UNITEDHEALTH GROUP INC
Form 10-K
February 11, 2009
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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, 2008**

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	**(I.R.S. Employer**

incorporation or organization) **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 x No ¨

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No 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, a non-accelerated filer or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

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

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

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2008 was $31,658,322,386 (based on the last reported sale price of $26.25 per share on June 30, 2008, on the New York Stock Exchange).*

As of February 4, 2009, there were 1,215,615,705 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 June 2, 2009. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer

to such information.

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

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group Incorporated is a diversified health and well-being company, serving more than 70 million Americans (the terms we, our, us or the Company used in this report refer to UnitedHealth Group Incorporated and our subsidiaries). Our focus is on enhancing the performance of the health system and improving the overall health and well-being of the people we serve and their communities. We work with physicians and other health care professionals, hospitals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost, support the physician/patient relationship, and empower people with the information, guidance and tools they need to make personal health choices and decisions.

During 2008, we managed approximately $115 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our primary focus is on improving the health care system by simplifying the administrative components of health care delivery, promoting evidence-based medicine as the standard for care, and providing relevant, actionable data that physicians, health care professionals, consumers, employers and other participants in health care can use to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable. These core competencies are focused in two market areas health benefits and health services. Health benefits are offered by UnitedHealthcare and our Public and Senior Markets Group, which includes Ovations and AmeriChoice. Health services are provided by our Enterprise Services Markets Group, which includes OptumHealth, Ingenix and Prescription Solutions.

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. We have four reporting segments:

- Health Care Services, which includes UnitedHealthcare, Ovations and AmeriChoice;
- OptumHealth;
- Ingenix; and
- Prescription Solutions

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

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our Company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K,

along with amendments to those reports. You can also download from our website our Articles of Incorporation, bylaws and corporate governance policies, including

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our Principles of Governance, Board of Directors Committee Charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

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

DESCRIPTION OF REPORTING SEGMENTS

Health Care Services

Our Health Care Services reporting segment consists of the following businesses: UnitedHealthcare, Ovations and AmeriChoice. The financial results of UnitedHealthcare, Ovations and AmeriChoice have been aggregated in the Health Care Services reporting segment due to their similar economic characteristics, products and services, types of customers, distribution methods and operational processes, and regulatory environment. These businesses also share significant common assets, including our contracted networks of physicians, health care professionals, hospitals and other facilities, information technology infrastructure and other resources.

UnitedHealthcare

UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare facilitated access to health care services on behalf of approximately 26 million Americans as of December 31, 2008. 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 employees dependants, for which UnitedHealthcare receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees dependants, while UnitedHealthcare provides coordination and facilitation of medical services, customer and health care professional services and access to a contracted network of physicians, hospitals and other health care professionals. These arrangements are typically used by the larger employer groups, especially those serviced by UnitedHealthcare National Accounts (formerly known as Uniprise). At December 31, 2008, UnitedHealthcare National Accounts served approximately 400 large employer groups under these arrangements, including 164 of the Fortune 500 companies. Small employer groups are more likely to purchase risk-based products because they are less willing to bear a greater potential liability for health care expenditures. UnitedHealthcare also offers a variety of non-employer based insurance options for purchase by individuals, which are designed to meet the health coverage needs of these consumers and their families.

UnitedHealthcare offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs). UnitedHealthcare s product strategy centers on several principles: consumer choice, broad access to health professionals, and use of data and science to promote better outcomes, quality service and 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 approximately 580,000 physicians and other health care professionals, and 4,900 hospitals across the United States, which are also leveraged by our Ovations

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and AmeriChoice businesses. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare to contract for cost-effective access to a large number of conveniently located care professionals. Directly or through UnitedHealth Group s family of companies, UnitedHealthcare offers:

- A comprehensive range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;
- Affordability across a broad set of price points and a wide product line, from offerings covering essential needs to comprehensive benefit plans, all of which offer access to our broad-based proprietary network of contracted physicians, hospitals and other health care professionals with economic benefits reflective of the aggregate purchasing capacity of our organization;
- Innovative clinical programs that are built around an extensive clinical data set and the principles of evidence-based medicine;
- Consumer access to information about physician and hospital performance against quality and cost efficiency criteria based on claims data assessment through the UnitedHealth Premium program;
- Physician and facility access to performance feedback information to support continuous quality improvement;
- Care facilitation services that use several identification tools, including proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risks for potential health problems, and then facilitate appropriate interventions;
- Disease and condition management programs to help individuals address significant, complex disease states; and
- Convenient self-service tools for health transactions and information.

UnitedHealthcare s regional and national access to broad, affordable and quality networks of health care professionals has advanced over the past several years, with significant increases in access to services throughout the United States. UnitedHealthcare has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

We believe that UnitedHealthcare s innovation distinguishes its product offerings from its competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. Data-driven networks and clinical management are organized around clinical lines of service such as 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 better value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare provides innovative programs that enable consumers to take ownership and control of their health care benefits. These products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs), or health savings accounts (HSAs), and are offered on a self-funded and fully insured basis. UnitedHealthcare provided these products to approximately 24,000 group health plans, including approximately 150 employers in the large group self-funded market serviced by the UnitedHealthcare National Accounts teams.

UnitedHealthcare s distribution system consists primarily of brokers and direct and internet sales in the individual market; brokers in the small employer group market; and brokers and other consultant-based or direct

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sales for large employer and public sector groups. UnitedHealthcare s direct distribution efforts are generally limited to the individual market, portions of the large employer group and public sector markets, and cross-selling of specialty products to existing customers.

Ovations

Ovations provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations is fully dedicated to this market segment, as it provides products and services in all 50 states, the District of Columbia, and the U.S. territories. Ovations participates nationally in the Medicare program, offering a wide-ranging spectrum of Medicare products, including Medigap products that supplement traditional fee-for-service coverage, more traditional health-plan-type programs under Medicare Advantage, Medicare Part D prescription drug coverage, and special offerings for beneficiaries who are chronically ill and/or Medicare and Medicaid dual-eligible.

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

We currently have a number of contracts with Centers for Medicare & Medicaid Services (CMS), which primarily relate to the Medicare health benefit programs authorized under the 2003 Medicare Modernization Act. Beginning January 1, 2006, we began serving as a plan sponsor offering Medicare Part D prescription drug insurance coverage. Premium revenues from CMS were 25% of our total consolidated revenues for the year ended December 31, 2008, most of which were generated by Ovations.

Ovations is organized into four major groups: SecureHorizons, Ovations Part D, Insurance Solutions and Evercare.

SecureHorizons. SecureHorizons provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS. SecureHorizons offers Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Special Needs Plans, Point-of-Service (POS) plans, and Private-Fee-for-Service plans. Under the Medicare Advantage programs, SecureHorizons provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside, demographic factors such as age, gender, and institutionalized status, and the health status of the individual. Most products are offered under the AARP Medicare Complete provided through SecureHorizons brand name. SecureHorizons offers Medicare Advantage products in all 50 states. As of December 31, 2008, Ovations had approximately 1.5 million enrolled individuals in its Medicare Advantage products, including approximately 245,000 individuals served by Evercare.

Ovations Part D. Ovations provides the Medicare prescription drug benefit (Part D) to beneficiaries throughout the United States and its territories. Among the several Part D plans it offers, Ovations provides Medicare Part D coverage plans with the AARP brand. Ovations provides Part D drug coverage through its Medicare Advantage program, Special Needs Plans (covering individuals who live in an institutional long-term care setting, individuals dual-eligible for Medicaid and Medicare services or individuals with severe or disabling chronic conditions) and stand-alone Part D plans. As of December 31, 2008, Ovations had enrolled approximately 5.5 million members in the Part D program, including approximately 4.1 million members in the stand-alone Part D plans and approximately 1.4 million members in Medicare Advantage plans incorporating Part D coverage.

Insurance Solutions. Insurance Solutions 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

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provides standardized 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 standardized Medicare supplement offering that provides consumers with a national hospital network, 24-hour access to health care information, and access to discounted health services from a network of physicians.

Evercare. Evercare offers complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. Evercare serves approximately 400,000 individuals (including approximately 245,000 individuals in the Medicare Advantage products) across the nation in long-term care settings including nursing homes, community-based settings and private homes, as well as through hospice and palliative care. Evercare offers services through innovative care management and clinical programs. Evercare integrates federal, state and personal funding through a continuum of products from Special Needs Plans and long-term care Medicaid programs to hospice care, and serves people in 36 states and in the District of Columbia in home, community and nursing home settings. These services are provided primarily through nurse practitioners, nurses and care managers.

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 10 states (15 markets).

AmeriChoice

AmeriChoice provides network-based health and well-being services to beneficiaries of State Medicaid Children s Health Insurance Programs (SCHIP), and other government-sponsored health care programs. AmeriChoice provides health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state. At December 31, 2008, AmeriChoice provided services to approximately 2.4 million individuals in 22 states and in the District of Columbia. AmeriChoice also offers government agencies a number of diverse management service programs, including clinical care consulting program, disease and conditions management, pharmacy benefit services and administrative and technology services, to help them effectively administer their distinct health care delivery systems and benefits for individuals in their programs. AmeriChoice also contracts with CMS for the provision of Special Needs Plans serving individuals dual-eligible for Medicaid and Medicare services. These programs are primarily organized toward enrolling individuals dual-eligible 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, behavioral, economic, environmental, and physical) that affect a person s life. AmeriChoice coordinates resources among family members, physicians, other health care professionals and government and community-based agencies and organizations to provide continuous and effective care. For members, this means that the AmeriChoice Personal Care Model offers them a holistic approach to health care, emphasizing practical programs to improve their living circumstances as well as quality medical care and treatment in accessible, culturally sensitive, community-oriented settings. For example, AmeriChoice s disease management and outreach programs focus on high-prevalence and debilitating illnesses such as hypertension and cardiovascular disease, asthma, sickle cell disease, diabetes, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), cancer and high-risk pregnancy. 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

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treatment protocols to support care management. AmeriChoice operates advanced and unique pharmacy administrative services, including benefit design, generic drug incentive programs, drug utilization review and preferred drug list development to help optimize the use of appropriate quality pharmaceuticals and concurrently manage pharmacy expenditures to levels appropriate to the specific clinical situations. For state customers, the AmeriChoice Personal Care Model means increased access to care and improved quality for their beneficiaries, in a measurable system that reduces their administrative burden and lowers their costs.

AmeriChoice considers a variety of factors when determining in which state programs to participate and on what basis. They include a state s consistency of support for service innovation and funding of its Medicaid program, the population base, the commitment of the physician/provider community to the AmeriChoice Personal Care Model, and the presence of community-based organizations that can partner with AmeriChoice to meet member needs. AmeriChoice launched Medicaid programs in two new markets and expanded its presence and program offerings in several existing markets during 2008.

OptumHealth

OptumHealth serves approximately 60 million individuals with its diversified offering of health, financial and ancillary benefit services and products that assist consumers in navigating the health care system and accessing services, support their emotional health, provide ancillary insurance benefits and facilitate the financing of health care services through account-based programs. OptumHealth seeks to simplify the consumer health care experience and facilitate the efficient and effective delivery of care. Its capabilities can be deployed individually or integrated to provide comprehensive, consumer-focused health and financial well-being solutions.

OptumHealth s simple, modular service designs can be easily integrated to meet varying health plan, employer, payer, public sector and consumer needs at a wide range of price points. OptumHealth offers its products on an administrative fee basis where it manages and administers benefit claims for self-insured customers in exchange for a fixed fee per individual served, and on a risk basis, where OptumHealth assumes responsibility for health care in exchange for a fixed monthly premium per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth s products are distributed through the three strategic markets: the employer market for both UnitedHealth Group customers and unaffiliated parties; the payer market for Health Care Services health plans, independent health plans, third-party administrators and reinsurers; and the public and senior markets for Medicare and state Medicaid offerings through partnerships with Ovations, AmeriChoice and other intermediaries. Approximately 50 percent of the consumers that OptumHealth serves receive their major medical health benefits from a source other than UnitedHealth Group.

OptumHealth is organized into four major groups: Care Solutions, Behavioral Solutions, Specialty Benefits and Financial Services.

Care Solutions. Care Solutions serves approximately 40 million people through personalized health management solutions that improve the health and well-being of members, improve clinical outcomes and work force productivity, and reduce costs for customers. It delivers its services through the use of evidence-based best practices and technology. Its clinically focused product portfolio includes programs focused on disease management, care advocacy, wellness and complex condition management, such as cancer, solid organ transplant, infertility and congenital heart disease. To support its complex condition management programs, Care Solutions negotiates competitive rates with medical institutions 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.

Care Solutions also provides benefit administration and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services through its national network consisting of approximately 23,000 chiropractors, 15,000 physical and occupational therapists and 7,000

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complementary and alternative health professionals. Care Solutions also offers treatment decision support, consumer health information, private health portals and consumer health marketing services to address daily living concerns and assist individuals in accessing the health care system.

Behavioral Solutions. Behavioral Solutions serves 43 million individuals with its employee assistance programs, work/life offerings, and clinically driven behavioral health, substance abuse and psychiatric disability management programs. Its consumer-focused programs employ predictive modeling, outcomes management, supportive coaching and evidenced-based best practices to assist individuals in managing stress, depression, substance abuse and other personal challenges while seeking to increase overall health, wellness and productivity. Its outreach programs promote timely detection and intervention to optimize the treatment for people struggling with both psychological and medical conditions. Behavioral Solutions customers have access to a national network of approximately 83,000 clinicians and counselors and approximately 2,500 facilities in 4,600 locations.

Specialty Benefits. Specialty Benefits includes dental, vision, life, critical illness, short-term disability and stop loss product offerings delivered through an integrated platform that enhances efficiency and effectiveness. Approximately 15 million individuals receive their vision benefits through Specialty Benefits and its network of approximately 30,000 vision professionals in private and retail settings. Dental benefit management and related services are provided to six million consumers through a network of approximately 110,000 dentists. Stop-loss insurance is marketed throughout the United States through a network of third-party administrators, brokers and consultants.

Financial Services. Financial services are provided through OptumHealth Bank and OptumHealth Financial Services (formerly known as Exante Bank and Exante Financial Services, respectively). As of December 31, 2008, Financial Services had approximately $660 million in assets under management. Financial Services provides health-based financial services for consumers, employers, payers and health care professionals. These financial services include HSAs, HRAs, and Flexible Spending Accounts offered through OptumHealth Bank, a Utah-chartered industrial bank. Financial Services health benefit card programs include electronic systems for verification of benefit coverage and eligibility. Financial Services also provides electronic payment and statement services for health care professionals and payers. In 2008, Financial Services electronically transmitted $26 billion in medical payments to physicians and other health care providers.

Ingenix

Ingenix offers database and data management services, software products, publications, consulting and actuarial services, business process outsourcing services and pharmaceutical data consulting and research services in conjunction with the development of pharmaceutical products on a nationwide and international basis. As of December 31, 2008, Ingenix s customers include approximately 6,000 hospitals, 240,000 physicians, 1,500 payers and intermediaries, 260 *Fortune 500* companies, 300 life sciences companies, and 250 government entities, as well as other UnitedHealth Group businesses.

Ingenix is engaged in the simplification of health care administration with information and technology. Ingenix helps customers accurately and efficiently document, code and bill for the delivery of care services. It also sells reference materials and coding guides that health care professionals use to bill payers for their services. Ingenix uses data to help advance transparency on cost and quality and help customers streamline their processes to make health care more efficient. Ingenix is a leader in contract research services, and pharmacoeconomics, outcomes, drug 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, payer and property and casualty insurance market segments. Ingenix s products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface its products with their applications.

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Many of our contract research services, consulting arrangements and software and related information services are performed over an extended period of time, often several years. We maintain an order backlog to track anticipated revenues yet to be earned for work that has not yet been performed under these long-term arrangements. Our backlog generally consists of estimated revenue from signed contracts or other legally binding agreements that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. Our estimated aggregate backlog at December 31, 2008 was approximately $1.8 billion, including approximately $0.4 billion of intersegment agreements. We cannot provide any assurance that we will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services and the potential for cancellation or early termination of certain service arrangements.

The Ingenix companies are divided into two groups: Information Services and i3.

Information Services. Information Services diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trend management, physician practice revenue cycle management, including integrated electronic medical record systems, revenue cycle management for payer and health care professional organizations, decision-support portals for evaluation of health benefits and treatment options, risk management solutions, connectivity solutions and claims management tools to reduce administrative errors and support fraud recovery services. Information Services uses proprietary software applications that manage clinical and administrative data across diverse information technology environments. Information Services also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets. Information Services offers comprehensive Electronic Data Interchange (EDI) services helping health care professionals and payers decrease costs of claims transmission, payment and reimbursement through both networked and direct connection services.

Information Services provides other services on an outsourced basis, such as verification of physician credentials, health care professional directories, Healthcare Effectiveness Data and Information Set (HEDIS) reporting, and fraud and abuse detection and prevention services. Information Services also offers consulting services, including actuarial and financial advisory work through its Ingenix Consulting division and health care policy research, implementation, strategy and management consulting through its subsidiary, The Lewin Group, as well as product development, health care professional contracting and medical policy management. Information Services also provides health care IT consulting for health care professionals. Information Services publishes print and electronic media products that provide customers with information regarding medical claims coding, reimbursement, billing and compliance issues.

i3. i3 helps to coordinate and manage clinical trials on a nationwide and international basis for products in development for pharmaceutical and biotechnology companies. i3 s focus is to help these customers effectively and efficiently get drug data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. i3 s capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology and safety and outcomes research. i3 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. i3 delivers contract research services in 56 countries and is therapeutically focused on oncology, the central nervous system, respiratory, infectious and pulmonary diseases, and endocrinology. i3 uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical and biotechnology development.

Prescription Solutions

Prescription Solutions offers a comprehensive suite of integrated pharmacy benefit management (PBM) services to approximately 10 million people, delivering drug benefits through approximately 60,000 retail network

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pharmacies and two mail service facilities as of December 31, 2008. Prescription Solutions processed approximately 295 million adjusted scripts in 2008 by servicing internal customers such as UnitedHealthcare, Ovations and AmeriChoice as well as external employer groups, union trusts, managed care organizations, Medicare-contracted plans (Part D, SecureHorizons and Evercare), Medicaid plans and TPAs, including mail service only and carve-out accounts.

Prescription Solutions integrated PBM services include retail network pharmacy management, mail order pharmacy services, specialty pharmacy services, benefit design consultation, drug utilization review, formulary management programs, disease therapy management and adherence programs. Prescription Solutions products and services are designed to enhance clinical outcomes with reduced costs for those served. The fulfillment capabilities of Prescription Solutions are an important strategic component in serving commercial health plans and Medicare-contracted businesses, including Part D.

Prescription Solutions distribution system consists primarily of health insurance brokers and other health care consultant-based or direct sales. In addition to PBM services, Prescription Solutions Consumer Health Products division delivers diabetic testing and other specialized medical supplies, over the counter items, vitamins and supplements directly to members homes.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated by federal and state regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. This regulation can vary significantly from jurisdiction to jurisdiction. Federal and state governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system, including proposals to address the affordability and availability of health insurance and to reduce the number of uninsured individuals. The interpretation of existing laws and rules also may change periodically. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, could negatively impact our business. We believe we are in compliance in all material respects with applicable laws, regulations and rules. In the event we fail to comply with federal and state regulations, or fail to respond quickly and appropriately to health care reforms and frequent changes in federal and state regulations, our business, financial condition and results of operations could be materially adversely affected. See Item 1A, Risk Factors for a discussion of the risks related to compliance with federal and state government regulations.

Federal Laws and Regulation

We are subject to various levels of federal regulation. Ovations and AmeriChoice Medicare and Medicaid businesses 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 reporting segment, through AmeriChoice and Ovations, also has Medicaid and SCHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services, and other aspects of these programs. There are many regulations surrounding Medicare and Medicaid compliance. When we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. Government contracts. In addition, the portion of Ingenix s business that includes clinical research is subject to regulation by the U.S. Food and Drug Administration. We are also affected by laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, anti-money laundering, securities and antitrust.

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

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promulgated pursuant to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. The HIPAA privacy regulations do not preempt more stringent state laws and regulations that may also apply to us.

Federal privacy and security requirements change frequently as a result of legislation, regulations and judicial or administrative interpretation. The U.S. Congress is currently considering new privacy and security legislation. Some of the proposed changes include: new contracting requirements for HIPAA business associate agreements; new agreements for covered entities logging disclosures for treatment, payment and health care operations; HIPAA business associates being subject to most parts of the HIPAA Security Rule; and certain limitations on receiving direct or indirect remuneration for the exchange of health information. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personal identifiable information. The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to opt out of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information. See Item 1A, Risk Factors for a discussion of the risks related to compliance with HIPAA, GLBA and other privacy-related regulations.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations 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. Recent final and proposed regulations would require additional disclosures to employers of certain types of indirect compensation we receive. Additionally, some states require licensure or registration of companies providing third-party claims administration services for health care plans.

FDIC. The Federal Deposit Insurance Corporation (FDIC) has federal regulatory and supervisory authority over OptumHealth Bank and performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements. In addition to such annual examinations, the FDIC performs periodic examinations of the bank s compliance with applicable federal banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subjected to increased operational expenses, governmental oversight and monetary penalties.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. With the amendment of the Annual Financial Reporting Model Regulation by the National Association of Insurance Commissioners to incorporate elements of the Sarbanes-Oxley Act of 2002, we expect that these states will continue to expand the regulations of corporate governance and internal control activities of HMOs and insurance companies.

Health plans and insurance companies are also regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends.

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In addition, some of our business and related activities may be subject to other health care-related regulations and requirements, including PPO, managed care organization (MCO), utilization review (UR) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices, and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing unnecessary medical services, and improper marketing. Our AmeriChoice and Ovations Medicaid businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits by AmeriChoice to its Medicaid and SCHIP beneficiaries and by Ovations to its Medicaid beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

Pharmacy Regulation. Prescription Solutions mail order pharmacies must be licensed to do business as a pharmacy in the state in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. Many of the states where our mail order pharmacies deliver pharmaceuticals have laws and regulations that require out-of-state mail order pharmacies to register with that state s board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs require the pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our mail order pharmacies include federal and state statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Item 1A, Risk Factors for a discussion of the risks related to our PBM businesses.

Privacy and Security Laws. States have adopted regulations to implement provisions of the GLBA. Like HIPAA, GLBA allows states to adopt more stringent requirements governing privacy protection. A number of states have also adopted other laws and regulations that may affect our privacy and security practices, for example, state laws that govern the use, disclosure, and protection of social security numbers. State and local authorities are increasingly focused on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personal identifiable information. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines. See Item 1A, Risk Factors for a discussion of the risks related to compliance with state privacy-related regulations.

UDFI. In addition, the Utah State Department of Financial Institutions (UDFI) has state regulatory and supervisory authority over OptumHealth Bank and in conjunction with federal regulators performs annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements. In addition to such annual examinations, the UDFI in conjunction with federal regulators performs periodic examinations of the bank s compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results, the bank could be subjected to increased operational expenses, governmental oversight and monetary penalties.

Commitments. In connection with the PacifiCare Health Systems, Inc. (PacifiCare) and Sierra Health Services, Inc. (Sierra) acquisitions, which closed in December 2005 and February 2008, respectively, as typically occurs in connection with comparable sized transactions, certain of our subsidiaries entered into various commitments with state regulatory departments, principally in California and Nevada. We believe that none of these commitments will materially affect our operations.

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Audits and Investigations

We have been and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the Internal Revenue Service and other governmental authorities. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. See Note 15 of Notes to the Consolidated Financial Statements for details. In addition, disclosure of any adverse investigation, audit results or sanctions could negatively affect our reputation in various markets and make it more difficult for us to sell our products and services and retain our current business.

International Regulation

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

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 professionals that have formed networks to directly contract with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our Health Care Services businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas. For our Prescription Solutions businesses, competitors include Medco Health Solutions, Inc., CVS/Caremark Corporation, and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a 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. If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected. See Item 1A, Risk Factors, for additional discussion of our risks related to competition.

EMPLOYEES

At December 31, 2008, we employed approximately 75,000 individuals. We believe our employee relations are generally positive.

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EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 4, 2009, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	56	President and Chief Executive Officer
George L. Mikan III	37	Executive Vice President and Chief Financial Officer
Gail K. Boudreaux	48	Executive Vice President of UnitedHealth Group and President of UnitedHealthcare
William A. Munsell	56	Executive Vice President of UnitedHealth Group and President of the Enterprise Services Group
Eric S. Rangen	52	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	55	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations
Lori K. Sweere	50	Executive Vice President of Human Capital
Anthony Welters	53	Executive Vice President of UnitedHealth Group and President of the Public and Senior Markets Group
David S. Wichmann	46	Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations

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

Mr. Hemsley is President and Chief Executive Officer of UnitedHealth Group, has served in that capacity since November 2006, and has been a member of the Board of Directors since February 2000. Mr. Hemsley served as President and Chief Operating Officer from 2004 to November 2006. He joined UnitedHealth Group in 1997 and held various executive positions with the Company from 1997 to 2004.

Mr. Mikan is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since November 2006. Mr. Mikan served as Senior Vice President of Finance of UnitedHealth Group from February 2006 to November 2006. From June 2004 to February 2006, Mr. Mikan served as Chief Financial Officer of UnitedHealthcare and as President of UnitedHealth Networks. Mr. Mikan was Chief Financial Officer of Specialized Care Services (now OptumHealth) in 2004. Mr. Mikan joined UnitedHealth Group in 1998 and held various executive positions with the Company from 1998 to 2004.

Ms. Boudreaux is Executive Vice President of UnitedHealth Group and President of UnitedHealthcare and has served in that capacity since May 2008. Prior to joining UnitedHealth Group, Ms. Boudreaux served as Executive Vice President of Health Care Services Corporation (HCSC) from December 2005 to May 2008 and as President of Blue Cross and Blue Shield of Illinois, a division of HCSC, from 2002 to December 2005.

Mr. Munsell is Executive Vice President of UnitedHealth Group and President of the Enterprise Services Group and has served in that capacity since September 2007. From December 2006 to August 2007, Mr. Munsell served as Executive Vice President of UnitedHealth Group. From November 2004 to December 2006, Mr. Munsell served as Chief Executive Officer of Specialized Care Services (now OptumHealth). In 2004, Mr. Munsell served as the Chief Administrative Officer and Chief Operating Officer of UnitedHealthcare. Mr. Munsell joined UnitedHealth Group in 1997 and held various executive positions with the Company from 1997 to 2004.

Mr. Rangen is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since December 2006. From November 2006 to December 2006, Mr. Rangen was Senior Vice President

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of UnitedHealth Group. Mr. Rangen joined UnitedHealth Group in November 2006. Prior to joining UnitedHealth Group, Mr. Rangen served as Executive Vice President and Chief Financial Officer of Alliant Techsystems Inc. from April 2004 to March 2006 and as Vice President and Chief Financial Officer of Alliant Techsystems, Inc. from 2001 to April 2004.

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations and has served in that capacity since January 2009. Prior to joining UnitedHealth Group, Mr. Renfro served as President of Fidelity Developing Businesses at Fidelity Investments and as a member of the Fidelity Executive Committee from June 2008 to January 2009. From November 2005 to May 2008, Mr. Renfro held several senior positions at AARP Services Inc., including President and Chief Executive Officer of AARP Services Inc., Chief Operating Officer of AARP Services Inc., President and Chief Executive Officer of AARP Financial and President of the AARP Funds. From November 2004 to October 2005, Mr. Renfro served as Managing Director of Devonshire Financial Group. Mr. Renfro served as Chairman and Chief Executive Officer of New River Inc. from 1998 to October 2004.

Ms. Sweere is Executive Vice President of Human Capital of UnitedHealth Group and has served in that capacity since June 2007. Prior to joining UnitedHealth Group, Ms. Sweere served as Executive Vice President of Human Resources of CNA Corporation from October 2004 to April 2007 and held various leadership positions with CNA Corporation from 2003 to October 2004.

Mr. Welters is Executive Vice President of UnitedHealth Group and President of the Public and Senior Market Group and has served in that capacity since September 2007. Mr. Welters was named Executive Vice President of UnitedHealth Group in November 2006. From 2004 to November 2006, Mr. Welters was President and Chief Executive Officer of AmeriChoice. Mr. Welters joined UnitedHealth Group in 2002 and held various executive positions with the Company from 2002 to 2004.

Mr. Wichmann is Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since April 2008. From December 2006 to April 2008, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of the Commercial Markets Group (now UnitedHealthcare). From July 2004 to December 2006, Mr. Wichmann served as President and Chief Operating Officer of UnitedHeathcare. In 2004, Mr. Wichmann served as Chief Executive Officer of Specialized Care Services (now OptumHealth). Mr. Wichmann joined UnitedHealth Group in 1998 and held various executive positions with the Company from 1998 to 2004.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words or phrases believe, expect, intend, estimate, anticipate, plan, project, should c expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the safe harbor provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

The following discussion contains certain cautionary statements regarding our business that investors and others should consider. We do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Form 10-K and in any other public filings or statements we make may turn out to be wrong. They can be affected by inaccurate

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assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed in this report or any of our prior communications.

If we fail to effectively estimate, price for and manage our health care costs, the profitability of our risk-based products could decline and could materially adversely affect our future financial results.

Under our risk-based product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based products comprise approximately 90% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our risk-based products depends in large part on our ability to predict, price for, and effectively manage health care costs.

We manage health care costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue on commercial policies is typically fixed for a 12-month period and is generally priced one to four months before the contract commences. Our revenue on Medicare policies is based on bids submitted in June the year before the contract year. We base the premiums we charge and our Medicare bids on our estimate of future health care costs over the fixed contract period; however, medical cost inflation, regulation and other factors may cause actual costs to exceed what was estimated and reflected in premiums or bids. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical cost on our financial results, relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for commercial insured products, our annual net earnings for 2008 would have been reduced by approximately $200 million.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove too low, they will have a negative impact on our future results.

If we fail to comply with federal and state regulations, or fail to respond quickly and appropriately to health care reforms and frequent changes in federal and state regulations, our business, financial condition and results of operations could be materially adversely affected.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. The broad latitude that is given to the agencies administering those regulations, as well as future laws and rules, could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. See Item 1, Business Government Regulation for a discussion of various federal and state laws and regulations governing our businesses.

We must obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions, including integration of certain acquisitions. Delays in obtaining approvals or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

Legislative proposals that would reform the health care system have been advanced by Congress and state legislatures and are currently pending at the state and federal levels. These changes include policy changes that

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would fundamentally change the dynamics of our industry, such as having the federal or one or more state governments assume a larger role in the health care industry or a fundamental restructuring of the Medicare or Medicaid programs. These proposals may also affect certain aspects of our business, including contracting with physicians, hospitals and/or other health care professionals; physician reimbursement methods and payment rates; coverage determinations; mandated benefits; minimum medical expenditures; claim payments and processing; drug utilization and patient safety efforts; collection, use, disclosure, maintenance and disposal of individually identifiable health information; personal health records; consumer-driven health plans and health savings accounts and insurance market reforms; and government-sponsored programs.

For example, the new administration and various congressional leaders have signaled their interest in reducing payments to private plans offering Medicare Advantage. Depending on the extent and phasing of these potential reductions, the number of seniors participating in Medicare Advantage and the industry-wide earnings derived from these plans may fall. In addition, Massachusetts has enacted comprehensive reform, including an individual health coverage mandate coupled with an employer mandate and a new state connector authority. A number of other state legislatures, including California, Colorado, New York, Ohio and Pennsylvania, have contemplated but have not enacted significant reform of their health insurance markets. Other states are expected to consider these types of reforms as well as more modest reforms aimed at expanding Medicaid and/or SCHIP eligibility as well as new coverage options for those not eligible for government programs. These proposals include provisions affecting both public programs and privately financed health insurance arrangements. States also are considering proposals that would reform the underwriting and marketing practices of individual and group health insurance products by, for example, placing restrictions on rating and pricing and mandating minimum medical benefit cost ratios. In addition, from time to time, Congress has considered various forms of managed care reform legislation which if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. Additionally, there is legislative interest in modifying ERISA s preemptive effect on state laws. If adopted, such limitations could increase our liability exposure and could permit greater state regulation of our operations.

We cannot predict if any of these initiatives will ultimately become law, or, if enacted, what their terms or the regulations promulgated pursuant to such laws will be, but their enactment could increase our costs, expose us to expanded liability and require us to revise the ways in which we conduct business or put us at risk for loss of business. In addition, our operating results could be adversely affected by such changes even if we correctly predict their occurrence.

In addition, the health care industry is subject to negative publicity. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by: adversely affecting our ability to market our products and services; requiring us to change our products and services; or increasing the regulatory burdens under which we operate.

In August 2007, we entered into a multi-state national agreement with regulatory offices in 39 states and the District of Columbia relating to the legacy UnitedHealthcare fully insured commercial business. The agreement covers several key areas of review of our business operations, including claims payment accuracy and timeliness, appeals and grievances resolution timeliness, health care professional network/service, utilization review, explanation of benefits accuracy, and oversight and due diligence of contracted entities and vendor performance. The agreement addressed and resolved past regulatory matters related to the areas of review prior to August 2007 and establishes a transparent framework for evaluating and regulating performance through December 2010. On a prospective basis, the agreement is similar to a customer performance guarantee, whereby we will self report quarterly and annually our operational performance on a set of national performance standards agreed to by the participating states. We must perform to the standards set forth in the agreement, or be subject to fines and penalties.

We are also involved in various governmental investigations, audits and reviews. These regulatory activities include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and

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welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor and other governmental authorities. For example, in 2007, the California Department of Insurance examined the Company s PacifiCare health insurance plan in California. The examination findings related to claims processing accuracy and timeliness, accurate and timely interest payments, timely implementation of provider contracts, timely, accurate provider dispute resolution, and other related matters. To date, the California Department of Insurance has not levied a financial penalty related to its findings. The Company is working closely with the department to resolve any outstanding issues arising from the findings of its examination. In addition, the U.S. Department of Labor is conducting an investigation of our administration of our employee benefit plans with respect to ERISA compliance. Reviews and investigations of this sort can lead to government actions, which can result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, and could have a material adverse effect on our business and financial results.

In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services.

Adverse conditions in the global economy and extreme disruption of financial markets could adversely affect our revenues, sources of liquidity, investment portfolio and our results of operations.

As widely reported, worldwide financial markets have been experiencing extreme disruption, including volatility in the prices of securities and severely diminished liquidity and availability of credit. These extreme events, along with a recession, inflation or other unfavorable changes in economic conditions, could adversely affect our business and results of operations.

For example, higher unemployment rates and significant employment layoffs and downsizings could lead to lower enrollment in our employer group plans, lower enrollment in our non-employer individual plans and a higher number of employees opting out of our employer group plans. The adverse economic conditions could also cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, the economic downturn could negatively impact our employer group renewal prospects and our ability to increase premiums and could result in cancellation of products and services by our customers. All of these could lead to a decrease in our membership levels and premium and fee revenues and could adversely affect our financial results. In addition, a prolonged economic downturn could negatively impact the financial position of hospitals and other care providers and therefore could adversely affect our contracted rates with these parties and increase our medical costs.

During a prolonged economic downturn, state and federal budgets could be adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and SCHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to payments already negotiated and/or received from the government and could adversely affect our revenues and financial results. In addition, the state and federal budgetary pressures could cause the government to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health maintenance organizations and surcharges on select fee-for-service and capitated medical claims, and could adversely affect our results of operations.

The current economic crisis is causing contraction in the availability of credit in the marketplace. While our largest source of funding has historically been cash flow from operations, the commercial paper markets have been a source of liquidity for us and we continue to issue commercial paper, although at higher interest rates as a result of the diminished availability of credit. However, there can be no assurance that the commercial paper

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markets will continue to be a reliable source of short-term financing. If the commercial paper markets are unavailable or not cost effective, we would use cash on hand and/or draw on our contractually committed revolving credit facilities to refinance the commercial paper when it matures. However, there can be no assurance that, under extreme market conditions, such sources would be available or sufficient.

In addition, if the global capital markets continue to deteriorate, including if more financial institutions and companies file for bankruptcy protection, or are taken over by governmental authorities, and if the prices of securities continue to deteriorate and experience extreme volatility, our investment portfolio may be impacted. Some of our investments could further experience other-than-temporary declines in fair value, requiring us to record an impairment charge that could adversely impact our financial results.

Our businesses providing PBM services are subject to federal and state regulations associated with the PBM industry and if we fail to comply with these regulations, our business, financial condition and results of operations could be materially adversely affected.

We provide PBM services through our Prescription Solutions and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry that could adversely affect current industry practices, including the receipt or required disclosure of rebates from pharmaceutical companies. See Item 1, Business Government Regulation for a discussion of various federal and state laws and regulations governing our PBM businesses.

In the event a court were to determine that one of our PBM businesses acts as a fiduciary under ERISA, we could be subject to claims for alleged breaches of fiduciary obligations in implementation of formularies, preferred drug listings and drug management programs, contracting network practices, specialty drug distribution and other transactions. Our PBM businesses also conduct business as mail order pharmacies, which subjects them to extensive federal, state and local laws and regulations. The failure to adhere to these laws and regulations could expose our PBM subsidiaries to civil and criminal penalties.

In addition, we would be adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and could face potential claims in connection with purported errors by our mail order pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Further, our PBM businesses are subject to the Payment Card Industry Data Security Standards, which is a multifaceted security standard that includes requirements for security management, policies, procedures, network architecture, software design and other critical protective measures to protect customer account data as mandated by the credit card brands. The failure to adhere to such standards could expose our PBM subsidiaries to liability or impact their ability to process credit card transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations could be materially adversely affected.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which we operate. We compete with other companies on the basis of many factors, including price of benefits offered and cost and risk of alternatives, location and choice of health care providers, quality of customer service, comprehensiveness of coverage offered, reputation for quality care, financial stability and diversity of product offerings. For our Health Care Services reporting segment, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Kaiser Permanente, WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises that serve more limited geographic areas or market segments such as Medicare specialty services. For our Prescription Solutions business, competitors include Medco Health Solutions, Inc., CVS/ Caremark Corporation and Express Scripts, Inc. Our OptumHealth and Ingenix reporting segments also compete with a number of other businesses.

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We believe that barriers to entry in many markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. In particular markets, competitors may have capabilities or resources that give them a competitive advantage. Greater market share, established reputation, superior supplier or health care professional arrangements, existing business relationships, and other factors all can provide a competitive advantage to our businesses or to their competitors.

In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers (including hospitals, physician groups and other care professionals) in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or advance profitability. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect, if membership or demand for other services declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products, our business and results of operations could be materially adversely affected.

As a payer in various government health care programs, we are exposed to additional risks associated with program funding, enrollments, payment adjustments and audits that could adversely affect our revenues, cash flows and financial results.

We participate in various federal, state and local government health care coverage programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and SCHIP, and receive revenues from these programs. These programs generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or health care costs under such programs. Such changes have adversely affected our financial results and willingness to participate in such programs in the past, and may do so in the future.

Our participation in the Medicare Advantage, Medicare Part D, and various Medicaid programs and SCHIP occurs through bids that are submitted periodically. Revenues for these programs are dependent upon periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs is dependent upon many factors outside of our control, including general economic conditions at the federal or applicable state level, and general political issues and priorities. A reduction or less than expected increase in government funding for these programs or change in allocation methodologies may adversely affect our revenues and financial results.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including determining payments by considering the risk status of our Medicare members as supported by provider medical record documentation. Federal regulators audit the supporting documents and can revise payments based on the audit findings. CMS announced in 2008 that it will perform audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by care providers. These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in retrospective or prospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. We are unable to predict the outcome of the audits. However, a material adjustment could have a material effect on our financial results.

Our ability to retain and acquire Medicare, Medicaid and SCHIP enrollees is impacted by bids and plan designs submitted by us and our competitors. Under the Medicaid Managed Care program, state Medicaid agencies are periodically required by federal law to seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid Managed

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Care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a threshold, which is set by the government after our bids are submitted. If the enrollee premium is not below the government threshold, we risk losing the members who were auto-assigned to us and we will not have additional members auto-assigned to us. For example, we lost approximately 650,000 of our auto-enrolled low-income subsidy members in 2008 because our bids exceeded thresholds set by the government. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs, and other factors. In the event any of these assumptions are materially incorrect or our competitors bids and positioning are different than anticipated, either as a result of unforeseen changes to the Medicare program or otherwise, our financial results could be materially affected.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals, and other health care providers, our business could be adversely affected.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices and services. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices and services. Failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could adversely affect our business and results of operations.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be adversely affected.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the health care provider receives a fixed percentage of premium to cover all or a defined portion of the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the professional. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. There can be no assurance that health care providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have an adverse effect on the provision of services to our members and our operations.

In addition, some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding with the provider about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us. For example,

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we are involved in litigation with out-of-network providers that is described in more detail in Legal Matters in Note 15 of Notes to the Consolidated Financial Statements. Failure to maintain satisfactory relationships with these out-of-network health care providers could adversely affect our business and results of operations.

Sales of our products and services are dependent on our ability to attract, retain and provide support to a network of independent third party brokers, consultants and agents.

Our products are sold in part through independent brokers, consultants and agents who assist in the production and servicing of business. We typically do not have long-term contracts with our independent brokers, consultants and agents, who generally are not exclusive to us and who frequently also recommend and/or market health care products and services of our competitors. As a result, we must compete intensely for their services and allegiance. Our sales would be adversely affected if we are unable to attract or retain independent brokers, consultants and agents or if we do not adequately provide support, training and education to them regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling these companies products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practice which could adversely impact our ability to market our products.

If we fail to comply with restrictions on patient privacy and information security, including taking steps to ensure that our business associates who obtain access to sensitive patient information maintain its confidentiality, our reputation and business operations could be materially adversely affected.

The collection, maintenance, use, disclosure and disposal of individually identifiable data by our businesses are regulated at the international, federal and state levels. These laws and rules are subject to change by legislation or administrative or judicial interpretation. Various state laws address the use and disclosure of individually identifiable health data to the extent they are more restrictive than those contained in the privacy and security provisions in the federal GLBA and in HIPAA. HIPAA also requires that we impose privacy and security requirements on our business associates (as such term is defined in the HIPAA regulations). See Item 1, Business Government Regulation for a discussion of various federal and state privacy laws and regulations governing our businesses.

Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Privacy and security requirements regarding personally identifiable information are also imposed on us through controls with our customers. In addition, despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers may be vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Congress and many states are considering new privacy and security requirements that would apply to our business. Compliance with new privacy and security laws, requirements, and new regulations may result in cost increases due to necessary systems changes, new limitations or constraints on our business models, the development of new administrative processes, and the effects of potential noncompliance by our business associates. They also may impose further restrictions on our collection, disclosure and use of patient identifiable data that are housed in one or more of our administrative databases. Noncompliance with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive or confidential member information, whether by us or by one of our vendors, could have a material adverse effect on our business, reputation and results of operations, including: material fines and penalties; compensatory, special, punitive, and statutory damages; consent orders regarding our privacy and security practices; adverse actions against our licenses to do business; and injunctive relief.

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Our relationship with AARP is important and the loss of such relationship could have an adverse effect on our business and results of operations.

Under our agreements with AARP, we provide AARP-branded Medicare Supplement insurance, hospital indemnity insurance and other products to AARP members and Medicare Part D prescription drug plans to AARP members and non-members. One of our agreements with AARP expands the relationship to include AARP-branded Medicare Advantage plans for AARP members and non-members. Our agreements with AARP contain commitments regarding corporate governance, corporate social responsibility, diversity and measures intended to improve and simplify the health care experience for consumers. The AARP agreements may be terminated early under certain circumstances, including, depending on the agreement, a material breach by either party, insolvency of either party, a material adverse change in the financial condition of the Company, material changes in the Medicare programs, material harm to AARP caused by the Company, and by mutual agreement. The success of our AARP arrangements depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, meet our corporate governance, corporate social responsibility, and diversity commitments, and respond effectively to federal and state regulatory changes. The loss of our AARP relationship could have an adverse effect on our business and results of operations.

Because of the nature of our business, we are routinely subject to various litigation actions, which, if resolved unfavorably, could result in substantial penalties and/or monetary damages and adversely affect our financial position, results of operations and cash flows.

Periodically, we become a party to the types of legal actions that can affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, and intellectual property-related litigation. In addition, because of the nature of our business, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. These matters include, among others, claims related to health care benefits coverage and payment (including disputes with enrollees, customers, and contracted and non-contracted physicians, hospitals and other health care professionals), medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups.

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

A description of material legal actions in which we are currently involved is included in Note 15 of Notes to the Consolidated Financial Statements. We cannot predict the outcome of these actions with certainty, and we are incurring expenses in resolving these matters. Therefore, these legal actions could further increase our cost of doing business and adversely affect our financial position, results of operations and cash flows.

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

In early 2006, our Board of Directors initiated an independent review of the Company s historical stock option practices from 1994 to 2005. The independent review was conducted by an independent committee comprised of three independent directors of the Company (Independent Committee) with the assistance of independent counsel and independent accounting advisors. On October 15, 2006, we announced that the Independent Committee had

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completed their review of the Company s historical stock option practices and reported the findings to the non-management directors of the Company. As a result of our historical stock option practices, we restated our previously filed financial statements, we incurred certain cash and non-cash charges, we are subject to various regulatory inquiries and litigation matters, and we may be subject to further regulatory inquiries, litigation matters, and cash and noncash charges, the outcome of any or all of which could have a material adverse effect on us. See Note 15 of Notes to the Consolidated Financial Statements for a more detailed description of these regulatory inquiries and litigation matters.

Our investment portfolio may suffer losses which could materially adversely affect our financial results.

Fluctuations in the fixed income or equity markets could impair our profitability and capital position. Volatility in interest rates affects our interest income, and the market value of, our investments in fixed income debt securities of varying maturities, which comprise the majority of the fair value of our investments at December 31, 2008. In addition, defaults by issuers, primarily from investments in liquid corporate and municipal bonds, who fail to pay or perform on their obligations, could reduce our investment income and net realized investment gains or result in net realized investment losses as we may be required to write down the value of our investments, which would adversely affect our profitability and shareholders equity.

We also invest a small proportion of our investments in equity investments, which are subject to greater volatility than fixed income investments. General economic conditions, stock market conditions, and many other factors beyond our control can adversely affect the value of our equity investments and may result in investment losses.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than the carrying value of these investments. Changes in the value of our investment assets, as a result of interest rate fluctuations, illiquidity or otherwise, could have a negative effect on our shareholders equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have an adverse effect on our results of operations.

If the value of our intangible assets is materially impaired, our results of operations, shareholders equity and debt ratings could be materially adversely affected.

Due largely to our past acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately $22.4 billion as of December 31, 2008, representing approximately 40% of our total assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our books. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. Any future evaluations requiring an asset impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders equity in the period in which the impairment occurs. A material decrease in shareholders equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Large-scale medical emergencies may result in significant health care costs and may have a material adverse effect on our business, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. Such emergencies could materially and adversely affect the U.S. economy in general and the health care industry specifically. For example, in the event of a natural disaster, bioterrorism attack, pandemic or other extreme events, we could face, among other things, significant health care costs and increased use of health care services. Any such disaster or similar event could have a material adverse effect on our business, financial condition and results of operations.

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If we fail to properly maintain the integrity or availability of our data or to strategically implement new or upgrade or consolidate existing information systems, our business could be materially adversely affected.

Our ability to adequately price our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to accurately report our financial results depends on the integrity of the data in our information systems. As a result of technology initiatives, changes in our system platforms and integration of new business acquisitions, we have been taking steps to consolidate and integrate the number of systems we operate and have upgraded and expanded our information systems capabilities. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards, and changing customer patterns. If the information we rely upon to run our businesses were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have disputes with customers, physicians and other health care professionals, have regulatory problems, have increases in operating expenses or suffer other adverse consequences. There can be no assurance that our process of consolidating the number of systems we operate, upgrading and expanding our information systems capabilities, protecting and enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology will be successful or that additional systems issues will not arise in the future. Failure to consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management s time and energy, which could materially impact our business, financial condition and operating results.

If we are not able to protect our proprietary rights to our databases and related products, our ability to market our knowledge and information-related businesses could be hindered and our business could be adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our revenues and results of operations could be adversely affected.

Our ability to obtain funds from some of our subsidiaries is restricted and if we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from some of our subsidiaries to fund our obligations. These subsidiaries generally are regulated by states departments of insurance. We are also required by law to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily upon the volume of premium revenues generated. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by these state regulatory authorities before we transfer money or pay dividends from these subsidiaries that exceed specified amounts. In addition, we normally notify the state departments of insurance prior to making payments that do not require approval. An inability of our regulated subsidiaries to pay dividends to their parent companies could impact the scale to which we could reinvest in our business through capital expenditures, business acquisitions and the repurchase of shares of our common stock and our ability to repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our operations or financial position may be adversely affected.

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Any failure by us to manage and complete acquisitions and other significant transactions successfully could harm our financial results, business and prospects.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Downgrades in our debt ratings, should they occur, may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are increasingly important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency s opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders. Downgrades in our ratings, should they occur, may adversely affect our business, financial condition and results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2008, we owned and/or leased real properties totaling approximately 15.4 million square feet to support our business operations in the United States and other countries (net of approximately 0.4 million square feet of space subleased to third parties). Of this total, we owned approximately 1 million aggregate square feet of space and leased the remainder. Our leases expire at various dates through September 30, 2028. Our facilities are primarily located in the United States. Our various reporting segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

During 2008, we completed a sale-leaseback transaction for six properties resulting in gross proceeds of $185 million, and pre-tax gains of $72 million that have been deferred and will be amortized straight-line against rent expense over the term of the underlying leases of 12.5 years.

ITEM 3. LEGAL PROCEEDINGS

See Note 15 of Notes to the Consolidated Financial Statements in this Form 10-K, which is incorporated by reference herein.

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

None.

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PART II

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

MARKET PRICES

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On February 4, 2009, there were 14,183 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE were as follows:

	High	Low
2009		
First quarter (through February 4, 2009)	$ 30.25	$ 23.77
2008		
First quarter	$ 57.86	$ 33.57
Second quarter	$ 38.33	$ 25.50
Third quarter	$ 33.49	$ 21.00
Fourth quarter	$ 27.31	$ 14.51
2007		
First quarter	$ 57.10	$ 50.51
Second quarter	$ 55.90	$ 50.70
Third quarter	$ 54.10	$ 45.82
Fourth quarter	$ 59.46	$ 46.59

DIVIDEND POLICY

Our Board of Directors established our dividend policy in August 1990. Pursuant to our dividend policy, our Board of Directors reviews our consolidated financial statements following the end of each fiscal year and decides whether to declare a dividend on the outstanding shares of common stock. On February 3, 2009, our Board of Directors approved an annual dividend of $0.03 per share, which will be paid on April 16, 2009 to shareholders of record on April 2, 2009. Shareholders of record on April 2, 2008 received an annual dividend for 2008 of $0.03 per share and shareholders of record on April 2, 2007 received an annual dividend for 2007 of $0.03 per share.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)

Fourth Quarter 2008

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, 2008	3,320,145(b)	$ 22.38	3,317,220	106,768,839
November 30, 2008	939,797	$ 20.21	939,797	105,829,042
December 31, 2008	2,996,758(c)	$ 25.31	2,921,480	102,907,562
TOTAL	7,256,700	$ 23.31	7,178,497	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. On October 30, 2007, the Board renewed and increased our share repurchase program, and authorized us to repurchase up to 210 million shares of our common stock at prevailing market prices. There is no established expiration date for the program.

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(b) Represents 3,317,220 shares of our common stock repurchased during the period, and 2,925 shares of our common stock withheld by us, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

(c) Represents 2,921,480 shares of our common stock repurchased during the period, and 75,278 shares of our common stock withheld by us, as permitted by the applicable equity award certificates, to satisfy tax withholding obligations upon vesting of shares of restricted stock.

PERFORMANCE GRAPHS

The following two performance graphs compare the Company s total return to shareholders with indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on UnitedHealth Group s common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group (the *Fortune 50* Group), an index of certain *Fortune 50* companies for the five-year period ended December 31, 2008. 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, 2008. 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, 2003 in Company common stock and in each index, and that dividends were reinvested when paid.

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Fortune 50 Group

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation, and Johnson & Johnson. Although there are differences in terms of size and industry, like UnitedHealth Group, all of these companies are large multi-segment companies using a well-defined operating model in one or more broad sectors of the economy.

	12/03	12/04	12/05	12/06	12/07	12/08
UnitedHealth Group	**100.00**	**151.38**	**213.78**	**184.95**	**200.45**	**91.69**
S&P 500	**100.00**	**110.88**	**116.33**	**134.70**	**142.10**	**89.53**
Fortune 50 Group	**100.00**	**110.48**	**109.42**	**124.08**	**116.03**	**61.10**

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

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Peer Group

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

	12/03	12/04	12/05	12/06	12/07	12/08
UnitedHealth Group	**100.00**	**151.38**	**213.78**	**184.95**	**200.45**	**91.69**
S&P 500	**100.00**	**110.88**	**116.33**	**134.70**	**142.10**	**89.53**
Peer Group	**100.00**	**154.34**	**225.34**	**222.47**	**268.41**	**119.65**

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

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ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(in millions, except percentages and per share data)	For the Year Ended December 31, 2008 (a,b)	2007 (a,b)	2006 (a,b)	2005 (b)	2004 (b)
Consolidated Operating Results					
Revenues	$ 81,186	$ 75,431	$ 71,542	$ 46,425	$ 38,217
Earnings From Operations	$ 5,263	$ 7,849	$ 6,984	$ 5,080	$ 3,858
Net Earnings	$ 2,977	$ 4,654	$ 4,159	$ 3,083	$ 2,411
Return on Shareholders Equity	14.9%	22.4%	22.2%	25.2%	29.0%
Basic Net Earnings per Common Share	$ 2.45	$ 3.55	$ 3.09	$ 2.44	$ 1.93
Diluted Net Earnings per Common Share	$ 2.40	$ 3.42	$ 2.97	$ 2.31	$ 1.83
Common Stock Dividends per Share	$ 0.030	$ 0.030	$ 0.030	$ 0.015	$ 0.015
Consolidated Cash Flows From (Used For)					
Operating Activities	$ 4,238	$ 5,877	$ 6,526	$ 4,083	$ 3,923
Investing Activities	$ (5,072)	$ (4,147)	$ (2,101)	$ (3,489)	$ (1,644)
Financing Activities	$ (605)	$ (3,185)	$ 474	$ 836	$ (550)
Consolidated Financial Condition					
(As of December 31)					
Cash and Investments	$ 21,575	$ 22,286	$ 20,582	$ 14,982	$ 12,253
Total Assets	$ 55,815	$ 50,899	$ 48,320	$ 41,288	$ 27,862
Total Commercial Paper and Long-Term Debt	$ 12,794	$ 11,009	$ 7,456	$ 7,095	$ 4,011
Shareholders Equity	$ 20,780	$ 20,063	$ 20,810	$ 17,815	$ 10,772
Debt-to-Total-Capital Ratio	38.1%	35.4%	26.4%	28.5%	27.1%

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

(a) On January 1, 2006, we began serving as a plan sponsor offering Medicare Part D drug insurance coverage under a contract with CMS. Total revenues generated under this program were $4.6 billion, $5.9 billion and $5.7 billion for the years ended December 31, 2008, 2007 and 2006, respectively. See Note 2 of Notes to the Consolidated Financial Statements for a detailed discussion of this program.

(b) We acquired Unison Health Plans in May 2008 for total consideration of approximately $930 million, Sierra Health Services, Inc. in February 2008 for total consideration of approximately $2.6 billion, Fiserv Health, Inc. in January 2008 for total consideration of approximately $740 million, PacifiCare Health Systems, Inc. in December 2005 for total consideration of approximately $8.8 billion, Oxford Health Plans, Inc. in July 2004 for total consideration of approximately $5.0 billion and Mid-Atlantic Medical Services, Inc. in February 2004 for total consideration of approximately $2.7 billion. The results of operations and financial condition of the acquisitions discussed above have been included in our Consolidated Financial Statements since the respective acquisition dates.

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

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto. Readers should be cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, or PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements. A description of some of the risks and uncertainties can be found in Item 1A, Risk Factors.

BUSINESS OVERVIEW

UnitedHealth Group is a diversified health and well-being company, serving more than 70 million Americans. Our focus is on enhancing the performance of the health system and improving the overall health and well-being of the people we serve and their communities. We work with health care professionals and other key partners to expand access to high quality health care. We help people get the care they need at an affordable cost, support the physician/patient relationship, and empower people with the information, guidance and tools they need to make personal health choices and decisions.

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

BUSINESS TRENDS

Our businesses participate in the U.S. health economy, which comprises approximately 16% of gross domestic product and which has grown consistently for many years. Management expects overall spending on health care in the U.S. to continue to rise in the future, based on inflation, demographic trends in the U.S. population and national interest in health and well-being. The rate of growth may be impacted by a variety of factors, including macro-economic conditions and proposed health care reforms, which could also impact our results of operations.

Adverse Economic Conditions

The current U.S. recessionary economic environment has impacted demand for certain of our products and services. For example, decreases in employment have reduced the number of workers and dependants offered health care benefits by our employer customers and will pressure top line growth for our UnitedHealthcare business. In contrast, our AmeriChoice business has seen increased participation in its state Medicaid offerings as employment rates fall. If the recessionary economic environment continues for a prolonged period, federal and state governments may decrease funding for various health care government programs in which we participate and/or impose new or higher levels of taxes or assessments. In total, management believes that economic recessions will slow our revenue growth rate and could impact our operating profitability. Management also believes that government funding pressure, coupled with recessionary economic conditions, will impact the financial positions of hospitals, physicians and other care providers and could therefore increase medical cost trends experienced by our businesses. For additional discussions regarding how a prolonged economic downturn could affect our business, see Item 1A, Risk Factors.

Proposed Federal Economic Stimulus Package

In the short term, our businesses may benefit if proposed elements of the federal economic stimulus package responding to the current recession are signed into law. These include expansion of funding to state programs,

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which could mitigate funding pressure for AmeriChoice Medicaid offerings at the state level, expansion of coverage for recently unemployed workers through their former employers plans, which could enhance participation in UnitedHealthcare benefit programs, and funding for health care information technology, which could expand market opportunities for Ingenix.

Proposed Health Care Reforms

There is regular dialogue about health care reforms at both state and national levels, due to the size of and national interest in the health economy. Examples of these health care reform proposals include policy changes that would change the dynamics of the health care industry, such as having the federal or one or more state governments assume a larger role in the health care system or a fundamental restructuring of the Medicare or Medicaid programs.

The new administration and various congressional leaders have signaled their interest in reducing payments to private plans offering Medicare Advantage. Depending on the extent and phasing of these potential reductions, management believes that the number of seniors participating in Medicare Advantage and the industry-wide earnings derived from these plans may fall. However, if payment rates do come down, management believes that there are a number of adjustments we can make to our operations annually, which may partially offset any earnings impact. For example, we can adjust members benefits, we can decide on a county-by-county basis which geographies to participate in, and we can seek to intensify our medical and operating cost management. Any payment reductions may be phased in over a number of years. If industry-wide Medicare Advantage membership reduces, there is likely to be increased demand for Medicare Supplemental insurance and Part D prescription drug coverage, and in both categories Ovations is also a market leader.

We operate a diversified set of health care focused businesses; this business model has been intentionally designed to address a multitude of market sectors. Therefore, we could see simultaneous increases and decreases in demand for various of our products and services, depending on the scope, shape and timing of health care reforms. It is difficult to predict the outcome of reform discussions with precision over the mid- to long-term time horizon. For additional discussions regarding our risks related to health care reforms, see Item 1A, Risk Factors.

2008 FINANCIAL PERFORMANCE SUMMARY

We generated net earnings of $3.0 billion, representing a decrease of 36% compared to 2007. Other financial performance measures include:

Diluted net earnings per common share of $2.40, a decrease of 30% compared to 2007.

Consolidated revenues of $81.2 billion, an increase of 8% over 2007.

Earnings from operations of $5.3 billion, down $2.6 billion over 2007.

The operating margin of 6.5%, down from 10.4% in 2007.

Cash flows from operations of $4.2 billion, representing 142% of 2008 net earnings.

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RESULTS SUMMARY

The following summarizes the consolidated financial results for the years ended December 31:

(in millions, except percentages and per share data)	2008	2007	2006	Increase (Decrease) 2008 vs. 2007		Increase (Decrease) 2007 vs. 2006	
REVENUES							
Premiums	$ 73,608	$ 68,781	$ 65,666	$ 4,827	7 %	$ 3,115	5 %
Services	5,152	4,608	4,268	544	12 %	340	8 %
Products	1,655	898	737	757	84 %	161	22 %
Investment and Other Income	771	1,144	871	(373)	(33) %	273	31 %
Total Revenues	81,186	75,431	71,542	5,755	8 %	3,889	5 %
OPERATING COSTS							
Medical Costs	60,359	55,435	53,308	4,924	9 %	2,127	4 %
Medical Cost Ratio	82.0 %	80.6 %	81.2 %		1.4 %		(0.6) %
Operating Costs	13,103	10,583	9,981	2,520	24 %	602	6 %
Operating Cost Ratio	16.1 %	14.0 %	14.0 %		2.1 %		%
Cost of Products Sold	1,480	768	599	712	93 %	169	28 %
Depreciation and Amortization	981	796	670	185	23 %	126	19 %
Total Operating Costs	75,923	67,582	64,558	8,341	12 %	3,024	5 %
EARNINGS FROM OPERATIONS	5,263	7,849	6,984	(2,586)	(33) %	865	12 %
Operating Margin	6.5 %	10.4 %	9.8 %		(3.9) %		0.6 %
Interest Expense	(639)	(544)	(456)	95	17 %	88	19 %
EARNINGS BEFORE INCOME TAXES	4,624	7,305	6,528	(2,681)	(37) %	777	12 %
Provision for Income Taxes	(1,647)	(2,651)	(2,369)	(1,004)	(38) %	282	12 %
Tax Rate	35.6 %	36.3 %	36.3 %		(0.7) %		%
NET EARNINGS	$ 2,977	$ 4,654	$ 4,159	$ (1,677)	(36) %	$ 495	12 %
DILUTED NET EARNINGS PER COMMON SHARE	$ 2.40	$ 3.42	$ 2.97	$ (1.02)	(30) %	$ 0.45	15 %
RETURN ON EQUITY	14.9 %	22.4 %	22.2 %		(7.5) %		0.2 %
TOTAL PEOPLE SERVED	73	71	71	2	3 %		%

ACQUISITIONS

Unison Health Plans. On May 30, 2008, we acquired all of the outstanding shares of Unison Health Plans (Unison) for approximately $930 million in cash. Unison provides government-sponsored health plan coverage to people in Pennsylvania, Ohio, Tennessee, Delaware, South Carolina and Washington, D.C. through a network of independent health care professionals. This acquisition strengthened our resources and capabilities in these areas. The results of operations and financial condition of Unison have been included in our consolidated results and the results of our Health Care Services reporting segment since the acquisition date.

Sierra Health Services, Inc. On February 25, 2008, we acquired all of the outstanding shares of Sierra Health Services, Inc. (Sierra), a diversified health care services company based in Las Vegas, Nevada, for approximately $2.6 billion in cash, representing a price of $43.50 per share of Sierra common stock. This acquisition strengthened our position in the southwest region of the United States. The U.S. Department of Justice approved the acquisition conditioned upon the divestiture of our individual SecureHorizons Medicare Advantage HMO plans in Clark and Nye Counties, Nevada, which represented approximately 30,000 members. The divestiture was completed on April 30, 2008. We received proceeds of $185 million for this transaction which were recorded as a reduction to Operating Costs. Group SecureHorizons Medicare Advantage plans offered through commercial

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contracts were excluded from the divestiture. Also, we retained Sierra s Medicare Advantage HMO plans in Nevada. The results of operations and financial condition of Sierra have been included in our consolidated results and the results of the Health Care Services, OptumHealth and Prescription Solutions reporting segments since the acquisition date.

Fiserv Health, Inc. On January 10, 2008, we acquired all of the outstanding shares of Fiserv Health, Inc. (Fiserv Health), a subsidiary of Fiserv, Inc., for approximately $740 million in cash. Fiserv Health is a leading administrator of medical benefits and also provides care facilitation services, specialty health solutions and pharmacy benefit management (PBM) services. This transaction allows us to expand the capacity of our existing benefits administration businesses and enables existing and new customers to leverage our full range of assets, including ancillary services, our national network and technology tools.

The results of operations and financial condition of Fiserv Health have been included in our consolidated results and the results of the Health Care Services, OptumHealth, Ingenix and Prescription Solutions reporting segments since the acquisition date.

2008 RESULTS COMPARED TO 2007 RESULTS

Consolidated Financial Results

Revenues

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

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers health care benefits 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 dependants. For both premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; health care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. Through our Prescription Solutions PBM business, revenues are derived from both products sold and administrative services. Product revenues also include sales of Ingenix publishing and software products.

Consolidated revenues for 2008 increased from 2007 primarily due to the increase in premium revenue in the Health Care Services reporting segment. The following is a discussion of consolidated revenues for each of our revenue components.

Premium Revenues. The premium revenue growth generated by our Health Care Services reporting segment was the primary driver in the consolidated premium revenues increase. This increase was due to the growth in individuals served by our Public and Senior Markets Group, premium rate increases for medical cost inflation and acquisitions completed in 2008, partially offset by a decline in individuals served through both UnitedHealthcare risk-based products and Medicare Part D prescription drug plans.

Service Revenues. The increase in service revenues for 2008 was driven by an increased number of individuals served by fee-based product arrangements in the Health Care Services reporting segment, primarily due to the Fiserv Health acquisition. In addition, our Ingenix reporting segment generated service revenue growth from its health intelligence and contract research businesses as well as from business acquisitions.

Product Revenues. Product revenues for 2008 increased due to increased prescription volume at our Prescription Solutions reporting segment, primarily related to the Fiserv Health acquisition.

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Investment and Other Income. The decrease in investment and other income in 2008 was primarily due to lower investment yields primarily as a result of the decrease in interest rates on our cash equivalents, decreased average investment balances related to lower operating cash flows, decreased deposits held for certain government-sponsored programs and increased other-than-temporary impairment charges related to the disruption in the financial markets.

Medical Costs

Medical costs for 2008 increased primarily due to medical cost inflation, acquisitions completed in 2008 and growth in Ovations Medicare Advantage and Medicare Supplement products, partially offset by a decrease in the number of individuals served through both UnitedHealthcare risk-based products and Medicare Part D prescription drug plans.

The medical care ratio, calculated as medical costs as a percentage of premium revenues, reflects the combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts. Our consolidated medical care ratio increase was primarily driven by premium rates advancing more slowly than medical costs in 2008 for certain risk-based products in the commercial, senior and behavioral care markets.

For each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior periods, resulting from more complete claim information identified in the current period, are included in total medical costs reported for the current period. Medical costs for 2008 included approximately $230 million of net favorable medical cost development related to prior fiscal years. Medical costs for 2007 included approximately $420 million of net favorable medical cost development related to prior fiscal years.

Operating Costs

The operating cost ratio, calculated as operating costs as a percentage of total revenues, increased in 2008 primarily due to certain expenses as discussed below, acquisitions completed in 2008, costs for anticipated revenue growth that did not fully materialize and a change in business mix towards service revenues from fee-based businesses.

Operating costs for 2008 include $882 million for the proposed settlements of two class action lawsuits related to our historical stock option practices and related legal costs, net of expected insurance proceeds, and $350 million for the settlement of class action litigation related to reimbursement for out-of-network medical services, partially offset by a $185 million reduction in expenses for proceeds from the sale of certain assets and membership of our individual Medicare Advantage HMO plans in Clark and Nye Counties, Nevada relating to the Sierra acquisition. These amounts have been recorded in the corporate segment. For a discussion of the proposed settlements, see Note 15 of Notes to the Consolidated Financial Statements.

Operating costs for 2007 include $176 million of expenses recorded in the first quarter of 2007 related to application of deferred compensation rules under Section 409A of the Internal Revenue Code (Section 409A) to our historical stock option practices. The $176 million Section 409A charge includes $87 million of expenses for the payment of certain optionholders tax obligations for stock options exercised in 2006 and early 2007 and $89 million of expenses for the modification related to increasing the exercise price of unexercised stock options granted to nonexecutive officer employees and the related cash payments. These amounts have been recorded in the corporate segment. For an expanded discussion of our Section 409A charges, see Note 12 of Notes to the Consolidated Financial Statements.

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Cost of Products Sold

Cost of products sold increased due to increased prescription volume at our Prescription Solutions reporting segment, primarily related to the Fiserv Health acquisition.

Depreciation and Amortization

The increase in depreciation and amortization was primarily related to higher levels of computer equipment and capitalized software as a result of technology development and enhancements, as well as additional depreciation and amortization related to recent business acquisitions.

Interest Expense

Interest expense increased due to an increase in our debt outstanding, which was partially offset by lower market interest rates on our floating-rate debt.

Income Taxes

The decrease in our effective income tax rate was primarily due to lower earnings resulting in an increased proportion of tax-free investment income to total earnings.

Reporting Segments

We have four reporting segments:

- Health Care Services, which includes UnitedHealthcare, Ovations and AmeriChoice;
- OptumHealth;
- Ingenix; and
- Prescription Solutions.

Transactions between reporting segments principally consist of sales of pharmacy benefit products and services to Health Care Services customers by Prescription Solutions, certain product offerings sold to Health Care Services customers by OptumHealth, and medical benefits cost, quality and utilization data and predictive modeling sold to Health Care Services by Ingenix. These transactions are recorded at management s estimate of fair value. Intersegment transactions are eliminated in consolidation.

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The following summarizes the operating results of our reporting segments for the years ended December 31:

(in millions)	2008	2007	2006	Increase (Decrease) 2008 vs. 2007		Increase (Decrease) 2007 vs. 2006	
Revenues							
Health Care Services	$ 75,857	$ 71,199	$ 67,817	$ 4,658	7 %	$ 3,382	5 %
OptumHealth	5,225	4,921	4,342	304	6 %	579	13 %
Ingenix	1,552	1,304	956	248	19 %	348	36 %
Prescription Solutions	12,573	13,249	4,084	(676)	(5)%	9,165	224 %
Eliminations	(14,021)	(15,242)	(5,657)	1,221	nm	(9,585)	nm
Consolidated Revenues	$ 81,186	$ 75,431	$ 71,542	$ 5,755	8 %	$ 3,889	5 %
Earnings from Operations							
Health Care Services	$ 5,068	$ 6,595	$ 5,860	$ (1,527)	(23)%	$ 735	13 %
OptumHealth	718	895	809	(177)	(20)%	86	11 %
Ingenix	229	266	176	(37)	(14)%	90	51 %
Prescription Solutions	363	269	139	94	35 %	130	94 %
Corporate	(1,115)	(176)		(939)	nm	(176)	nm
Consolidated Earnings from Operations	$ 5,263	$ 7,849	$ 6,984	$ (2,586)	(33)%	$ 865	12 %
Operating Margin							
Health Care Services	6.7 %	9.3 %	8.6 %		(2.6)%		0.7 %
OptumHealth	13.7 %	18.2 %	18.6 %		(4.5)%		(0.4)%
Ingenix	14.8 %	20.4 %	18.4 %		(5.6)%		2.0 %
Prescription Solutions	2.9 %	2.0 %	3.4 %		0.9 %		(1.4)%
Consolidated Operating Margin	6.5 %	10.4 %	9.8 %		(3.9)%		0.6 %

nm = not meaningful

Health Care Services

The revenue growth in Health Care Services for 2008 was primarily due to growth in the number of individuals served by our Public and Senior Markets Group, premium rate increases for medical cost inflation and the 2008 acquisitions of Sierra, Fiserv Health, and Unison, partially offset by an organic decline in individuals served through commercial risk-based products and Medicare Part D products and a decrease in investment income. UnitedHealthcare revenues of $41.8 billion in 2008 increased over the comparable 2007 period by $1.6 billion, or 4%. The UnitedHealthcare increase was primarily driven by the same factors as discussed for Health Care Services in 2008. Ovations revenues of $28.1 billion in 2008 increased over the comparable 2007 period by $1.6 billion, or 6%. The increase was primarily due to an increase in individuals served with the standardized Medicare Supplement and Medicare Advantage products gained through both organic growth and the Sierra acquisition and premium rate increases, which were partially offset by a net organic decrease of 675,000 stand-alone Medicare Part D members primarily due to the reassignment by the Centers for Medicare and Medicaid Services (CMS) of certain dual-eligible low income beneficiaries based on annual price bids. AmeriChoice generated revenues of $6.0 billion in 2008, an increase of $1.5 billion, or 34%, over the comparable 2007 period, primarily due to an increase in the number of individuals served by Medicaid plans, premium rate increases and the acquisition of Unison in the second quarter of 2008.

The decrease in Health Care Services earnings from operations was primarily due to pressure on enrollment and gross margins in the UnitedHealthcare risk-based business and pressure on gross margins in Medicare Part D

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prescription drug plans, partially offset by acquisitions. The UnitedHealthcare medical care ratio increased to 83.5% in 2008 from 82.6% in 2007. This increase was primarily driven by the effects of a competitive pricing environment where price increases, net of customer benefit package changes, did not fully match the rise in medical costs, and an increased mix of national account pharmaceutical benefit business, which typically carries a higher medical care ratio. Health Care Services operating margin was 6.7% for the year ended December 31, 2008, a decrease from 9.3% in 2007 primarily driven by the factors discussed above.

The following summarizes the number of individuals served, by major market segment and funding arrangement, at December 31:

(in thousands)	2008	2007	2006	Increase (Decrease) 2008 vs. 2007		Increase (Decrease) 2007 vs. 2006	
Commercial Risk-based	10,360	10,805	11,285	(445)	(4)%	(480)	(4)%
Commercial Fee-based	15,985	14,720	14,415	1,265	9 %	305	2 %
Total Commercial	26,345	25,525	25,700	820	3 %	(175)	(1)%
Medicare Advantage	1,495	1,370	1,445	125	9 %	(75)	(5)%
Medicaid	2,515	1,710	1,465	805	47 %	245	17 %
Standardized Medicare Supplement	2,540	2,400	2,275	140	6 %	125	5 %
Total Public and Senior	6,550	5,480	5,185	1,070	20 %	295	6 %
Total Health Care Services Medical Benefits	32,895	31,005	30,885	1,890	6 %	120	%

The number of individuals served with commercial products increased due to acquisitions, which included the addition of 1,315,000 fee-based members from Fiserv Health and the addition of 310,000 risk-based individuals gained through the Sierra acquisition. These additions were partially offset by a net decline in individuals served with commercial products of 805,000, or 3%, from December 31, 2007, primarily due to a decline in individuals served with commercial risk-based products and the impact of a competitive commercial risk-based pricing environment. The number of individuals served by Medicare Advantage products at December 31, 2008 increased through the addition of 60,000 seniors from our acquisition of Sierra and organic growth of 95,000 seniors, partially offset by the divestiture of 30,000 individuals in Nevada related to the Sierra acquisition. Medicaid enrollment grew due to the addition of 320,000 and 60,000 individuals from our Unison and Sierra acquisitions, respectively, and strong organic growth of 425,000 individuals.

OptumHealth

Increased revenues in OptumHealth were driven by rate increases for medical cost inflation and an increased number of consumers served by this segment. OptumHealth provided services to approximately 60 million consumers at December 31, 2008, an increase of approximately 1 million individuals year-over-year.

Earnings from operations and operating margin decreased due to the increased costs for risk-based behavioral and specialty benefits businesses and the mix of continued growth in lower margin business.

Ingenix

The improvement in Ingenix revenues was due to continued growth in its health intelligence and contract research businesses as well as from business acquisitions. The decrease in earnings from operations and operating margin was primarily due to excess staffing costs during 2008 for certain research projects which were cancelled, as well as lower demand for certain consulting services due to the current economic environment.

Prescription Solutions

The decreased Prescription Solutions revenues were primarily due to the reduction in the number of individuals served related to the reassignment of dual-eligible beneficiaries described above through Medicare Part D

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prescription drug plans by our Ovations business, which is the largest customer of this reporting segment, and a shift from name brand pharmaceuticals towards generic utilization, partially offset by revenues related to the Fiserv Health acquisition and growth in business with unaffiliated clients. Intersegment revenues eliminated in consolidation were $11.0 billion and $12.4 billion for 2008 and 2007, respectively.

Prescription Solutions earnings from operations increased primarily due to the Fiserv Health acquisition, gains in mail service drug fulfillment, and a continuing favorable mix shift to generic pharmaceuticals.

2007 RESULTS COMPARED TO 2006 RESULTS

Consolidated Financial Results

Revenues

Consolidated revenues increased in 2007 primarily due to rate increases on premium-based and fee-based services and growth in the total number of individuals served by Health Care Services.

Premium Revenues. Consolidated premium revenues increased in 2007 primarily due to premium rate increases, partially offset by a decrease in the number of individuals served by our commercial risk-based products.

Premium revenues for UnitedHealthcare in 2007 totaled $36.2 billion, an increase of $623 million, or 2%, over 2006. This increase was primarily due to average net premium rate increases of 7% to 8% on UnitedHealthcare s renewing commercial risk-based products and due to premiums from businesses acquired since the beginning of 2006. This was partially offset by a 4% decrease in the number of individuals served by commercial risk-based products in 2007 primarily due to our internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of certain groups to commercial fee-based products. Ovations premium revenues in 2007 totaled $26.0 billion, an increase of $1.7 billion, or 7%, over 2006. This increase was driven primarily by an increase in individuals served by standardized Medicare Supplement and Evercare products, and rate increases on Medicare Advantage products as well as continued growth in our Medicare Part D program. AmeriChoice premium revenues increased by $732 million, or 20%, over 2006 primarily due to an increase in the number of individuals served by Medicaid products as well as rate increases. The remaining premium revenue increase resulted primarily from membership growth and rate increases at OptumHealth, which contributed a premium revenue increase of 11% over 2006.

Service Revenues. The 2007 increase in consolidated service revenues was driven primarily by a 38% increase in Ingenix service revenues due to new business growth in the health information and contract research businesses and from businesses acquired since the beginning of 2006. In addition, UnitedHealthcare service revenues increased due to a 3% increase in the number of individuals served under commercial fee-based arrangements during 2007, as well as annual rate increases.

Product Revenues. The 2007 increase in consolidated product revenues was driven by pharmacy sales growth at Prescription Solutions primarily due to providing prescription drug benefit services to an additional four million Ovations Medicare Advantage and Part D members.

Investment and Other Income. Interest income increased by $239 million in 2007, driven by increased levels of cash and fixed-income investments, due in part to deposits held for certain government-sponsored programs during 2007 and the lack of share repurchase activity in the first two and one half months of 2007. Net realized gains on sales of investments were $38 million in 2007 and $4 million in 2006.

Medical Costs

The consolidated medical care ratio decreased primarily due to a decrease in the medical care ratio relating to Ovations which was partially offset by an increase in the commercial medical care ratio resulting from our

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internal pricing decisions in a competitive commercial risk-based pricing environment, as well as a shift from favorable medical cost development for UnitedHealthcare during 2006 to unfavorable medical cost development during 2007.

Medical costs for 2007 included approximately $420 million of favorable medical cost development related to prior fiscal years. Medical costs for 2006 included approximately $430 million of favorable medical cost development related to prior fiscal years.

Medical costs for 2007 increased primarily due to an annual medical cost trend of 7% to 8% on commercial risk-based business due to medical cost inflation and increased utilization, as well as growth in Ovations Medicare programs, partially offset by a decrease in the number of individuals served by commercial risk-based products.

Operating Costs

The operating cost ratio for 2007 was consistent with 2006. The operating cost ratio reflected productivity gains from technology deployment and other cost management initiatives, offset by the effect of business mix change as fee-based businesses such as Ingenix increase in size and impact, as well as increased investment in technology, service and product enhancements; incremental marketing and advertising costs for Medicare Advantage products; and expenses in the first quarter of 2007 associated with the application of deferred compensation rules under Section 409A to our historical stock option practices, as described in 2008 Results Compared to 2007 Results above.

The increase in operating costs in 2007 was primarily due to general operating cost inflation and was also impacted by the items discussed above.

Cost of Products Sold

Cost of products sold increased in 2007 primarily due to costs associated with increased pharmacy sales at Prescription Solutions as a result of providing prescription drug benefit services to an additional four million Ovations Medicare Advantage and Part D members in 2007.

Depreciation and Amortization

The increase in depreciation and amortization in 2007 was primarily related to higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2006, as well as separately identifiable intangible assets acquired in business acquisitions since the beginning of 2006.

Reporting Segments

Health Care Services

UnitedHealthcare revenues of $40.3 billion in 2007 increased by $821 million, or 2%, over 2006. This increase was driven mainly by average net premium rate increases of 7% to 8% on UnitedHealthcare s renewing commercial risk-based products, an increase in the number of individuals served by commercial fee-based products and businesses acquired since the beginning of 2006. This was partially offset by a 4% decrease in the number of individuals served by commercial risk-based products in 2007 primarily due to our internal pricing decisions in a competitive commercial risk-based pricing environment and the conversion of certain groups to commercial fee-based products. Ovations revenues of $26.5 billion in 2007 increased by approximately $1.8 billion, or 7%, over 2006. The increase was primarily driven by an increase in individuals served by standardized Medicare supplement and Evercare products, and rate increases on Medicare Advantage products as well as continued growth in our Medicare Part D program. The remaining Health Care Services revenue increase

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resulted from an increase in AmeriChoice revenues of $750 million, or 20%, over 2006 primarily due to an increase in the number of individuals served by Medicaid products as well as rate increases.

The increase in Health Care Services earnings from operations in 2007 was principally driven by a decrease in the medical care ratio for Ovations primarily due to favorable medical cost trends and an increase in the number of individuals served by certain Medicare products and related rate increases discussed above, partially offset by a decrease in individuals served by commercial risk-based products and an increase in the related medical care ratio. The UnitedHealthcare medical care ratio increased to 82.6% in 2007 from 80.5% in 2006. This increase was mainly due to our internal pricing decisions in a competitive commercial risk-based pricing environment as well as a shift from favorable medical cost development for UnitedHealthcare during 2006 to unfavorable medical cost development during 2007, which was partially driven by costs from higher benefit utilization in December 2006 primarily relating to high-deductible risk-based products. The Health Care Services operating margin for 2007 was 9.3%, an increase from 8.6% in 2006, which reflected productivity gains from technology deployment and disciplined operating cost management as well as the factors discussed above.

The increase in the number of individuals served with commercial fee-based products as of December 31, 2007 was driven by new customer relationships and customers converting from risk-based products to fee-based products, partially offset by employment attrition at continuing customers. The number of individuals served with commercial risk-based products decreased primarily due to a competitive pricing environment and the conversion of individuals to fee-based products.

The number of individuals served by Medicare Advantage products as of December 31, 2007 decreased primarily due to a decline in participation in private-fee-for-service offerings, while individuals served by standardized Medicare supplement products increased due to new customer relationships. Medicaid enrollment increased in 2007 primarily due to new customer gains, including 180,000 individuals served under the TennCare program in Tennessee.

OptumHealth

The OptumHealth revenues 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.

OptumHealth earnings from operations increased in 2007 primarily due to the membership growth and rate increases. The OptumHealth operating margin declined from 18.6% in 2006 to 18.2% in 2007 due to a continued business mix shift toward higher revenue, lower margin products, partially offset by effective operating cost management.

Ingenix

The Ingenix revenues increase in 2007 was primarily driven by new business growth in the health information and contract research businesses as well as from businesses acquired since the beginning of 2006.

The increase in earnings from operations was primarily due to growth in the health information and contract research businesses, businesses acquired since the beginning of 2006 and effective operating cost management. The operating margin was 20.4% in 2007, up from 18.4% in 2006. This increase in operating margin was largely driven by business growth and operating cost management described above.

Prescription Solutions

The Prescription Solutions revenues increase in 2007 was primarily driven by providing prescription drug benefit services to an additional four million Ovations Medicare Advantage and stand-alone Part D members.

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Intersegment revenues were eliminated in consolidation and amounted to $12.4 billion and $3.4 billion for 2007 and 2006, respectively.

Prescription Solutions earnings from operations increased largely due to the expansion of services to Medicare Part D members discussed above. The operating margin was 2.0% in 2007, a decrease from 3.4% in 2006. The decrease in operating margin reflected the comparatively lower margin earned in the high volume Ovations Medicare Part D prescription drug service contracts.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity and Financial Condition

We manage our cash, investments and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. 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 exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to our Board of Directors approved investment policy, which generally governs return objectives, regulatory limitations, tax implications and risk tolerances, which focuses on preservation of capital, diversification and duration. 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 flows from operations for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of commercial paper and long-term debt, as well as the availability of committed credit facilities, further strengthen our operating and financial flexibility. We generally use these cash flows to reinvest in our businesses by making capital expenditures, expanding our services through business acquisitions and repurchasing shares of our common stock, depending on market conditions.

Cash flows generated from operating activities, our primary source of liquidity, are principally from net earnings, prior to depreciation and amortization and other non-cash expenses. As a result, any future decline in our profitability may have a negative impact on our liquidity. The level of profitability of our risk-based 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 and customer diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs.

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A summary of our major sources and uses of cash is reflected in the table below.

(in millions)	For the Year Ended December 31, 2008	2007	2006
Sources of Cash:			
Cash Provided by Operating Activities	$ 4,238	$ 5,877	$ 6,526
Maturities and Sales of Investments	8,598	3,365	4,096
Proceeds from Issuance of Long-Term Debt	2,981	3,582	3,000
Other	1,770	1,962	2,395
Total Sources of Cash	17,587	14,786	16,017
Uses of Cash:			
Purchases of Investments	(9,251)	(6,379)	(4,851)
Cash Paid for Acquisitions, net of cash assumed and dispositions	(3,813)	(262)	(670)
Common Stock Repurchases	(2,684)	(6,599)	(2,345)
Other	(3,278)	(3,001)	(3,252)
Total Uses of Cash	(19,026)	(16,241)	(11,118)
Net (Decrease) Increase in Cash	$ (1,439)	$ (1,455)	$ 4,899

Net cash flows from operating activities decreased $1.6 billion in 2008, or 28%, primarily due to the decrease in net earnings of $1.7 billion which included payments of $573 million, net of taxes, for the settlement of two class action lawsuits related to our historical stock option practices. For detail on these settlements, see Note 15 of Notes to the Consolidated Financial Statements.

As of December 31, 2008, our cash, cash equivalent and available-for-sale investment balances of $21.4 billion included $7.4 billion of cash and cash equivalents, $13.5 billion of debt securities and $477 million of equity securities and venture capital funds. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity. The use of different market assumptions or valuation methodologies, primarily used in valuing our Level 3 equity securities, may have an effect on the estimated fair value amounts of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if the investment was sold at the measurement date. Other sources of liquidity, primarily from operating cash flows, reduce the need to sell investments in adverse markets. See Note 5 of Notes to the Consolidated Financial Statements for further detail of our fair value measurements.

Our investment portfolio has a relatively short average duration and a weighted average credit rating of AA as of December 31, 2008. Included in the debt securities balance is $3.3 billion of state and municipal obligations that are guaranteed by third parties. The securities are guaranteed by a number of different guarantors, and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted average credit rating of these securities both with and without the guarantee is AA as of December 31, 2008 for the securities for which such information is available.

Commercial Paper. Commercial paper consisted of senior unsecured debt sold on a discount basis with maturities up to 270 days. As of December 31, 2008, we had $101 million of outstanding commercial paper with interest rates ranging from 5.1% to 7.1%. This range in rates reflects increases in the market rates for Tier-2 credit-rated commercial paper.

Share Repurchases. Under our Board of Directors authorization, we maintain a common share repurchase program. Repurchases may be made from time to time at prevailing prices. During 2008, we repurchased 72 million shares at an average price of approximately $37 per share and an aggregate cost of approximately $2.7 billion. As of December 31, 2008, we had Board of Directors authorization to purchase up to an additional 103 million shares of our common stock.

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Capital Resources

As of December 31, 2008 and December 31, 2007, we had commercial paper and long-term debt outstanding of $12.8 billion and $11.0 billion, respectively.

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital. We have therefore adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Cash, Cash Equivalents and Investments. We maintained a highly liquid position, with cash, cash equivalents and investments of $21.6 billion as of December 31, 2008. As further described under 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. As of December 31, 2008, approximately $865 million of our $21.6 billion of cash and investments was held by non-regulated subsidiaries and was available for general corporate use, including acquisitions and share repurchases.

Shelf Registration. In February 2008, we filed a universal S-3 shelf registration statement with the U.S. Securities and Exchange Commission (SEC) registering an unlimited amount of debt securities.

Credit Ratings. Our credit ratings at December 31, 2008 were as follows:

	Moody s		Standard & Poor s		Fitch	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior Unsecured Debt	Baa1	Stable	A-	Negative	A-	Negative
Commercial Paper	P-2	n/a	A-2	n/a	F1	n/a

See Item 1A, Risk Factors, for a discussion of our risks related to downgrades in our credit ratings.

Debt Covenants. Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 50%. Our debt-to-total-capital ratio (calculated as the sum of commercial paper and debt divided by the sum of commercial paper, debt and shareholders equity) was 38.1% and 35.4% as of December 31, 2008 and December 31, 2007, respectively. We were in compliance with the requirements of all debt covenants as of December 31, 2008. In August 2006, we received a purported notice of default from persons claiming to hold our 5.8% Senior Unsecured Notes due March 15, 2036 alleging a violation of the indenture governing those 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. See Note 15 of Notes to the Consolidated Financial Statements for a discussion of the proceeding regarding the purported default.

Bank Credit Facilities. In November 2008, we entered into a $750 million 364-day revolving bank credit facility which replaced our $1.5 billion 364-day revolving bank credit facility entered into in November 2007. The interest rate is variable based on term and amount and is calculated based on LIBOR plus a spread. At December 31, 2008, the interest rate ranged from 2.9% to 4.3%.

In May 2007, we amended and restated our $1.3 billion five-year revolving bank credit facility which included increasing the capacity. There is currently $2.5 billion available under this credit facility which matures in May 2012. The interest rate is variable based on term and amount and is calculated based on LIBOR plus a spread. At December 31, 2008, the interest rate ranged from 0.6% to 2.0%.

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These credit facilities support our commercial paper program and are available for general working capital purposes. As of December 31, 2008, we had no amounts outstanding under our credit facilities.

Dividend Restrictions. We conduct a significant portion of our operations through subsidiaries that are subject to regulations and standards established by their respective states of domicile. Most of these regulations and standards conform to those established by the National Association of Insurance Commissioners. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. 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.

An inability of our regulated subsidiaries to pay dividends to their parent companies could impact the scale to which we could reinvest in our business through capital expenditures, business acquisitions and the repurchase of shares of our common stock. In addition, an inability to pay regulated dividends could impact our ability to repay our debt; however, our cash flows from operations of our unregulated businesses, as well as liquidity at the parent level in the form of cash and cash equivalent balances and commercial paper or bank funding, mitigate this risk. See Item 1A, Risk Factors for a discussion of our risks related to dividend restrictions on our regulated subsidiaries.

In 2008, based on the 2007 statutory net income and statutory capital and surplus levels, the maximum amount of dividends which could be paid without prior regulatory approval was $3.0 billion. As of December 31, 2008, our regulated subsidiaries have paid their parent companies dividends of $4.2 billion, including $1.2 billion of extraordinary dividends approved by state insurance regulators. In 2007, the maximum amount of dividends which could be paid without prior regulatory approval was $2.5 billion. In 2007, $2.9 billion was paid to their parent companies, including $400 million of extraordinary dividends approved by state insurance regulators.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2008, under our various contractual obligations and commitments:

(in millions)	2009	2010 to 2011	2012 to 2013	Thereafter	Total
Debt and Commercial Paper (a)	$ 1,456	$ 1,819	$ 1,515	$ 8,004	$ 12,794
Interest on Debt and Commercial Paper (b)	425	793	724	5,792	7,734
Operating Leases	258	425	303	688	1,674
Purchase Obligations (c)	149	45	1		195
Future Policy Benefits (d)	154	335	326	1,196	2,011
Unrecognized Tax Benefits (e)	2			205	207
Unfunded Investment Commitments (f)	134	82	10	10	236
Other Long-Term Obligations (g)	56	2		319	377
Total Contractual Obligations	$ 2,634	$ 3,501	$ 2,879	$ 16,214	$ 25,228

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

(b) 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, 2008 to estimate all remaining contractual payments. Includes unamortized discounts from par values.

(c) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements which are cancelable with the payment of an early termination penalty. Excludes

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agreements that are cancelable without penalty and also excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2008.

(d) Estimated payments required under life and annuity contracts held by a divested entity. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica, but we remain liable to the policyholders if they are unable to pay. We have recorded a corresponding reinsurance receivable from OneAmerica in our Consolidated Financial Statements.

(e) Unrecognized tax benefits relate to the provisions of Financial Accounting Standards Board (FASB) Interpretation No. 48 (FIN 48). Since the timing of future settlements is uncertain, the long-term portion has been classified as Thereafter. See Note 10 of Notes to the Consolidated Financial Statements for more detail.

(f) Includes remaining capital commitments for venture capital funds and the investment commitment related to the PacifiCare acquisition. See Note 15 of Notes to the Consolidated Financial Statements for more detail.

(g) Includes future payments to optionholders related to the application of Section 409A, as well as obligations associated with certain employee benefit programs and charitable contributions related to the PacifiCare acquisition discussed below, which have been classified as Thereafter due to uncertainty regarding payment timing.

We do not have other significant contractual obligations or commitments that require cash resources; however, we continually evaluate opportunities to expand our operations. This includes internal development of new products, programs and technology applications, and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

We do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities (SPEs), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2008, we were not involved in any SPE transactions.

RECENTLY ISSUED ACCOUNTING STANDARDS

In April 2008, the FASB issued FASB Staff Position FAS 142-3, Determination of the Useful Life of Intangible Assets (FSP 142-3). FSP 142-3 amends the factors to be considered in developing renewal and extension assumptions used to determine the useful life of a recognized intangible asset accounted for under FAS No. 142, Goodwill and Other Intangible Assets. FSP 142-3 is effective for our fiscal year 2009 and must be applied prospectively to intangible assets acquired after January 1, 2009. Early adoption is not permitted. We do not expect the adoption of FSP 142-3 will have a material impact on our Consolidated Financial Statements.

In December 2007, the FASB issued FAS No. 141 (Revised 2007), Business Combinations (FAS 141R), which replaces FAS No. 141, Business Combinations. FAS 141R establishes principles and requirements for how an acquirer recognizes and measures in our financial statements the identifiable assets acquired, the liabilities assumed, any noncontrolling interest in the acquiree and the goodwill acquired. The statement also establishes disclosure requirements that will enable users to evaluate the nature and financial effects of the business combination. FAS 141R is effective for our fiscal year 2009 and must be applied prospectively to all new acquisitions closing on or after January 1, 2009. Early adoption of this standard is not permitted. We do not expect the adoption of FAS 141R will have a material impact on our Consolidated Financial Statements.

In December 2007, the FASB issued FAS No. 160, Noncontrolling Interests in Consolidated Financial Statements An Amendment of ARB No. 51 (FAS 160). FAS 160 requires that accounting and reporting for minority interests be recharacterized as noncontrolling interests and classified as a component of equity. The

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standard is effective for our fiscal year 2009 and must be applied prospectively. We do not expect the adoption of FAS 160 will have a material impact on our Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs

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

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

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, we actuarially calculate completion factors using an analysis of claim adjudication patterns over the most recent 36-month period. A completion factor is an actuarial estimate, based upon historical experience, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. For months prior to the most recent three months, we apply the completion factors to actual claims adjudicated-to-date 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

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Control, as well as through a review of near-term completion factors. 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, 2008:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs (in millions)
(0.75)%	$ 148
(0.50)%	$ 99
(0.25)%	$ 49
0.25%	$ (49)
0.50%	$ (98)
0.75%	$ (146)

Medical cost PMPM trend factors are the most significant factors we use in developing our medical costs payable estimates for the most recent three months. The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent three months as of December 31, 2008:

Medical Cost PMPM Trend

Increase (Decrease) in Factors	Increase (Decrease) in Medical Costs (in millions)
3%	$ 281
2%	$ 187
1%	$ 94
(1)%	$ (94)
(2)%	$ (187)
(3)%	$ (281)

The analyses above include those outcomes that are considered reasonably likely based on our historical experience estimating 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 peri