | Communication Measurement Dates | Legal Execution Measurement Dates |
| pre-1994 | n/a | n/a | $ | $ |
| 1994 | n/a | n/a | | |
| 1995 | $ | $ 1 | | 1 |
| 1996 | | 1 | | 1 |
| 1997 | | | | 1 |
| 1998 | | 1 | | 1 |
| 1999 | | 1 | | 1 |
| 2000 | | 41 | | 54 |
| 2001 | 3 | 27 | 7 | 36 |
| 2002 | 3 | 19 | 4 | 23 |
| 2003 | 5 | 21 | 9 | 35 |
| 2004 | 8 | 19 | 12 | 25 |
| 2005 | | | | |