UNITEDHEALTH GROUP INC
Form 10-K
February 12, 2014

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2013

or

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

For the transition period from _____ to _____
Commission file number: 1-10864

_____

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Minnesota	41-1321939
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota	55343
(Address of principal executive offices)	(Zip Code)
(952) 936-1300 (Registrant's telephone number, including area code)	

_____

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 o

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 o 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 o

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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. x

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 o	Non-accelerated filer o	Smaller reporting company o

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

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2013 was $64,914,032,649 (based on the last reported sale price of $65.48 per share on June 30, 2013, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2014, there were 989,191,844 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2014 Annual Meeting of Stockholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP
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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and our subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to a full spectrum of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, as well as students and other individuals, and serves the nation's active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare International includes Amil, a health care company providing health and dental benefits and hospital and clinical services to individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, government, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance including optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: integrated care delivery, care management, consumer engagement, distribution services, health financial services, operational services and support, health care information technology and pharmacy services.

Through UnitedHealthcare and Optum, in 2013, we managed over $160 billion in aggregate health care spending on behalf of the constituents and consumers we served. Our revenues are derived from premiums 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. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

For our financial results and the presentation of certain other financial information by segment, including revenues and long-lived fixed assets by geographic source, see Note 13 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

2014 Business Realignment

On January 1, 2014, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. Our Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, will be included in OptumInsight's results of operations. Our periodic filings with the Securities and Exchange Commission (SEC) beginning with our first quarter 2014 Form 10-Q will include historical segment results restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

UnitedHealthcare

UnitedHealthcare is advancing strategies to improve the way health care is delivered and financed, offering consumers a simpler, more affordable health care experience. Our market position is built on:

- a national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers.

UnitedHealthcare utilizes the expertise of UnitedHealth Group affiliates for capabilities in specialized areas, such as OptumRx pharmacy benefit products and services, certain OptumHealth care management and integrated care delivery services and OptumInsight health information and technology solutions, consulting and other services.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include a total of over 820,000 physicians and other health care professionals and approximately 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive regulations. See further discussion of our regulatory environment below under “Government Regulation” and in Item 7, “Management Discussion and Analysis of Financial Condition and Results of Operations.”

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, individuals, and the military, specifically TRICARE west region members. UnitedHealthcare Employer & Individual provides over 30 million Americans access to health care as of December 31, 2013. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups are more likely to purchase risk-based products because they are less willing or able to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual 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 per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees’ dependants, UnitedHealthcare Employer & Individual 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 Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

UnitedHealthcare Employer & Individual also offers a variety of non-employer based insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families. As part of the new public health care exchange market that opened October 1, 2013, UnitedHealthcare Employer & Individual now offers health benefit plans through exchanges in 10 states and District of Columbia, including four individual exchanges and nine small group (SHOP) exchanges.

The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals.

UnitedHealthcare Employer & Individual typically distributes its products through consultant or direct sales in the larger employer and public sector segments. In the smaller group size segment of the commercial marketplace, UnitedHealthcare Employer & Individual’s distribution system consists primarily of direct sales and producers, including brokers and agents. UnitedHealthcare Employer & Individual also distributes products through general agents, each of which is a wholesale agent or agency that contracts with a carrier to distribute individual or group benefits, providing extensive services to customers. In recent years, UnitedHealthcare Employer & Individual has

diversified its model more extensively, distributing through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. UnitedHealthcare Employer & Individual offers its products through

affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third party administrators (TPAs).

Direct-to-consumer sales will be supported by industry participation in multi-carrier health insurance marketplaces for individuals and small groups through state or federally led exchanges for coverage effective January 1, 2014. Additionally, UnitedHealthcare Employer & Individual has expanded distribution to include retail offerings responsive to the needs of individual consumers. Over the last few years, UnitedHealthcare Employer & Individual has opened several retail storefronts in various locations across the United States that provide solutions to consumers at all stages in life, from individual plans to employer coverage, as well as solutions for Medicare-Medicaid eligible (MME) individuals.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provide the flexibility to meet the needs of employers of all sizes as well as individuals shopping for health benefits coverage. UnitedHealthcare Employer & Individual emphasizes local markets and leverages its national scale to adapt products to meet specific local market needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans such as Choice and Options PPO to more traditional indemnity offerings. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products and Tools. Consumer engagement products couple plan design with financial accounts to increase employee responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer activation services such as personalized behavioral incentive programs and consumer education information. For example, UnitedHealthcare Employer & Individual's Diabetes Health Plan emphasizes health engagement for diabetics and prediabetics, with personalized health action plans, scorecards and benefits that are specifically designed to encourage consumers to participate actively in maintaining their health. During 2013, more than 45,000 employer-sponsored benefit plans, including nearly 270 employers in the large group self-funded market, purchased an HRA or HSA product. UnitedHealthcare Employer & Individual's consumer engagement tools provide members with online and/or mobile access to benefit, cost and quality information, such as myHealthcare Cost Estimator, Health4Me, and myClaims Manager with online bill payment.

Value-Based Products. UnitedHealthcare Employer & Individual's suite of consumer incentive products increases individual awareness for heightened consumer responsibility and behavior change. These products include: Small Business Wellness, which is a packaged wellness and incentives product offering gym reimbursement and encouraging completion of important wellness activities. For mid-sized clients, SimplyEngaged is a scalable activity-based reward program that ties incentives to completion of health improvement activities, while SimplyEngaged Plus provides richer incentives for achieving health outcome goals. For large, self-funded customers, the UnitedHealthcare Healthy Rewards program offers a flexible incentive design for employers to choose the right activities and biometric outcomes that best fit the needs of their population. Additionally, UnitedHealth Personal Rewards leverages a tailored approach to incentives by combining personalized scorecards with financial incentives for improving biometric scores, compliance with key health treatments and preventive care.

Essential Benefits Products. UnitedHealthcare Employer & Individual's portfolio of products drives value to consumers with lower costs, innovative designs and unique network programs that guide people to physicians recognized for providing high-quality, cost-efficient care to their patients. These approaches are designed to deliver sustainable health care costs for employers, enabling them to continue to offer their employees coverage at more affordable prices through benefit and local network access tradeoffs. UnitedHealthcare Employer & Individual's tiered benefit plans offer enhanced benefits in the form of greater coinsurance coverage and/or lower copays for using UnitedHealth Premium® designated care providers.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management programs, which complement our service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, improving health and decreasing medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured and self-funded), line of business (e.g. small business, key accounts, public sector and national accounts), and clinical need. UnitedHealthcare Employer & Individual's spectrum of clinical programs include:

- wellness programs;
- decision support;

- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to drive better unit costs, encouraging consumers to use drugs that offer better value and outcomes, and by supporting the appropriate use of drugs based on clinical evidence through physician and consumer programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life, and disability product offerings through an integrated approach including a network of more than 58,000 vision professionals in private and retail settings, and more than 250,000 dental providers.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans is the provider of health care services for more than 2.9 million active duty and retired military service members and their families in 21 states (West Region) under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013 and includes a transition period and five one-year renewals at the government's option.

UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration, and customer services.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to 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. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia, and most U.S. territories. It has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a spectrum of risk-based Medicare products which may be purchased by individuals or on a group basis, including Medicare Advantage plans, Medicare Prescription Drug Benefit (Medicare Part D) and Medicare Supplement/Medigap products that supplement traditional fee-for-service coverage. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 29% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2013, most of which were generated by UnitedHealthcare Medicare & Retirement under a number of contracts.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, 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. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS and in some cases consumer premiums. Premium amounts vary 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. UnitedHealthcare Medicare & Retirement had approximately 3 million people

enrolled in its Medicare Advantage products as of December 31, 2013.

Medicare Advantage plans are designed at the local level taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the long-term payment rate outlook for that geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly, see Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" for further information.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to outreach to members to create individualized care plans and to help members obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. UnitedHealthcare Medicare & Retirement offers two standalone Medicare Part D plans: the AARP Medicare Rx Preferred and the AARP Medicare Rx Saver plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans cover the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2013, UnitedHealthcare had enrolled approximately 8 million people in the Medicare Part D program, including approximately 5 million individuals in the stand-alone Medicare Part D plans and approximately 3 million in its Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers plans in all 50 states, the District of Columbia, and most U.S. territories. These products cover varying levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to providing diversified solutions to states' programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage in exchange for a fixed monthly premium per member from the applicable state. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), and other federal, state and community health care programs. As of December 31, 2013, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 4 million beneficiaries.

The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation) provides for optional Medicaid expansion effective January 1, 2014. Currently, more than half of our state customers have elected to expand Medicaid. For further discussion of the Medicaid expansion under Health Reform Legislation, see Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations."

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and our participation are:

- Temporary Assistance to Needy Families, primarily young women and children – 19 markets;
- CHIP – 19 markets;
- Dual SNP – 18 markets;

- Aged, Blind and Disabled (ABD) – 14 markets;
- Long-Term Care (LTC) – 10 markets;
- childless adults & programs for the uninsured – 7 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 5 markets; and
- administrative service offering – 1 market.

The health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group, delivering them at the local market level to support effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care.

UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are eligible for care in nursing homes and assisted living. They often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also tend to face significant social and economic challenges. UnitedHealthcare Community & State recognizes that within these broad groups, there exist individuals whose collective physical, behavioral and social challenges are so significant that they drive an inordinate percentage of UnitedHealthcare Community & State's total medical costs. In UnitedHealthcare Community & State's insured Medicaid population, approximately 1% of its membership accounts for about 30% of total costs. Care providers sometimes refer to this group as super utilizers.

The LTC market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTC population is made up of nearly 4 million individuals who qualify for additional benefits under LTC programs and represent a subset of the more than 15 million ABD Americans. Currently, only one-quarter of the ABD population and less than 20% of the LTC eligible population are served by managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are nearly 10 million individuals eligible for both Medicare and Medicaid. This group has historically been referred to as dually eligible. MME beneficiaries typically have complex conditions with costs of care that are far higher than a typical Medicare or Medicaid beneficiary. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and optimize people's health status through close coordination of care.

Total annual expenditures for dually eligibles are estimated at more than $300 billion, or more than 10% of the total health care costs in the United States. As of December 31, 2013, UnitedHealthcare served more than 275,000 people in legacy dually eligible programs through Medicare Advantage and SNPs. In 2013, UnitedHealthcare Community & State implemented a managed fee-for-service demonstration model in the state of Washington. In 2014, UnitedHealthcare Community & State will help implement MME programs in the states of Ohio, Washington and Michigan. These programs are among the first in the country to leverage CMS' demonstrations to serve MMEs.

UnitedHealthcare International

UnitedHealthcare International participates in international markets through national "in country" and cross-border strategic approaches. UnitedHealthcare International's cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals around the world. UnitedHealthcare International's goal is to create business solutions that are based on local infrastructure, culture and needs, and that blend local expertise with experiences from the U.S. health care industry. As of December 31, 2013, UnitedHealthcare International provided medical benefits to 4.8 million people, principally in Brazil, but also residing in more than 125 countries.

Amil. In 2012, UnitedHealthcare International acquired Amil, which provides health and dental benefits to nearly 7 million people and also operates 25 acute hospitals, as well as specialty clinics, primary care, and emergency services across Brazil, principally for the benefit of its members. Amil's patients are also treated in its contracted provider network of 21,000 physicians and other health care professionals, 2,100 hospitals and 7,900 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil's products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare International also includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;

- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers and patients who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: physicians and other care providers, hospitals and clinical facilities seeking to modernize in ways that enable the best patient care and experience possible, delivered cost-effectively.
- Those who pay for care: insurers, employers and government agencies devoted to ensuring that those they sponsor receive high-quality care, administered and delivered efficiently.
- Those who innovate for care: life sciences and research focused organizations dedicated to developing more effective approaches, enabling technologies and medicines that improve the delivery and quality of care.

Using advanced data, analytics and technology, Optum helps improve overall health system performance by optimizing care quality, reducing costs and improving the consumer experience and care provider performance.

Optum is organized in three reportable segments:

- OptumHealth focuses on care management, integrated care delivery, and consumer solutions, including financial services;
- OptumInsight delivers operational services and support and health information technology services; and
- OptumRx specializes in pharmacy services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and financial needs of more than 62 million unique individuals and enabling consumer health management through programs offered by employers, payers, government entities and, increasingly, directly through the care delivery system. OptumHealth's products and services can be deployed individually or integrated to provide more comprehensive solutions, addressing a broad base of needs within the health care system. These solutions are focused on improving quality and patient satisfaction and lowering costs by working to optimize the care delivery system through the creation of high-performing networks, centers of excellence across the care continuum, working directly with physicians to advance population health management and focusing on caring for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a fixed monthly premium per individual served, and on an administrative fee basis whereby it manages or administers delivery of the products or services in exchange for a fixed fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and integrated care delivery businesses.

OptumHealth is organized into two major operating groups: Physician Solutions and Consumer Solutions.

Physician Solutions. Physician Solutions includes the Specialty Networks and Integrated Care Delivery offerings.

Specialty Networks. Within Specialty Networks, OptumHealth serves nearly 57 million people in two primary ways:

- 1) creating access to networks of provider specialists in the areas of behavioral health management (e.g., mental health, substance abuse), global well-being (e.g., international work/life solutions), chronic physical health management (e.g., chiropractic, physical therapy), and complex medical conditions (e.g., transplant, infertility); and 2) managing the care and health needs for consumers through a variety of programs utilizing predictive modeling, evidence-based clinical outcomes management and peer support. Specialty Networks address areas likely to have significant variation in clinical practice, where a disciplined, evidence-based approach can drive improved health outcomes and reduced costs. These range from more commonly accessed services (e.g., behavioral health and chiropractic) to less common procedures (e.g. transplant, infertility, bariatric surgery and kidney disease/end stage renal disease).

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- Integrated Care Delivery. Integrated Care Delivery serves patients through a collaborative network aligned around total population health management and outcomes-based reimbursement. Within its local care delivery systems, OptumHealth works directly with medical groups and Independent Practice Associations to deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. Integrated Care Delivery's complex population management services focus on improving care for patients with very challenging medical conditions by providing the optimal care in the most desirable setting. Integrated Care Delivery's LHI business designs and implements mobile care delivery solutions, providing occupational health, medical and dental readiness services, treatments and immunization programs for the U.S. military and U.S. Department of Health and Human Services (HHS), as well as for many commercial companies.
- Consumer Solutions. Consumer Solutions includes health management solutions, distribution and financial services operations.
  - Health Management Solutions: OptumHealth serves over 37 million people through population health management services including care management, complex conditions (e.g., cancer, neonatal and maternity) health and wellness, and advocacy decision support solutions. This set of services helps consumers navigate the health care system and make decisions about their care and treatment, resulting in better clinical outcomes and lower medical costs.
  - Distribution: This business provides capabilities to help payers, aggregators and employers meet the needs of the consumers they serve. The consumer engagement and sales distribution platform is backed by a spectrum of health and wellness services. The consumer engagement platform is a technology-enabled engagement model that is helping health care companies, including health plans, grow and manage their consumer relationships. OptumHealth provides call center support, multi-modal communications software, data analysis and trained nurses that help clients acquire, retain and service large populations of health care consumers.
  - Financial Services: This business is dedicated solely to providing financial solutions for the health care market, serving the needs of individuals, employers, health care professionals and payers. OptumHealth is a leading provider of consumer health care accounts including health savings, health reimbursement, health incentive, retiree reimbursement and flexible spending accounts, that help people plan and save for current and future health care expenses. Payers, health care professionals and employers rely upon OptumHealth's electronic payment solutions to manage compliance and improve the administrative efficiency of electronic claim payments. OptumHealth also offers health care related lending and credit to health care providers to support the modernization of their practices, and financial risk protection for third-party payers and self-funded employers. As of December 31, 2013, Financial Services and its wholly owned subsidiary, Optum Bank, had $2.3 billion in customer assets under management and during 2013 processed $78 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides technology, operational and consulting services to participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system use OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape.

Many of OptumInsight's software and information products, advisory consulting arrangements, and outsourcing contracts are performed over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience that either have not started but are anticipated to begin in the near future, or are in process and have not been completed. OptumInsight's aggregate backlog at December 31, 2013 was $5.5 billion, of which $2.7 billion is expected to be realized within the next 12 months. This includes $1.1 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2012 was $4.6 billion. The increase in 2013 backlog was attributable to the partnership with Dignity Health that established the Optum360 provider revenue management business. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in backlog due to uncertainty regarding the timing and scope of services, the potential for cancellation, non-renewal, or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliance and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospitals), commercial payers, governments and life sciences.

Care Providers. Serving four out of five U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements, and deliver health intelligence. OptumInsight's offerings in clinical workflow, revenue management, health IT and analytics helps hospitals and physician practices improve patient outcomes, strengthen financial performance and meet quality measurement and compliance requirements, as well as transition to new collaborative and accountable care business models.

Commercial Payers. OptumInsight serves approximately 300 health plans with employer, individual, Medicare, and Medicaid membership. OptumInsight applies its solutions across the payer's operations, helping clients to improve operational and administrative efficiency, meet clinical performance and compliance goals, develop strong provider networks, manage risk and drive growth. OptumInsight is also helping payer clients adapt to new market models, including health insurance exchanges, consumer driven health care and engagement, pay-for-value contracting, and population health management.

Governments. OptumInsight provides services to state, federal and municipal agencies and departments, across 35 states and the District of Columbia. Services include financial management and program integrity services, policy and compliance consulting, data and analytics technology, systems integration and expertise to improve medical quality, access and costs.

Life Sciences. OptumInsight's Life Sciences business provides services to more than 400 global life sciences organizations. OptumInsight's services use real-world evidence to support market access and positioning of their products, to deliver strategic regulatory services, to provide insights into patient reported outcomes and to optimize and manage risk.

OptumRx

OptumRx provides a range of pharmacy benefit management (PBM) services to nearly 28 million people nationwide, managing approximately $33 billion in pharmaceutical spending annually and processing an annual run rate of more than one-half billion adjusted retail, mail and specialty drug prescriptions. OptumRx's PBM services include retail pharmacy network management services, mail order and specialty pharmacy services, manufacturer rebate contracting and administration, benefit plan design and consultation, claims processing, Medicare Part D services, and a variety of clinical programs such as formulary management and compliance, drug utilization review and disease and drug therapy management services. OptumRx has a network of more than 67,000 retail pharmacies and two mail services facilities in California and Kansas.

The mail order and specialty pharmacy fulfillment capabilities of OptumRx are an important strategic component of its business, providing patients with convenient access to maintenance medications, offering a broad range of complex drug therapies and patient management services for individuals with chronic health conditions, and enabling OptumRx to manage its clients' drug costs through operating efficiencies and economies of scale.

OptumRx provides PBM services to UnitedHealthcare members enrolled in benefit plans that offer pharmacy benefits. Throughout the course of 2013, OptumRx transitioned 12 million new or migrating UnitedHealthcare commercial members. Additionally, OptumRx managed specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services including patient support and clinical programs that ensure quality and value for consumers. Specialty drug management is important in managing overall drug spend, as biologicals and other specialty medications are fast growing pharmacy expenditures. OptumRx also provides PBM services to non-affiliated external clients, including public and private sector employer groups, insurance companies, Taft-Hartley Trust Funds, TPAs, managed care organizations (MCOs), Medicare-contracted plans, Medicaid plans and other sponsors of health benefit plans and individuals throughout the United States. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

GOVERNMENT REGULATION

Most of our health and well-being businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing

laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

In the event we fail to comply with, or we fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Item 1A, “Risk Factors” for a discussion of the risks related to compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, 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. CMS regulates our UnitedHealthcare businesses, and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations including the submission of information relating to the health status of enrollees for purposes of determining the amount of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business will also be subject to audits related to risk adjustment and reinsurance data when the programs are implemented starting in 2014.

UnitedHealthcare Community & State has Medicaid and CHIP 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 affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs has become and will continue to become increasingly complex as a result of Health Reform Legislation. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies that are held by our Optum businesses and UnitedHealthcare Military & Veterans business, such as our TRICARE West Region contract with the DoD.

Certain of our businesses, such as UnitedHealthcare's eyeglass manufacturing activities and Optum's high acuity clinical workflow software, hearing aid products and clinical research activities, are subject to regulation by the U.S. Food and Drug Administration (FDA). Optum's clinical research activities are subject to laws and regulations outside of the United States that regulate clinical trials. Our business is also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust.

Health Care Reform. Health Reform Legislation expands access to coverage and modifies aspects of the commercial insurance market, as well as the Medicaid and Medicare programs, CHIP and other aspects of the health care system. Among other requirements, Health Reform Legislation has expanded dependant coverage to age 26, expanded benefit requirements, eliminated certain annual and lifetime maximum limits, eliminated certain pre-existing condition limits, required coverage for preventative services without cost to members, required premium rebates if certain medical loss ratios (MLRs) are not met, granted members new and additional appeal rights, created new premium rate review processes, established a system of state and federal exchanges through which consumers can purchase health coverage, imposed new requirements on the format and content of communications (such as explanations of benefits) between health insurers and their members, reduced the Medicare Part D coverage gap and reduced payments to private plans offering Medicare Advantage.

Health Reform Legislation and the related federal and state regulations are affecting how we do business and could impact our results of operations, financial position and cash flows. The full impact of Health Reform Legislation remains difficult to predict and is not yet fully known. See also Item 1A, "Risk Factors" and Item 7, "Management Discussion and Analysis of Financial Condition and Results of Operations" for a discussion of the risks related to Health Reform Legislation and related matters.

Privacy, Security, and Data Standards 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. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, will be replaced by ICD-10 code sets on October 1, 2014, and health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures for dates of services on or after such date.

The Health Information Technology for Economic and Clinical Health Act (HITECH) significantly expanded the privacy and security provisions of HIPAA. HITECH imposes additional requirements on uses and disclosures of health information; includes new contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds new federal data breach notification requirements for covered entities and business associates and new reporting requirements to HHS and the Federal Trade

Commission and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, we may act, depending on the circumstances, as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally 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. These federal laws and state statutes 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 generally require safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the DOL 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 DOL subject us to additional requirements for claims payment and member appeals under health care plans governed by ERISA.

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. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where implemented by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures expanding the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. The NAIC also established the Risk Management and Own Risk and Solvency Assessment Model Act that by 2015 will require us to conduct additional group solvency assessments, maintain a risk management framework and file additional reports with state insurance regulators. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with Health Reform Legislation, which may affect our operations and our financial results.

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

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, MCO, utilization review (UR), or TPA-related regulations and licensure requirements. These regulations differ from state to state, and 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, appeals, grievances and 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. Certain of our businesses are subject to state general agent, broker, and sales distributions laws and regulations. Our UnitedHealthcare Community & State and certain Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and 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.

Guaranty Fund Assessments. Under state guaranty fund laws, certain insurance companies (and HMOs in some states) doing business in those states, including those issuing health, long-term care, life and accident insurance policies, can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance

companies that write the same line or lines of business. Assessments generally are based on a formula relating to premiums in the state compared to the premiums of other insurers and could be spread out over a period of years. Some states permit member insurers to recover assessments paid through full or partial premium tax offsets.

Pharmacy Regulation. OptumRx's mail order pharmacies must be licensed as pharmacies in the states 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 to dispense controlled substances. In addition to the laws and regulations in the states where our mail order pharmacies are located, laws and regulations in non-resident states where we deliver pharmaceuticals may also

apply, including the requirement to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our mail order pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Our mail order pharmacies maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires 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 governing 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.

State Privacy and Security Regulations. A number of states have adopted 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 and sensitive health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus 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 personally identifiable information, including information related to consumers and care providers. Additionally, different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and 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 and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct service providers to care delivery systems and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit certain entities from practicing medicine or employing physicians to practice medicine. Additionally, some states prohibit certain entities from sharing in the fees or revenues of a professional practice (fee-splitting). These prohibitions may be statutory or regulatory, or may be a matter of judicial or regulatory interpretation. These laws, regulations and interpretations have, in certain states, been subject to limited judicial and regulatory interpretation and are subject to change.

Consumer Protection Laws. Certain of our businesses participate in direct-to-consumer activities and are subject to emerging regulations applicable to on-line communications and other general consumer protection laws and regulations.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank’s compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could be subjected to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses and operations are international in nature and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, tax, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary from jurisdiction to jurisdiction. We currently operate outside of the United States and may in the future acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our Amil business subjects us to Brazilian laws and regulations affecting the managed care and insurance industries and regulation by Brazilian regulators including the national regulatory agency for private health insurance and plans, the Agência Nacional de

Saúde Suplementar (ANS), whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

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, HMOs, TPAs and business services outsourcing companies, health care professionals that have formed networks to contract directly with employers or with CMS, specialty benefit providers, government entities, disease management companies, and various health information and consulting companies. For our UnitedHealthcare businesses, our competitors include Aetna Inc., Cigna Corporation, 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, with respect to our Brazilian operations, several established competitors in Brazil, and other enterprises that serve more limited geographic areas. For our OptumRx businesses, our competitors include CVS Caremark Corporation, Express Scripts, Inc. and Catamaran Corporation. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We compete on the basis of the sales, marketing and pricing of our products and services; product innovation; consumer engagement and satisfaction; the level and quality of products and services; care delivery; network and clinical management 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, financial position and cash flows could be materially and adversely affected. See Item 1A, “Risk Factors,” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2013, we employed approximately 156,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2014, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	61	President and Chief Executive Officer
David S. Wichmann	51	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations
Gail K. Boudreaux	53	Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare
Eric S. Rangen	57	Senior Vice President and Chief Accounting Officer
Larry C. Renfro	60	Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum
Marianne D. Short	62	Executive Vice President and Chief Legal Officer

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. Wichmann is Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations and has served in that capacity since January 2011. Mr. Wichmann has served as Executive Vice President and President of UnitedHealth Group Operations since April 2008.

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Ms. Boudreaux is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since January 2011. Ms. Boudreaux served as Executive Vice President of UnitedHealth Group and President of UnitedHealthcare from May 2008 to January 2011.

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

Mr. Renfro is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2011. From January 2011 to July 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group. From October 2009 to January 2011, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of the Public and Senior Markets Group. From January 2009 to October 2009, Mr. Renfro served as Executive Vice President of UnitedHealth Group and Chief Executive Officer of Ovations (now UnitedHealthcare Medicare & Retirement).

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

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 our Principles of Governance, Board of Directors Committee Charters, and Code of Conduct. 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. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

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.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections 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,” “forecast,” “plan,” “project,” “s similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our 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 Annual Report on 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 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.

If we fail to effectively estimate, price for and manage our medical costs, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits 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 products depends in large part on our ability to predict, price for, and effectively manage medical costs. In this regard, Health Reform Legislation established minimum MLRs for certain health plans and authorized HHS to maintain an annual price increase review process for commercial health plans, which could make it more difficult for us to price our products competitively. In addition, our OptumHealth Integrated Care Delivery business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to accurately predict, price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies is typically at a fixed rate per individual served 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. Although we base the premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, the introduction of new or costly treatments and technology, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. 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 our 2013 medical costs for commercial insured products were 1% higher, without proportionally higher revenues from such products, our annual net earnings for 2013 would have been reduced by approximately $200 million, excluding any offsetting impact from premium rebates.

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, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our results of operations, financial position and cash flows.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Some of our UnitedHealthcare and Optum businesses hold or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims, and other laws and regulations governing government contractors and the use of government funds. In addition, under state guaranty fund laws, certain health, life and accident insurance companies and, in certain cases, HMOs can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business in these states, which would expose our business to the risk of insolvency of a competitor in these states.

Certain of our businesses provide products or services to various government agencies. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations, which are distinct from those faced by our insurance and HMO subsidiaries, including, for example, FDA regulations, state telemedicine regulations, debt collection laws, and state corporate practice of medicine doctrines and fee-splitting rules, some of which could impact our relationships with physicians, hospitals and customers. Additionally, we participate in the emerging private exchange markets and it is not yet known to what extent the

states will issue new regulations that apply to private exchanges. These risks and uncertainties may materially and adversely affect our ability to market our products and services, or to do so at targeted margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change, and the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our business could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We must also obtain and maintain regulatory approvals to market many of our products, increase prices for certain regulated products, and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and/or managed care products are subject to regulatory review or approval in many states and by the federal government, and a number of states have enhanced (or are proposing to enhance) their rate review processes. Additionally, the final market reform rules released in February 2013 require that we submit data on all proposed rate increases to HHS for monitoring purposes on many of our products. Moreover, geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Some of our businesses and operations are international in nature and consequently face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. The regulatory environments and associated requirements and uncertainties regarding tax, licensing, tariffs, intellectual property, privacy, data protection, investment, capital (including minimum solvency margin and reserve requirements), management control, labor relations, fraud and corruption present compliance requirements and uncertainties for us that are different from those faced by U.S.-based businesses. We have acquired and may in the future acquire or commence additional businesses based outside of the United States. For example, our acquisition of Amil subjects us to Brazilian laws and regulations affecting the managed care and insurance industries, which vary from comparable U.S. laws and regulations, and to regulation by Brazilian regulators, whose approach to the interpretation, implementation and enforcement of industry regulations could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are also subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is also regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation, such as the implementation of Health Reform Legislation and associated exchanges. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

Health Reform Legislation could materially and adversely affect the manner in which we conduct business and our results of operations, financial position and cash flows.

Due to its complexity and ongoing implementation, Health Reform Legislation’s impact remains difficult to predict, is not yet fully known and could adversely affect us. For example, if we do not maintain certain minimum MLRs, we are required to rebate ratable portions of our premiums to our customers annually. Beginning in 2014, commercial MLRs will need to factor in the effect of new premium stabilization provisions (risk adjustment, risk corridor and transitional reinsurance) for individual and small group markets. These factors, along with uncertainties in how MLR rules may be amended to address other changes required by Health Reform Legislation, decrease the predictability of medical loss rebates. Some state Medicaid programs are also imposing MLR requirements on Medicaid MCOs, which generally require such plans to rebate ratable portions of their premiums to their state customers if they cannot demonstrate they have met the minimum MLRs. Depending on our calculations of the MLR for each of our plans and the manner in which we adjust our business model in light of these requirements, there could be meaningful disruptions in our

market share, results of operations, financial position and cash flows could be materially and adversely affected. Several states have indicated they may not expand their Medicaid programs based on concerns over the costs of such programs when expanded federal funding is reduced starting in 2017. The extent to which states expand their Medicaid programs, or discontinue current expansion programs, could adversely impact our Medicaid enrollment levels, which could in turn materially and adversely affect our results of operations, financial position and cash flows. Health Reform Legislation also includes a “maintenance of effort” (MOE) provision that requires states to maintain their eligibility rules for adults covered by Medicaid, until the Secretary of HHS determines that an insurance exchange is operational in a given state, and for children covered by Medicaid or CHIP, through the end of the 2019 federal fiscal year.

States with, or projecting, a budget deficit may apply for an exception to the MOE provision. If states are successful in obtaining MOE waivers and allow certain Medicaid programs to expire, we could experience reduced Medicaid enrollment, which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, Health Reform Legislation requires the establishment of state based health insurance exchanges for individuals and small employers by 2014. The types of exchange participation requirements ultimately enacted by each state, the availability of federal subsidies for premiums and cost-sharing reductions within exchanges, the potential for differential imposition of state benefit mandates inside and outside the exchanges, the operation of reinsurance, risk corridors and risk adjustment mechanisms inside and outside the exchanges and the possibility that certain states may restrict the ability of health plans to continue to offer coverage to individuals and small employers outside of the exchanges could result in disruptions in local health care markets and adversely affect our results of operations, financial position and cash flows.

Health Reform Legislation also includes for 2014 specific reforms for the individual and small group marketplace, including guaranteed availability of coverage, adjusted community rating requirements (which include elimination of health status and gender rating factors), essential health benefit requirements (resulting in benefit changes for many members) and actuarial value requirements resulting in expanded benefits or reduced member cost sharing (or a combination of both) for many policyholders. These changes may lead to significant disruptions in local health care markets, which could materially and adversely affect our results of operations, financial position and cash flows.

Further, while risk adjustment will apply to most individual and small group plans in the commercial markets beginning in 2014, the availability of transitional relief makes the full extent of its impact difficult to predict and could further disrupt underlying exchange risk pools, impact pricing and market strategies, and result in adverse consequences to the marketplace. While we have made certain assumptions in our premium rate development relating to projected risk adjustment transfers, actual risk adjustment calculations and transfers could materially differ from our assumptions.

Premium increases or benefit reductions will be necessary to offset Health Reform Legislation’s impact on our medical and operating costs. These premium increases are often subject to state regulatory approval, and the federal government is encouraging states to intensify their reviews of requests for rate increases by commercial health plans and providing funding to assist in those state-level reviews. If we are not able to secure approval for adequate premium increases to offset increases in our cost structure or if consumers forego coverage as a result of such premium increases, our margins, results of operations, financial position and cash flows could be materially and adversely affected. In addition, plans deemed to have a history of “unreasonable” rate increases may be prohibited from participating in the state-based exchanges that become active under Health Reform Legislation in 2014.

Our results of operations, financial position and cash flows could be materially and adversely affected if fewer individuals gain coverage under Health Reform Legislation than we expect, if we are unable to attract these new individuals to our UnitedHealthcare offerings, or if the demand for Health Reform Legislation related products and capabilities offered by our Optum businesses is less than anticipated.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

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, CHIP and our TRICARE West Region contract with the DoD, and receive substantial revenues from these programs. We also provide services to payers through our Optum businesses. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or, as is a typical feature of many government contracts, termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal

government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are expected in the next few years. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. For 2014, CMS has asked plans to submit additional information indicating whether or not medical conditions were diagnosed in a clinical setting. CMS has indicated that it will publish further guidance on the treatment of risk adjustment data in early 2015, including with respect to diagnoses made during “risk assessments,” that may change the way in which Medicare Advantage payments are determined. Although

we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

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 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 regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. 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, either as a result of unforeseen changes to the Medicare program or other programs on which we bid, or our competitors submit bids at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of Health Reform Legislation, CMS has a system that provides various quality bonus payments to plans that meet certain quality star ratings at the local plan level. In addition, under Health Reform Legislation, Congress authorized CMS and the states to implement MME managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Health plan participation in these demonstration programs is subject to CMS approval of specified care delivery models and the satisfaction of conditions to participation, including meeting certain performance requirements. Any changes in standards or care delivery models that apply to government health care programs, including Medicare, Medicaid and the MME demonstration programs for dually eligible beneficiaries, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjusting monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers, and certain of our local plans have been selected for audit. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the "error rate" identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service "error rate" adjuster that will be used in determining the payment adjustment. Depending on the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been and may in the future become involved in routine, regular, and special governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. Such investigations, audits or reviews sometimes arise out of or prompt claims by private

litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could 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, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. While we have prepared for the transition to ICD-10 as a HIPAA-regulated entity, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2014, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and as a result, they collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

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

We provide PBM services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. OptumRx also conducts business as a mail order pharmacy and specialty pharmacy, which subjects it to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions at any of our mail order or specialty pharmacies due to an accident or an event that is beyond our control could affect our ability to process and dispense

prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our PBM businesses provide services to sponsors of health benefit plans that are subject to ERISA. The DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our PBM businesses even where our PBM businesses are not contractually obligated to assume fiduciary obligations. In the event a court were to determine that fiduciary obligations apply to our PBM businesses in connection with services for which our PBM businesses are not contractually obligated to assume fiduciary obligations, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited 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, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; or other factors that give such competitors a competitive advantage. In addition, our competitive position may be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability. Our business, results of operations, financial position and cash flows could be materially and adversely affected 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 are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

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

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for services. Our results of operations and prospects are substantially dependent on our continued ability to contract for these services at competitive prices. Any failure to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, distract managements' attention and result in negative publicity.

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 medical 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, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, 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 materially and adversely affected.

We have capitation arrangements with some physicians, hospitals and other health care providers. 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 health care provider. 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 could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a

material adverse effect on the provision of services to our members and our operations.

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 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, the amount is either not defined or is established by a standard that does not clearly specify 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.

The success of certain businesses, including OptumHealth Integrated Care Delivery and Amil, depend on maintaining satisfactory physician relationships. The primary care physicians that practice medicine or contract with our affiliated physician

organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with primary care physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with health insurance and HMO competitors of UnitedHealthcare. Our business could suffer if our affiliated physician organizations fail to maintain relationships with these health insurance or HMO companies, or to adequately price their contracts with these third party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and certain health care providers are customers of our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

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

Because of the nature of our business, we are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include 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), tort (including claims related to the delivery of health care services, such as medical malpractice by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we periodically acquire businesses or commence operations in jurisdictions outside of the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. 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. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in select markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, 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 placed 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. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations, including our internal control environment, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we are unable to successfully integrate and grow these acquisitions and to realize contemplated revenue synergies and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we continue to expand our business outside the United States, acquired non-U.S. businesses, such as Amil, will present challenges that are different from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, business, labor and cultural practices and regulatory environments that are different from those with which we are familiar in our U.S. operations. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated benefits or synergies from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation, and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through independent producers and consultants who assist in the sales and servicing of our business. We typically do not have long-term contracts with our producers and consultants, who generally do not provide services to us exclusively, but instead typically also 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 materially and adversely affected if we were unable to attract or retain independent producers and consultants or if we do not adequately provide support, training and education to them regarding our product portfolio, or if our sales strategy is not appropriately aligned across distribution channels.

Producer commissions will be under the same cost reduction pressures as other administrative costs. For example, such commissions are included as administrative expenses under MLR requirements of Health Reform Legislation and, therefore, are not included in the minimum MLR calculation. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commissions.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive. These have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment rates have caused and could continue to cause lower enrollment or lower rates of renewal in our employer group plans and our non-employer individual plans. Unfavorable economic conditions have also caused and could continue to 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, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. All of these could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated and/or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or

assessments for our commercial programs, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, HMOs, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could materially and adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which comprise the vast majority of the fair value of our investments as of December 31, 2013. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income, and the continuation of the current low interest rate environment could further adversely affect our investment income. In addition, a delay in payment of principal and/or interest by issuers, or defaults by issuers (primarily from investments in corporate and municipal bonds), could reduce our net investment income and require us to write down the value of our investments, which could materially and adversely affect our profitability and shareholders' equity.

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 their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our shareholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have a material adverse effect on our results of operations and the capital position of regulated subsidiaries.

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

Goodwill and other intangible assets were $35.4 billion as of December 31, 2013, representing 43% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. For example, the manner in or the extent to which Health Reform Legislation is implemented may impact our ability to maintain the value of our goodwill and other intangible assets in our business. Similarly, the value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely 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, adversely impact our credit ratings and potentially impact our compliance with the covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. As a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions, we periodically consolidate, integrate, upgrade and expand 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 is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur 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, 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 protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which

could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install hardware and software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

We could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences if we sustain cyber-attacks or other privacy or data security incidents, that result in security breaches that disrupt our operations or result in the unintended dissemination of sensitive personal information or proprietary or confidential information.

We routinely process, store and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We may be subject to breaches of the information technology systems we use for these purposes. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human errors; or other similar events that could negatively affect our systems and our and our customer's data.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and 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 results of operations, financial position and cash flows could be materially and 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 results of operations, financial position and cash flow could be materially and 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. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities outside the United States such as the ANS in Brazil. We are also required by law or regulation 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 by the applicable subsidiary. A significant increase in premium volume will require additional capitalization from us. In most states, we are required to seek prior approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment cycle, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations,

financial position, and cash flow could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and credit ratings by Nationally Recognized Statistical Rating Organizations are 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 credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's

opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Downgrades in our credit ratings, should they occur, could materially increase our costs of or ability to access funds in the debt and capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions “Litigation Matters” and “Governmental Investigations, Audits and Reviews” in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements.”

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

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

MARKET PRICES AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2014, there were 14,575 registered holders of record of our common stock. The per share high and low common stock sales prices reported by the NYSE and cash dividends declared were as follows:

	High	Low	Cash Dividends Declared
2013			
First quarter	$58.26	$51.36	$0.2125
Second quarter	$66.19	$57.01	$0.2800
Third quarter	$75.88	$64.65	$0.2800
Fourth quarter	$75.54	$66.72	$0.2800
2012			
First quarter	$59.43	$49.82	$0.1625
Second quarter	$60.75	$53.78	$0.2125
Third quarter	$59.31	$50.32	$0.2125
Fourth quarter	$58.29	$51.09	$0.2125

DIVIDEND POLICY

In June 2013, our Board of Directors increased the Company’s cash dividend to shareholders to an annual dividend rate of $1.12 per share, paid quarterly. Since June 2012, we had paid an annual cash dividend of $0.85 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES
Issuer Purchases of Equity Securities (a)
Fourth Quarter 2013

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
	(in millions)		(in millions)	(in millions)
October 31, 2013	1	$68	1	94
November 30, 2013	—	—	—	94
December 31, 2013	11	71	11	83
Total	12	$71	12	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2013, the Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock in open market purchases or other types of transactions (including structured repurchase programs). There is no established expiration date for the program.

PERFORMANCE GRAPHS
The following two performance graphs compare our total return to shareholders with the returns of indexes of other specified companies and the S&P 500 Index. The first graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index and a customized peer group of certain Fortune 50 companies (the “Fortune 50 Group”) for the five-year period ended December 31, 2013. 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, 2013. We are 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, 2008 in our common stock and in each index, and that dividends were reinvested when paid.

Fortune 50 Group

The Fortune 50 Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. Although there are differences among the companies 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.

	12/08	12/09	12/10	12/11	12/12	12/13
UnitedHealth Group	$100.00	$114.75	$137.58	$195.62	$212.42	$299.58
S&P 500 Index	100.00	126.46	145.51	148.59	172.37	228.19
Fortune 50 Group	100.00	111.82	132.11	132.08	156.49	200.00

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

Peer Group

The companies included in our peer group are Aetna Inc., Cigna Corporation, Humana Inc. and WellPoint, Inc. We believe that this peer group reflects publicly traded peers to our UnitedHealthcare businesses.

	12/08	12/09	12/10	12/11	12/12	12/13
UnitedHealth Group	$100.00	$114.75	$137.58	$195.62	$212.42	$299.58
S&P 500 Index	100.00	126.46	145.51	148.59	172.37	228.19
Peer Group	100.00	134.91	137.44	178.55	180.35	280.25

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

ITEM 6. SELECTED FINANCIAL DATA

FINANCIAL HIGHLIGHTS

(in millions, except percentages and per share data)	For the Year Ended December 31, 2013	2012 [a]	2011	2010	2009
Consolidated operating results					
Revenues	$122,489	$110,618	$101,862	$94,155	$87,138
Earnings from operations	9,623	9,254	8,464	7,864	6,359
Net earnings attributable to UnitedHealth Group common shareholders	5,625	5,526	5,142	4,634	3,822
Return on equity (b)	17.7 %	18.7 %	18.9 %	18.7 %	17.3 %
Basic earnings per share attributable to UnitedHealth Group common shareholders	$5.59	$5.38	$4.81	$4.14	$3.27
Diluted earnings per share attributable to UnitedHealth Group common shareholders	5.50	5.28	4.73	4.10	3.24
Cash dividends declared per common share	1.0525	0.8000	0.6125	0.4050	0.0300
Consolidated cash flows from (used for)					
Operating activities	$6,991	$7,155	$6,968	$6,273	$5,625
Investing activities	(3,089)	(8,649)	(4,172)	(5,339)	(976)
Financing activities	(4,946)	471	(2,490)	(1,611)	(2,275)
Consolidated financial condition (as of December 31)					
Cash and investments	$28,818	$29,148	$28,172	$25,902	$24,350
Total assets	81,882	80,885	67,889	63,063	59,045
Total commercial paper and long-term debt	16,860	16,754	11,638	11,142	11,173
Redeemable noncontrolling interests	1,175	2,121	—	—	—
Shareholders' equity	32,149	31,178	28,292	25,825	23,606
Debt to debt-plus-equity ratio	34.4 %	35.0 %	29.1 %	30.1 %	32.1 %

(a) Includes the effects of the October 2012 Amil acquisition and related debt and equity issuances.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters of the year presented.

Financial Highlights should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

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 are 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 PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare International;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Item 1, "Business" and in Note 13 to the Consolidated Financial Statements in Item 8, "Financial Statements."

2014 Business Realignment. On January 1, 2014, we realigned certain of our businesses to respond to changes in the markets we serve and the opportunities that are emerging as the health system evolves. Our Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, will be included in OptumInsight's results of operations. Our periodic filings with the SEC beginning with our first quarter 2014 Form 10-Q will include historical segment results restated to reflect the effect of this realignment and will continue to present the same four reportable segments (UnitedHealthcare, OptumHealth, OptumInsight and OptumRx).

Business Trends

Our businesses participate in the U.S., Brazilian and certain other international health economies. In the United States, health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, including enacted health care reforms in the United States, which could also impact our results of operations.

Pricing Trends. We seek to price our health care benefit products consistent with anticipated underlying medical trends, while balancing growth, margins, and competitive dynamics (such as product positioning and price competitiveness) and legislative and regulatory changes such as cost increases for the industry fees and tax provisions of Health Reform Legislation. We continue to expect premium rates to be under pressure from ongoing market competition in commercial products and from government payment rates. Aggregating UnitedHealthcare's businesses, and before giving effect to Health Reform Legislation taxes, we believe the medical care ratio will rise over time as we continue to grow in the senior and public markets and participate in the emerging public health benefit exchange market.

In response to Health Reform Legislation, HHS established a review threshold of annual commercial premium rate increases generally at or above 10% and enacted a new rule requiring the production of information for any proposed rate increase. HHS review does not supersede existing state review and approval procedures. We have experienced regulatory challenges to appropriate premium rate increases in several states, including California and New York. The competitive forces common in our markets do not support unjustifiable rate increases. Further, our rates and rate filings are developed using methods

consistent with the standards of actuarial practices and we endeavor to sustain a commercial medical care ratio in a stable range for an equivalent mix of business. We have requested and received rate increases above 10% in a number of markets due to the combination of medical cost trends and the incremental costs of health care reform. We expect commercial pricing to continue to be highly competitive. The intensity of pricing competition depends on local market conditions and competitive dynamics. Overall, the industry has experienced lower medical costs trends due to moderated utilization, which has impacted pricing trends. Conversely, carriers are generally reflecting the 2014 Health Reform Legislation industry fees in their pricing. In some markets, competitors have adjusted their pricing to reflect recent medical cost trend experience as well as the implication of rate review rules and new benefit changes from Health Reform Legislation. In other areas we are seeing greater price competition due to pricing adjustments and other varied approaches used by competitors.

The Medicare Advantage rate structure is changing and funding has been cut in recent years, with additional reductions to take effect in 2014 and 2015, as discussed below in "Regulatory Trends and Uncertainties." We expect these factors to result in year-over-year pressure on gross margin percentages for our Medicare business during 2014.

States are struggling to balance budget pressures with increases in their Medicaid expenditures. During 2013, rate changes for some Medicaid programs were slightly negative year-over-year. In general, we expect continued pressure on net margin percentages due to the Medicaid reimbursement rate environment, which we expect will remain tight due to the potential non-collectability of the insurer fee primarily related to Medicare Dual SNP programs and Medicaid. We continue to work with our state customers to advocate for actuarially sound rates that are commensurate with our medical cost trends, including fees and related taxes, and to take a prudent, market-sustainable posture for both new bids and maintenance of existing Medicaid contracts.

Medical Cost Trends. We expect our 2014 commercial medical cost trend to be in the range of 6.0% plus or minus 50 basis points, compared to approximately 5% in 2013. In 2014, we expect relatively consistent unit cost and utilization trends compared to 2013, before taking into account reform impacts. The impact of Health Reform Legislation and mandates is expected to pressure 2014 medical cost trends. Driving the increases are mandated essential health benefits and limits on out-of-pocket maximums. Consistent with recent years, our 2014 trend is expected to be driven primarily by continued unit cost pressure from health care providers. We expect 2014 pharmacy trends to be consistent with 2013. The primary drivers of prescription drug trends continue to be unit cost pressure on brand name drugs and a shift towards expensive new specialty drugs. In recent years, the recent weak economic environment combined with our medical cost management strategies has had a favorable impact on utilization trends. We believe the expected stability in the utilization trends in 2014 is influenced by our medical management strategies, our continued focus on value-based contracting arrangements and greater consumer engagement.

Delivery System and Payment Modernization. The health care market is changing based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care for people, improve the health of populations and reduce costs. The focus on delivery system modernization and payment reform is critical and the alignment of incentives between key constituents remains an important theme.

Through expansion of our existing programs and the creation of new programs, we are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2013, more than 2 million people we serve were directly aligned through the most progressive of these arrangements, including full risk, shared risk and bundled episode of care payment approaches.

This trend is also creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investment in new clinical and administrative information and management systems, providing growth opportunities for our Optum business platform.

Government Reliance on Private Sector. The government, as a benefit sponsor, has been increasingly relying on private sector programs. We expect this trend to continue as we believe the private sector provides a more flexible, better managed, higher quality health care experience than do traditional passive indemnity programs typically used in governmental benefit programs.

Many states are expanding their interest in managed care with particular emphasis on consumers who have complex and expensive health care needs. Medicaid managed care is increasingly viewed as an effective method to improve

quality and manage costs. For example, there are nearly 10 million dually eligible beneficiaries who typically have complex conditions, with costs of care that are far higher than those of a typical Medicare or Medicaid beneficiary. Similarly, a small but complex group of nearly 4 million individuals who qualify for additional benefits under LTC programs represent only 6% of the total Medicaid population yet account for more than 30% of total Medicaid expenditures. The long-term care market represents a portion of the more than 15 million ABD Americans. While these individuals' health needs are more complex and more costly,

they have primarily been historically served in unmanaged environments. These markets provide UnitedHealthcare and Optum with an opportunity to work with governments to improve the health status of these populations through coordination of care. As of December 31, 2013, UnitedHealthcare served more than 275,000 people in legacy dually eligible programs through Medicare Advantage and SNPs. In the first half of 2014, UnitedHealthcare Community & State will help implement Integrated MME program awards in three states.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of Health Reform Legislation and other regulatory items; for additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Item 1, "Business - Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage payment benchmarks have been cut over the last several years, including 2013, with additional funding reductions to be phased-in through 2017. Additionally, Congress passed the Budget Control Act of 2011, which as amended by the American Taxpayer Relief Act of 2012, triggered automatic across-the-board budget cuts (known as sequestration), including a 2% reduction in Medicare Advantage and Medicare Part D payments beginning April 1, 2013. The CMS final notice of 2014 Medicare Advantage benchmark rates and payment policies includes significant reductions to 2014 Medicare Advantage payments, including the benchmark reductions described previously. These reductions and Health Reform Legislation insurance industry tax described below result in revenue reductions and incremental assessments totaling more than 4% in 2014, against a typical industry forward medical cost trend outlook of 3%. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. Compared to 2013, and prior to any efforts to mitigate these funding reductions, we estimate that the net impact on our 2014 consolidated after-tax earnings will be approximately $0.9 billion. These factors affected our plan benefit designs, market participation, growth prospects and earnings potential for our Medicare Advantage plans in 2014. Further, beginning in 2014, Medicare Advantage and Medicare Part D plans will be required to have minimum MLRs of 85%. We do not believe the minimum MLR standard will have a material impact on our earnings. CMS is expected to release the proposed 2015 Medicare Advantage Rates on February 21, 2014. We expect sustained Medicare Advantage rate pressures in 2015 due to the continuing effect of the factors described above.

Health Reform Legislation directed HHS to establish a program to reward high-quality Medicare Advantage plans beginning in 2012. Accordingly, our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on a plan's star rating. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan's revenue. The current expanded stars bonus program that pays bonuses to qualifying plans rated 3 stars or higher is set to expire after 2014. In 2015, quality bonus payments will only be paid to 4 and 5 star plans. For the 2014 payment year, approximately 57% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and approximately 9% are enrolled in plans that will be rated 4 stars or higher. For the 2015 payment year, based on scoring released by CMS in October 2013, approximately 70% of our current Medicare Advantage members are enrolled in plans that will be rated 3.5 stars or higher and approximately 24% are enrolled in plans that will be rated 4 stars or higher.

The ongoing reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we can make and are making to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase member premiums over and above the monthly payments we receive from the government, and decide on a county-by-county basis where we will offer Medicare Advantage plans. The depth of the underfunding of these benefits has caused us to exit certain plans and market areas for 2014 in which we served approximately 150,000 Medicare Advantage beneficiaries in 2013. In other markets, we may experience some reduction in membership in the plans with the greatest benefit cuts, but expect stable or growing membership in our strongest markets. We are dedicating substantial resources to improving our quality scores and star ratings to improve the performance and

sustainability of our local market programs for 2016 and beyond.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries increasing the demand for other senior health benefits products such as our Medicare Supplement and Medicare Part D insurance offerings.

Industry Fees and Taxes. Health Reform Legislation includes an annual, non-deductible insurance industry tax to be levied proportionally across the insurance industry for risk-based products, beginning January 1, 2014. The industry-wide amount of

the annual tax is $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will equal the annual tax for the preceding year increased by the rate of premium growth for the preceding year. The annual tax will be allocated to each market participant based on the ratio of the entity's net premiums written during the preceding calendar year to the total health insurance industry's net premiums written for any U.S. health risk-based products during the preceding calendar year, subject to certain exceptions. This tax will first be expensed ratably throughout 2014 and our first payment will be made in September 2014.

With the introduction of state health insurance exchanges and other significant market reforms in the individual and small group markets in 2014, Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs encompass: a transitional reinsurance program; a temporary risk corridors program; and a permanent risk adjustment program. The transitional reinsurance program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements, $25 billion over a three-year period beginning in 2014 of which $20 billion, subject to increases based on state decisions, will fund the reinsurance pool and $5 billion will fund the U.S. Treasury (Reinsurance Program). While funding for the Reinsurance Program will come from all commercial lines of business, only non-grandfathered, market reform compliant individual business will be eligible for reinsurance recoveries.

We expect our share of the industry fee to be approximately $1.3 billion to $1.4 billion in 2014. We estimate a significant increase of approximately 500 basis points in our 2014 effective income tax rate because this fee is not deductible. We estimate that the 2014 effect on earnings from operations due to our tax deductible contributions to the Reinsurance Program will be approximately $0.5 billion in 2014, payable in 2015. We do not expect material payments or receipts related to the temporary risk corridors program, permanent risk adjustment program or reinsurance recoveries in 2014. Our 2014 results of operations will include estimates related to these fees and programs. To the extent possible, we include the reform fees and related tax impacts in our pricing, which is expected to result in $1.4 billion to $1.6 billion of additional premium in 2014. Since the industry fee will be included in operating costs, we expect our medical care ratio to decrease in 2014 compared to historical results; the industry fee cost will be factored in, however, when calculating minimum MLR rebates.

Exchanges and Coverage Expansion. Across markets, we and our competitors are adapting product, network and marketing strategies to anticipate new distribution or expanding distribution channels including public exchanges, private exchanges and off exchange purchasing. Effective in 2014, states may create their own public exchange, enter a partnership exchange or rely on the federally facilitated exchange for individuals and small employers, with enrollment processes that commenced in October 2013. Exchanges create new market dynamics that could impact our existing businesses, depending on the ultimate member migration patterns for each market, the pace of migration in the market and the impact of the migration on our established membership. For example, over time certain employers may no longer offer health benefits to their employees and some employers purchasing full risk products could convert to self-funded programs. Our level of participation in public exchanges has been and will continue to be determined on a state-by-state basis. Each state is evaluated based on factors such as growth opportunities, our current local presence, our competitive positioning, our ability to honor our commitments to our local customers and members and the regulatory environment. In 2014, we are participating in 13 exchanges in 10 states and the District of Columbia, including four individual and nine SHOP exchanges.

Health Reform Legislation and related U.S. Supreme Court ruling also provide for optional expanded Medicaid coverage effective in January 2014. These measures remain subject to implementation at the state level, with varying levels of state adoption planned for January 1, 2014. We participate in programs in 24 states and the District of Columbia, and of these, more than half have opted to expand Medicaid.

Individual & Small Group Market Reforms. Health Reform Legislation includes several provisions, for most individual and small group plans with plan years beginning on January 1, 2014, that are expected to alter the individual and small group marketplace, including, among other matters: (1) adjusted community rating requirements, which will change how individual and small group plans are priced in many states; (2) essential health benefit requirements, which will result in benefit changes for many individual and small group policyholders; (3) actuarial value requirements, which will significantly impact benefit designs in the individual market, such as member cost sharing requirements; and (4) guaranteed issue requirements, which will require carriers to provide coverage to any qualified group or individual. These changes have resulted in significant benefit design and pricing changes for a

substantial portion of the fully insured individual and small group markets. In 2014, we expect a decrease in individual membership due to a reduction in the number of states in which we will offer policies to new customers.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2013	2012	2011	Increase/(Decrease) 2013 vs. 2012		Increase/(Decrease) 2012 vs. 2011	
Revenues:							
Premiums	$109,557	$99,728	$91,983	$9,829	10 %	$7,745	8 %
Services	8,997	7,437	6,613	1,560	21	824	12
Products	3,190	2,773	2,612	417	15	161	6
Investment and other income	745	680	654	65	10	26	4
Total revenues	122,489	110,618	101,862	11,871	11	8,756	9
Operating costs:							
Medical costs	89,290	80,226	74,332	9,064	11	5,894	8
Operating costs	19,362	17,306	15,557	2,056	12	1,749	11
Cost of products sold	2,839	2,523	2,385	316	13	138	6
Depreciation and amortization	1,375	1,309	1,124	66	5	185	16
Total operating costs	112,866	101,364	93,398	11,502	11	7,966	9
Earnings from operations	9,623	9,254	8,464	369	4	790	9
Interest expense	(708)	(632)	(505)	76	12	127	25
Earnings before income taxes	8,915	8,622	7,959	293	3	663	8
Provision for income taxes	(3,242)	(3,096)	(2,817)	146	5	279	10
Net earnings	5,673	5,526	5,142	147	3	384	7
Earnings attributable to noncontrolling interests	(48)	—	—	48	—	—	nm
Net earnings attributable to UnitedHealth Group common shareholders	$5,625	$5,526	$5,142	$99	2 %	$384	7 %
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$5.50	$5.28	$4.73	$0.22	4 %	$0.55	12 %
Medical care ratio (a)	81.5 %	80.4 %	80.8 %	1.1 %		(0.4)%	
Operating cost ratio	15.8	15.6	15.3	0.2		0.3	
Operating margin	7.9	8.4	8.3	(0.5)		0.1	
Tax rate	36.4	35.9	35.4	0.5		0.5	
Net margin	4.6	5.0	5.0	(0.4)		—	
Return on equity (b)	17.7 %	18.7 %	18.9 %	(1.0)%		(0.2)%	

nm= not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of the four quarters in the year presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select 2013 year-over-year operating comparisons to 2012 and other 2013 significant items.

- Consolidated revenues increased by 11%, UnitedHealthcare revenues increased by 10% and Optum revenues grew by 26%.
- Earnings from operations increased by 4%, including a decrease of 6% at UnitedHealthcare and an increase of 61% at Optum.
- UnitedHealthcare medical enrollment grew organically by 4.5 million people, including 2.9 million military beneficiaries through the TRICARE contract. Medicare Part D stand-alone membership grew by 725,000 people.

- OptumRx completed the insourcing of pharmacy services for 12 million new and migrating customers served by UnitedHealthcare.
- The consolidated medical care ratio of 81.5% increased 110 basis points.
- As of December 31, 2013, there was $1.0 billion of cash available for general corporate use and 2013 cash flows from operations were $7.0 billion.

2013 RESULTS OF OPERATIONS COMPARED TO 2012 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during 2013 were primarily driven by the full year effect of 2012 acquisitions, including Amil, growth in the number of individuals served through benefit products and overall organic growth in each of Optum's major businesses. The revenue impact of these factors was partially offset by the reduction in Medicare Advantage rates. Also offsetting the revenue increase was the first quarter conversion of a large fully-insured commercial customer from a risk-based to a fee-based arrangement affecting 1.1 million members. While this conversion reduced our full-year 2013 consolidated revenues by $2.3 billion, the impact to earnings from operations and cash flows was negligible.

Medical Costs and Medical Care Ratio

Medical costs during 2013 increased due to risk-based membership growth in our international and public and senior markets businesses, partially offset by the funding conversion of the large client discussed above. The year-over-year medical care ratio increased primarily due to funding reductions for Medicare Advantage products, changes in business mix favoring governmental benefit programs, and reduced levels of favorable medical cost reserve development for the year ended December 31, 2013 of $680 million, compared to $860 million for the year ended December 31, 2012.

Operating Costs

The increase in our operating costs during 2013 was due to business growth, including an increase in fee-based benefits and fee-based service revenues and a greater mix of international business, which carry comparatively higher operating costs, partially offset by our ongoing cost containment efforts.

The following table presents reportable segment financial information:

	For the Years Ended December 31,			Increase/(Decrease)		Increase/(Decrease)	
(in millions, except percentages)	2013	2012	2011	2013 vs. 2012		2012 vs. 2011	
Revenues							
UnitedHealthcare	$113,829	$103,419	$95,336	$10,410	10 %	$8,083	8 %
OptumHealth	9,855	8,147	6,704	1,708	21	1,443	22
OptumInsight	3,174	2,882	2,671	292	10	211	8
OptumRx	24,006	18,359	19,278	5,647	31	(919)	(5)
Total Optum	37,035	29,388	28,653	7,647	26	735	3
Eliminations	(28,375)	(22,189)	(22,127)	6,186	28	62	—
Consolidated revenues	$122,489	$110,618	$101,862	$11,871	11 %	$8,756	9 %
Earnings from operations							
UnitedHealthcare	$7,309	$7,815	$7,203	$(506)	(6)%	$612	8 %
OptumHealth	976	561	423	415	74	138	33
OptumInsight	603	485	381	118	24	104	27
OptumRx	735	393	457	342	87	(64)	(14)
Total Optum	2,314	1,439	1,261	875	61	178	14
Consolidated earnings from operations	$9,623	$9,254	$8,464	$369	4 %	$790	9 %
Operating margin							
UnitedHealthcare	6.4 %	7.6 %	7.6 %	(1.2)%		— %	
OptumHealth	9.9	6.9	6.3	3.0		0.6	
OptumInsight	19.0	16.8	14.3	2.2		2.5	
OptumRx	3.1	2.1	2.4	1.0		(0.3)	
Total Optum	6.2	4.9	4.4	1.3		0.5	
Consolidated operating margin	7.9 %	8.4 %	8.3 %	(0.5)%		0.1 %	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenue by business:

	For the Years Ended December 31,			Increase/(Decrease)		Increase/(Decrease)	
(in millions, except percentages)	2013	2012	2011	2013 vs. 2012		2012 vs. 2011	
UnitedHealthcare Employer & Individual	$44,951	$46,596	$45,404	$(1,645)	(4)%	$1,192	3 %
UnitedHealthcare Medicare & Retirement	44,225	39,257	34,933	4,968	13	4,324	12
UnitedHealthcare Community & State	18,268	16,422	14,954	1,846	11	1,468	10
UnitedHealthcare International	6,385	1,144	45	5,241	nm	1,099	nm
Total UnitedHealthcare revenue	$113,829	$103,419	$95,336	$10,410	10 %	$8,083	8 %

nm= not meaningful

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

	December 31,			Increase/(Decrease)		Increase/(Decrease)	
(in thousands, except percentages)	2013	2012	2011	2013 vs. 2012		2012 vs. 2011	
Commercial risk-based	8,185	9,340	9,550	(1,155)	(12)%	(210)	(2)%
Commercial fee-based	19,055	17,585	16,320	1,470	8	1,265	8
Commercial fee-based TRICARE	2,920	—	—	2,920	nm	—	nm
Total commercial	30,160	26,925	25,870	3,235	12	1,055	4
Medicare Advantage	2,990	2,565	2,165	425	17	400	18
Medicaid	4,035	3,830	3,600	205	5	230	6
Medicare Supplement (Standardized)	3,455	3,180	2,935	275	9	245	8
Total public and senior	10,480	9,575	8,700	905	9	875	10
International	4,805	4,425	—	380	9	4,425	nm
Total UnitedHealthcare - medical	45,445	40,925	34,570	4,520	11 %	6,355	18 %
Supplemental Data:							
Medicare Part D stand-alone	4,950	4,225	4,855	725	17 %	(630)	(13)%

nm= not meaningful

The number of people served under commercial risk-based arrangements decreased in 2013 primarily due to the conversion of 1.1 million risk-based consumers of a large public sector client to a fee-based arrangement. The number of individuals in commercial fee-based arrangements increased due to this conversion as well as new business awards and strong customer retention. On April 1, 2013, UnitedHealthcare Military & Veterans began service under the TRICARE West Region Managed Care Support Contract. This administrative services contract for health care operations added 2.9 million people and includes a transition period and five one-year renewals at the government’s option. Medicare Advantage participation increased due to solid execution in product design, marketing and local engagement, which drove sales growth. Medicaid growth was due to a combination of winning new state accounts and growth within existing state customers, partially offset by the first quarter 2013 divestiture of our Medicaid business in South Carolina and a fourth quarter 2012 market withdrawal from one product in Wisconsin, which combined affected 235,000 Medicaid beneficiaries. Medicare Supplement growth reflected strong customer retention and new sales. In our Medicare Part D stand-alone business, the number of people served increased primarily as a result of new product introductions and strong customer retention in the market. International represents commercial customers in Brazil added in the fourth quarter of 2012 as a result of the Amil acquisition, and subsequent organic growth.

UnitedHealthcare’s revenue growth in 2013 was primarily attributable to the impact of 2012 acquisitions and the growth in the number of individuals served. The effect of these factors was partially offset by the government funding reductions described previously and the customer funding conversion discussed above.

UnitedHealthcare’s earnings from operations and operating margins in 2013 decreased compared to the prior year as operating margins were pressured by the funding reductions that decreased revenues and by decreased levels of favorable reserve development.

Optum

Total revenues increased in 2013 primarily due to broad-based growth across Optum's services portfolio with growth in each of Optum's major businesses led by pharmacy growth from the insourcing of UnitedHealthcare commercial customers and external clients.

Optum's earnings from operations and operating margin in 2013 increased significantly compared to 2012, reflecting progress on Optum's plan to accelerate growth and improve productivity by strengthening integration and business alignment.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth in 2013 were primarily due to market expansion, including growth related to 2012 acquisitions in local care delivery, and organic growth.

Earnings from operations and operating margins in 2013 increased primarily due to revenue growth and an improved cost structure across the business, including local care delivery, population health and wellness solutions, and health-related financial services offerings.

OptumInsight

Revenues at OptumInsight in 2013 increased primarily due to the impact of a 2012 acquisition and growth in services to commercial payers.

The increases in earnings from operations and operating margins in 2013 reflected increased revenues, changes in product mix and continuing improvements in business alignment and efficiency.

OptumRx

The increase in OptumRx revenues in 2013 were due to the insourcing of UnitedHealthcare's commercial pharmacy benefit programs and growth in both UnitedHealthcare's Medicare Part D members and external clients. Over the course of 2013, we completed our transition of 12 million migrating and new members to the OptumRx platform from a third party.

Earnings from operations and operating margins in 2013 increased primarily due to strong revenue growth, pricing disciplines, and greater use of generic medications.

2012 RESULTS OF OPERATIONS COMPARED TO 2011 RESULTS

Consolidated Financial Results

Revenues

Revenue increases in 2012 were driven by growth in the number of individuals served and premium rate increases related to underlying medical cost trends in our UnitedHealthcare businesses and growth in our Optum health service and technology offerings.

Medical Costs

Medical costs increased in 2012 due to risk-based membership growth in our public and senior markets businesses, unit cost inflation across all businesses and continued moderate increases in health system use, partially offset by an increase in favorable medical reserve development. Unit cost increases represented the primary driver of our medical cost trend, with the largest contributor being price increases to hospitals.

Operating Costs

The increases in operating costs for 2012 were due to business growth, including increases in revenues from UnitedHealthcare fee-based benefits and Optum services, which carry comparatively higher operating costs, as well as investments in the OptumRx pharmacy management services and UnitedHealthcare Military & Veterans businesses.

Income Tax Rate

The increase in our effective income tax rate for 2012 was due to the favorable resolution of various tax matters in 2011, which lowered the 2011 effective income tax rate.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue growth in 2012 was primarily due to growth in the number of individuals served, commercial premium rate increases related to expected increases in underlying medical cost trends and the impact of lower premium rebates.

UnitedHealthcare's earnings from operations for 2012 increased compared to the prior year primarily due to the factors that increased revenues combined with an improvement in the medical care ratio that was driven by effective management of medical costs and increased favorable medical reserve development. The favorable development for 2012 was driven by lower than expected health system utilization levels and increased efficiency in claims handling and processing.

Optum. Total revenues increased in 2012 due to business growth and 2011 acquisitions at OptumHealth, partially offset by a reduction in pharmacy service revenues related to reduced levels of UnitedHealthcare Medicare Part D prescription drug membership and related prescription volumes.

Optum's earnings from operations and operating margin for 2012 increased compared to 2011 due to improvements in operating cost structure stemming from advances in business simplification, integration and overall efficiency and revenue growth in higher margin products.

The results by segment were as follows:

OptumHealth

Revenue increases at OptumHealth for 2012 were primarily due to market expansion, including growth related to 2011 acquisitions in integrated care delivery, and strong overall business growth.

Earnings from operations for 2012 and operating margins increased compared to 2011 primarily due to gains in operating efficiency and cost management as well as increases in earnings from integrated care operations.

OptumInsight

Revenues at OptumInsight for 2012 increased primarily due to the impact of growth in compliance services for care providers and payment integrity offerings for commercial payers, which was partially offset by the June 2011 divestiture of the clinical trials services business.

The increases in earnings from operations and operating margins for 2012 reflect an improved mix of services and advances in operating efficiency and cost management.

OptumRx

The decreases in OptumRx revenues in 2012 were due to the reduction in UnitedHealthcare Medicare Part D plan participants.

OptumRx earnings from operations and operating margins for 2012 decreased primarily due to decreased prescription volume in the Medicare Part D business and investments to support growth initiatives, which were partially offset by earnings contributions from specialty pharmacy growth and greater use of generic medications.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before non-cash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the NAIC. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary

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dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

In 2013, based on the 2012 statutory net income and statutory capital and surplus levels, the maximum amount of ordinary dividends that could be paid by our U.S. regulated subsidiaries to their parent companies was $4.3 billion. In 2013, our regulated subsidiaries paid their parent companies dividends of $3.2 billion, including $430 million of extraordinary dividends. This level of dividends maintained our target consolidated risk-based capital level. In 2012, our regulated subsidiaries paid their parent companies dividends of $4.9 billion, including $1.2 billion of extraordinary dividends.

Our non-regulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash

	For the Years Ended December 31,			Increase/(Decrease)	
(in millions)	2013	2012	2011	2013 vs. 2012	2012 vs. 2011
Sources of cash:					
Cash provided by operating activities	$6,991	$7,155	$6,968	$(164)	$187
Proceeds from common stock issuances	598	1,078	381	(480)	697
Proceeds from issuances of long-term debt and commercial paper, net of repayments	152	4,567	346	(4,415)	4,221
Other	31	—	428	31	(428)
Total sources of cash	7,772	12,800	8,123		
Uses of cash:					
Common stock repurchases	(3,170)	(3,084)	(2,994)	(86)	(90)
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed and dispositions	(1,791)	(6,599)	(1,459)	4,808	(5,140)
Purchases of investments, net of sales and maturities	(1,611)	(1,299)	(1,695)	(312)	396
Purchases of property, equipment and capitalized software, net	(1,161)	(1,070)	(1,018)	(91)	(52)
Cash dividends paid	(1,056)	(820)	(651)	(236)	(169)
Customer funds administered	—	(324)	—	324	(324)
Other	(27)	(627)	—	600	(627)
Total uses of cash	(8,816)	(13,823)	(7,817)		
Effect of exchange rate changes on cash and cash equivalents	(86)	—	—	nm	nm
Net (decrease) increase in cash	$(1,130)	$(1,023)	$306	$(107)	$(1,329)

nm= not meaningful

2013 Cash Flows Compared to 2012 Cash Flows

Cash flows provided by operating activities in 2013 decreased due to the net effects of changes in operating assets and liabilities, including: (a) an increase in pharmacy rebates receivables stemming from the increased membership at OptumRx, the effects of which were partially offset by (b) increases in medical costs payable due to the growth in the number of individuals served in our public and senior markets and international businesses.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) decreased investments in acquisitions and noncontrolling interest shares (the activity in 2013 primarily related to the acquisition of the

remaining publicly traded shares of Amil during the second quarter of 2013 for $1.5 billion); (b) a decrease in net proceeds from commercial paper and long-term debt, as proceeds from 2013 debt issuances were fully offset by scheduled maturities and the redemption of all of our outstanding subsidiary debt (in 2012, the increased cash flows from common stock issuances and proceeds from issuances of commercial paper and long-term debt primarily related to the Amil acquisition); and (c) increased net purchases of investments.

2012 Cash Flows Compared to 2011 Cash Flows

Cash flows from operating activities for 2012 increased due to increased net income and related tax accruals, which were partially offset by the payment in 2012 of 2011 premium rebate obligations as 2012 was the first year in which rebate payments were made under Health Reform Legislation.

Other significant items contributing to the overall decrease in cash year-over-year included: (a) increased investments in acquisitions in 2012; (b) increases in long-term debt, commercial paper and common stock issuances, primarily related to the Amil acquisition; (c) increases in cash paid for customer funds related to Medicare Part D and increased shareholder dividend payments.

Financial Condition

As of December 31, 2013, our cash, cash equivalent and available-for-sale investment balances of $28.3 billion included $7.3 billion of cash and cash equivalents (of which $1.0 billion was available for general corporate use), $19.4 billion of debt securities and $1.6 billion of investments in 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 or capital position. The use of different market assumptions or valuation methodologies, especially those used in valuing our $311 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), 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 we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our cash, cash equivalent and available-for-sale debt portfolio had a weighted-average duration of 2.5 years. Our available-for-sale debt portfolio had a weighted-average duration of 3.6 years and a weighted-average credit rating of “AA” as of December 31, 2013. Included in the debt securities balance was $1.4 billion of state and municipal obligations that are guaranteed by a number of third parties. Due to the high underlying credit ratings of the issuers, the weighted-average credit rating of these securities with and without the guarantee was “AA” as of December 31, 2013. We do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flow from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper. We maintain a $4.0 billion commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers. The commercial paper program is supported by the bank credit facilities described below. As of December 31, 2013, we had $1.1 billion of commercial paper outstanding at a weighted-average annual interest rate of 0.2%.

Bank Credit Facilities. We have $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2018 and November 2014, respectively. These facilities provide liquidity support for our commercial paper program and are available for general corporate purposes. There were no amounts outstanding under these facilities as of December 31, 2013. The interest rates on borrowings are variable depending on term and are calculated based on the LIBOR plus a credit spread based on our senior unsecured credit ratings. As of December 31, 2013, the annual interest rates on both bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Our bank credit facilities contain various covenants, including covenants requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, which reasonably approximates the actual covenant ratio, was 34.4% as of December 31, 2013. We were in compliance with our debt covenants as of December 31, 2013.

Long-term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

In February 2013, we issued $2.25 billion in senior unsecured notes, which included: $250 million of floating-rate notes due August 2014, $500 million of 1.625% fixed-rate notes due March 2019, $750 million of 2.875% fixed-rate notes due March 2023 and $750 million of 4.250% fixed-rate notes due March 2043.

In March and April of 2013, we redeemed all of our outstanding subsidiary variable rate debt for $619 million.

Credit Ratings. Our credit ratings at December 31, 2013 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A	Positive	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

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 adopted strategies and actions toward maintaining financial flexibility to mitigate the impact of such factors on our ability to raise capital.

Share Repurchase Program. Under our Board of Directors' authorization, we maintain a share repurchase program. The objectives of the share repurchase program are to optimize our capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including structured share repurchase programs), subject to certain Board restrictions. In June 2013, our Board renewed and expanded our share repurchase program with an authorization to repurchase up to 110 million shares of our common stock. As of December 31, 2013, we had Board authorization to purchase up to an additional 83 million shares of our common stock.

Dividends. In June 2013, our Board of Directors increased our cash dividend to shareholders to an annual dividend rate of $1.12 per share, paid quarterly. Since June 2012, we had paid an annual cash dividend of $0.85 per share, paid quarterly. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Amil Tender Offer. We acquired all of Amil's remaining public shares for $1.5 billion in the second quarter of 2013, bringing our ownership in Amil to 90%.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2013, under our various contractual obligations and commitments:

(in millions)	2014	2015 to 2016	2017 to 2018	Thereafter	Total
Debt (a)	$2,644	$3,450	$3,411	$18,147	$27,652
Operating leases	487	800	572	544	2,403
Purchase obligations (b)	250	174	14	—	438
Future policy benefits (c)	136	258	267	1,940	2,601
Unrecognized tax benefits (d)	—	—	—	78	78
Other liabilities recorded on the Consolidated Balance Sheet (e)	186	43	—	1,482	1,711
Other obligations (f)	94	113	49	12	268
Redeemable noncontrolling interests (g)	54	158	963	—	1,175
Total contractual obligations	$3,851	$4,996	$5,276	$22,203	$36,326

(a) Includes interest coupon payments and maturities at par or put values. For variable rate debt, the rates in effect at December 31, 2013 were used to calculate the interest coupon payments. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2013.

(c) Future policy benefits represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products and for long-duration health policies sold to individuals for which some of the premium received in the earlier years is intended to pay benefits to be incurred in future years. See Note 2 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for more detail.

(d) As the timing of future settlements is uncertain, they have been classified as due "Thereafter."

(e) Includes obligations associated with contingent consideration and other payments related to business acquisitions, certain employee benefit programs, and various other long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions and other liabilities have been classified as "Thereafter."

(f) Includes remaining capital commitments for venture capital funds and other funding commitments.

(g) Includes commitments for redeemable shares of our subsidiaries, primarily the shares owned by Amil's remaining non-public shareholders.

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

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2013, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

We have determined that there have been no recently issued, but not yet adopted, accounting standards that 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 Payable

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 processing 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, the introduction of new technologies, 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. As of December 31, 2013, our days outstanding in medical payables was 47 days, calculated as total medical payables divided by total medical costs times 365 days.

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. Therefore, 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). Medical costs in 2013, 2012, and 2011 included favorable medical cost development related to prior years of $680 million, $860 million and $720 million, respectively.

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 and analysis of current trends, 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 to estimate the expected amount of ultimate incurred claims for those months. 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.

Completion factors. 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. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserves may be significantly impacted. 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, 2013:

Completion Factors Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable (in millions)
(0.75)%	$291
(0.50)	194
(0.25)	97
0.25	(96)
0.50	(192)
0.75	(287)

Medical cost PMPM trend factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent three months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design, and by reviewing a broad set of health care utilization indicators including, but not limited to, pharmacy utilization trends, inpatient hospital census data and incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as gross-domestic product growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates including: our ability and practices to manage medical costs, changes in level and mix of services utilized, mix of benefits offered including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

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, 2013:

Medical Costs PMPM Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable (in millions)
3%	$573
2	382
1	191
(1)	(191)
(2)	(382)
(3)	(573)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims. Our estimate of medical costs payable represents management’s best estimate of our liability for unpaid medical costs as of December 31, 2013, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2013; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2013 estimates of medical costs payable and actual medical costs payable,

excluding AARP Medicare

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Supplement Insurance and any potential offsetting impact from premium rebates, 2013 net earnings would have increased or decreased by $65 million.

Revenues

We derive a substantial portion of our revenues from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services. Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We and health care providers collect, capture, and submit available diagnosis data to CMS within prescribed deadlines. CMS uses submitted diagnosis codes, demographic information, and special statuses to determine the risk score for most Medicare Advantage beneficiaries. CMS also retroactively adjusts risk scores during the year based on additional data. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. Risk adjustment data for certain of our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for additional information regarding these audits. Additionally, beginning in 2014, Medicare Advantage and Medicare Part D plans will be subject to a minimum MLR threshold of 85%. We will include in our estimates of premiums to be recognized the expected premium minimum MLR rebates, if any.

U.S. commercial health plans with MLRs on fully insured products, as calculated under the definitions in Health Reform Legislation, that fall below certain targets (85% for large employer groups, 80% for small employer groups and 80% for

individuals) are required to rebate ratable portions of their premiums to their customers annually. Premium revenues are recognized based on the estimated premiums earned net of projected rebates because we are able to reasonably estimate the ultimate premiums of these contracts. Each period, we estimate premium rebates based on the expected financial performance of the applicable contracts within each defined aggregation set (e.g., by state, group size and licensed subsidiary). The most significant factors in estimating the financial performance are current and future premiums and medical claim experience, effective tax rates and expected changes in business mix. The estimated ultimate premium is revised each period to reflect current and projected experience.

Goodwill and Intangible Assets

Goodwill. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Impairment tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform a multi-step impairment test. First, we can elect to perform a qualitative assessment of each reporting unit to determine whether facts and circumstances support a determination that their fair values are greater than their carrying values. If the qualitative analysis is not conclusive, or if we elect to proceed directly with quantitative testing, we will then measure the fair values of the reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- Revenue trends. Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: membership growth, medical trends, and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates, and inflation are also evaluated and incorporated, as appropriate.
- Medical cost trends. For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends above and the discussion in the “Medical Costs Payable” critical accounting estimate above.

Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.

- Operating productivity. We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- Capital levels. The operating and long-term capital requirements for each business are considered.

Although we believe that the financial projections used are reasonable and appropriate for all of our reporting units, due to the long-term nature of the forecasts there is significant uncertainty inherent in those projections. That uncertainty is increased by the impact of health care reforms as discussed in Item 1, “Business - Government Regulation.” For additional discussions regarding how the enactment or implementation of health care reforms and other factors could affect our business and the related long-term forecasts, see Item 1A, “Risk Factors” in Part I and “Regulatory Trends and Uncertainties” above.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. This risk is evaluated using comparisons to market information such as peer company weighted average costs of capital and peer company stock prices in the form of revenue and earnings multiples. Beyond our selection of the most appropriate risk-free rates and equity risk premiums, our most significant estimates in the discount rate determinations involve our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. Such adjustments include the addition of size premiums and company-specific risk premiums intended to compensate for apparent forecast risk. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty.

The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future.

We elected to bypass the optional qualitative reporting unit fair value assessment and completed our annual quantitative tests for goodwill impairment as of January 1, 2014. All of our reporting units had fair values substantially in excess of their carrying values.

Intangible assets. Our recorded separately-identifiable intangible assets were acquired in business combinations and represent future expected benefits but they lack physical substance (e.g., membership lists, customer contracts, trademarks and technology). These intangible assets are initially recorded at their fair values. Finite-lived intangible assets are amortized over their expected useful lives, while indefinite-lived intangible assets are evaluated for impairment on at least an annual basis. Both finite-lived and indefinite-lived intangible assets are evaluated for impairment between annual periods if an event occurs or circumstances change that may indicate impairment. Our most significant intangible assets are customer-related intangibles, which represent 73% of our total intangible asset balance of $3.8 billion as of December 31, 2013.

Customer-related intangible assets acquired in business combinations are typically valued using an income approach based on discounted future cash flows attributable to customers that exist as of the date of acquisition. The most significant assumptions used in the valuation of customer-related assets include: projected revenue and earnings growth, retention rates, perpetuity growth rates and discount rates. These initial valuations and the embedded assumptions contain uncertainty to the extent that those assumptions and estimates may ultimately differ from actual results (e.g., customer turnover may be higher or lower than the assumed retention rate suggested).

Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset’s (or asset group’s) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value, and other factors. Following the identification of any potential impairment indicators, we would calculate the estimated fair value of a finite-lived intangible asset (or asset group) using the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that an impairment exists, the amount by which the carrying value exceeds its estimated fair value would be recorded as an impairment.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we assess qualitative factors to

determine whether the existence of events and circumstances indicates that it is more-likely-than-not that the indefinite-lived intangible asset's carrying value exceeds its fair value. If, after assessing the totality of events and circumstances, we conclude that it is not more likely than not that the indefinite-lived intangible asset's carrying value exceeds its fair value, no impairment exists and no further testing is performed. If we conclude otherwise, we would perform a quantitative analysis by comparing its estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not materially impaired in 2013.

Investments

As of December 31, 2013, we had investments with a carrying value of $21.5 billion, primarily held in marketable debt securities. Our investments are principally classified as available-for-sale and are recorded at fair value. We exclude gross unrealized gains and losses on available-for-sale investments from net earnings and report net unrealized gains or losses, net of income tax effects, as other comprehensive income and as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2013, our available-for-sale investments had gross unrealized gains of $326 million and gross unrealized losses of $234 million.

For debt securities, if we intend to either sell or determine that we will be more likely than not be required to sell the security before recovery of the entire amortized cost basis or maturity of the security, we recognize the entire impairment in earnings. If we do not intend to sell the debt security and we determine that we will not be more likely than not be required to sell the debt security but we do not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, and recognized in net earnings, and all other causes, and recognized in other comprehensive income.

For equity securities, we recognize impairments in other comprehensive income if we expect to hold the equity security until fair value increases to at least the equity security's cost basis and we expect that increase in fair value to occur in a reasonably forecasted period. If we intend to sell the equity security or if we believe that recovery of fair value to cost will not occur in the near term, we recognize the impairment in net earnings.

The most significant judgments and estimates related to investments are related to determination of their fair values and the other-than-temporary impairment assessment.

Fair values. Fair values of available-for-sale debt and equity securities are based on quoted market prices, where available. We obtain one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates and prepayment speeds, and non-binding broker quotes. As we are responsible for the determination of fair value, we perform quarterly analyses of the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, we compare:

- prices received from the pricing service to prices reported by a secondary pricing service, our custodian, our investment consultant and/or third-party investment advisors; and
- changes in the reported market values and returns to relevant market indices and our expectations to test the reasonableness of the reported prices.

Based on our internal price verification procedures and our review of the fair value methodology documentation provided by independent pricing service, we have not historically adjusted the prices obtained from the pricing service.

Other-than-temporary impairment assessment. Individual securities with fair values lower than costs are reviewed for impairment considering the following factors: our intent to sell the security or the likelihood that we will be required to sell the security before recovery of the entire amortized cost, the length of time and extent of impairment and the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer. Other factors included in the assessment include the type and nature of the securities and their liquidity. Given the nature of our portfolio, primarily investment grade securities, historical impairments were largely market related (e.g., interest rate fluctuations) as opposed to credit related. We do not expect that trend to change in the near term. Our large cash holdings reduce the risk that we will be required to sell a security. However, our intent to sell a security may change from period to period if facts and circumstances change.

The unrealized losses of $234 million and $9 million at December 31, 2013 and 2012, respectively, were primarily caused by market interest rate increases and not by unfavorable changes in the credit standing. We believe we will collect the principal and interest due on our debt securities with an amortized cost in excess of fair value. We manage

our investment portfolio to limit our exposure to any one issuer or market sector, and largely limit our investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are of investment-grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with our investment policy. Total other-than-temporary impairments during the years ended December 31, 2013, 2012 and 2011 were $8 million, $6 million and $12 million, respectively. Our available-for-sale debt portfolio had a weighted-average credit rating of “AA” as of December 31, 2013. We have minimal securities collateralized by sub-prime or Alt-A securities, and a minimal amount of commercial mortgage loans in default.

The judgments and estimates related to fair value and other-than-temporary impairment may ultimately prove to be inaccurate due to many factors including: circumstances may change over time, industry sector and market factors may differ from expectations and estimates or we may ultimately sell a security we previously intended to hold. Our assessment of the financial condition and near-term prospects of the issuer may ultimately prove to be inaccurate as time passes and new information becomes available, including changes to current facts and circumstances, or as unknown or estimated unlikely trends develop.

As discussed further in Item 7A "Quantitative and Qualitative Disclosures About Market Risk" a 1% increase in market interest rates would have the effect of decreasing the fair value of our investment portfolio by $756 million.

Income Taxes

Our provision for income taxes, deferred tax assets and liabilities, and uncertain tax positions reflect our assessment of estimated future taxes to be paid on items in the consolidated financial statements.

Deferred income taxes arise from temporary differences between financial reporting and tax reporting bases of assets and liabilities, as well as net operating loss and tax credit carryforwards for tax purposes. We have established a valuation allowance against certain deferred tax assets for which it is more-likely-than-not that some portion, or all, of the deferred tax asset will not be realized.

An uncertain tax position is recognized when it is more likely than not that the position will be sustained upon examination, including resolutions of any related appeals or litigation processes, based on the technical merits. We prepare and file tax returns based on our interpretation of tax laws and regulations and record estimates based on these judgments and interpretations. In the normal course of business, our tax returns are subject to examination by various taxing authorities. Such examinations may result in future tax and interest assessments by these taxing authorities. Inherent uncertainties exist in estimates of tax positions due to changes in tax law resulting from legislation, regulation and/or as concluded through the various jurisdictions' tax court systems.

The significant assumptions and estimates described above are important contributors to our ultimate effective tax rate in each year. A hypothetical increase or decrease in our effective tax rate by 1% on our 2013 earnings before income taxes would have caused the provision for income taxes and net earnings to change by $89 million.

Contingent Liabilities

Because of the nature of our businesses, we are routinely involved in various disputes, legal proceedings and governmental audits and investigations. We record liabilities for our estimates of the probable costs resulting from these matters where appropriate. Our estimates are developed in consultation with legal counsel, if appropriate, and are based upon an analysis of potential results, assuming a combination of litigation and settlement strategies and considering our insurance coverage, if any, for such matters.

Estimates of costs resulting from legal and regulatory matters are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, in many cases, we are unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Similarly, the assessment of the likelihood of assertion of unasserted claims involves significant judgment.

Given this inherent uncertainty, it is possible that future results of operations for any particular quarterly or annual period could be materially affected by changes in our estimates or assumptions. We evaluate our related disclosures in each reporting period. See Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements" for a discussion of specific legal proceedings including an assessment of whether a reasonable estimate of the losses or range of loss could be determined.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and

generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and

other customers that constitute our client base. As of December 31, 2013, we had an aggregate $1.8 billion reinsurance receivable resulting from the sale of our Golden Rule Financial Corporation life and annuity business in 2005. We regularly evaluate the financial condition of the reinsurer and record the reinsurance receivable only to the extent that the amounts are deemed probable of recovery. Currently, the reinsurer is rated by A.M. Best as "A+." As of December 31, 2013, there were no other significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and (c) changes in equity prices that impact the value of our equity investments.

As of December 31, 2013, we had $8.7 billion of cash, cash equivalents and investments on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also, $9.6 billion of our commercial paper, debt and deposit liabilities as of December 31, 2013 were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2013, $18.5 billion of our investments were fixed-rate debt securities and $10.2 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or periodically through the use of interest rate swap contracts.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% or 2% as of December 31, 2013 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2013			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2 %	$175	$189	$(1,474)	$(1,786)
1	87	95	(756)	(974)
(1)	(52)	(17)	704	1,167
(2)	nm	nm	1,224	2,505

	December 31, 2012			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2 %	$189	$134	$(1,303)	$(2,200)
1	94	67	(656)	(1,194)
(1)	(18)	(14)	518	1,366
(2)	nm	nm	686	2,747

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2013 and 2012, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of December 31, 2013 and 2012, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign currency financial statements into U.S. dollars are included in shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of December 31, 2013, a hypothetical 10% increase in the value of the U.S. dollar against the

Brazilian real would have caused a reduction in net assets of approximately $490 million. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies. As of December 31, 2013, we had $1.6 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds, employee savings plan related investments, private equity funds, and dividend paying stocks. Valuations in non-US dollar funds are subject to foreign exchange rates. Valuations in private equity are subject to conditions affecting health care and technology stocks, and dividend paying equities are subject to more general market conditions.

ITEM 8. FINANCIAL STATEMENTS

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Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive income, changes in shareholders' equity and cash flows for each of the three years in the period ended December 31, 2013. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2013, based on the criteria established in Internal Control-Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 12, 2014, expressed an unqualified opinion on the Company's internal control over financial reporting.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2014

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UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	$7,276	$8,406
Short-term investments	1,937	3,031
Accounts receivable, net of allowances of $196 and $189	3,052	2,709
Other current receivables, net of allowances of $169 and $206	3,998	2,889
Assets under management	2,757	2,773
Deferred income taxes	430	463
Prepaid expenses and other current assets	930	781
Total current assets	20,380	21,052
Long-term investments	19,605	17,711
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $2,675 and $2,564	4,010	3,939
Goodwill	31,604	31,286
Other intangible assets, net of accumulated amortization of $2,283 and $1,824	3,844	4,682
Other assets	2,439	2,215
Total assets	$81,882	$80,885
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$11,575	$11,004
Accounts payable and accrued liabilities	7,458	6,984
Other policy liabilities	5,279	4,910
Commercial paper and current maturities of long-term debt	1,969	2,713
Unearned revenues	1,600	1,505
Total current liabilities	27,881	27,116
Long-term debt, less current maturities	14,891	14,041
Future policy benefits	2,465	2,444
Deferred income taxes	1,796	2,450
Other liabilities	1,525	1,535
Total liabilities	48,558	47,586
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,175	2,121
Shareholders' equity:		
Preferred stock, $0.001 par value - 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value - 3,000 shares authorized; 988 and 1,019 issued and outstanding	10	10
Additional paid-in capital	—	66
Retained earnings	33,047	30,664
Accumulated other comprehensive (loss) income	(908)	438
Total shareholders' equity	32,149	31,178
Total liabilities and shareholders' equity	$81,882	$80,885

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UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2013	2012	2011
Revenues:			
Premiums	$109,557	$99,728	$91,983
Services	8,997	7,437	6,613
Products	3,190	2,773	2,612
Investment and other income	745	680	654
Total revenues	122,489	110,618	101,862
Operating costs:			
Medical costs	89,290	80,226	74,332
Operating costs	19,362	17,306	15,557
Cost of products sold	2,839	2,523	2,385
Depreciation and amortization	1,375	1,309	1,124
Total operating costs	112,866	101,364	93,398
Earnings from operations	9,623	9,254	8,464
Interest expense	(708)	(632)	(505)
Earnings before income taxes	8,915	8,622	7,959
Provision for income taxes	(3,242)	(3,096)	(2,817)
Net earnings	5,673	5,526	5,142
Earnings attributable to noncontrolling interests	(48)	—	—
Net earnings attributable to UnitedHealth Group common shareholders	$5,625	$5,526	$5,142
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$5.59	$5.38	$4.81
Diluted	$5.50	$5.28	$4.73
Basic weighted-average number of common shares outstanding	1,006	1,027	1,070
Dilutive effect of common share equivalents	17	19	17
Diluted weighted-average number of common shares outstanding	1,023	1,046	1,087
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	17	47
Cash dividends declared per common share	$1.0525	$0.8000	$0.6125

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UnitedHealth Group
Consolidated Statements of Comprehensive Income

	For the Years Ended December 31,		
(in millions)	2013	2012	2011
Net earnings	$5,673	$5,526	$5,142
Other comprehensive (loss) income:			
Gross unrealized holding (losses) gains on investment securities during the period	(543)	217	422
Income tax effect	196	(78)	(154)
Total unrealized (losses) gains, net of tax	(347)	139	268
Gross reclassification adjustment for net realized gains included in net earnings	(181)	(156)	(113)
Income tax effect	66	57	41
Total reclassification adjustment, net of tax	(115)	(99)	(72)
Total foreign currency translation (losses) gains	(884)	(63)	13
Other comprehensive (loss) income	(1,346)	(23)	209
Comprehensive income	4,327	5,503	5,351
Comprehensive income attributable to noncontrolling interests	(48)	—	—
Comprehensive income attributable to UnitedHealth Group common shareholders	$4,279	$5,503	$5,351

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UnitedHealth Group
Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss) Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss) Foreign Currency Translation (Losses) Gains	Total Shareholders' Equity
Balance at January 1, 2011	1,086	$11	$—	$25,562	$280	$ (28)	$25,825
Net earnings				5,142			5,142
Other comprehensive income					196	13	209
Issuances of common shares, and related tax effects	18	—	308				308
Share-based compensation, and related tax benefits			453				453
Common share repurchases	(65)	(1)	(761)	(2,232)			(2,994)
Cash dividends paid on common shares				(651)			(651)
Balance at December 31, 2011	1,039	10	—	27,821	476	(15)	28,292
Net earnings				5,526			5,526
Other comprehensive income (loss)					40	(63)	(23)
Issuances of common shares, and related tax effects	37	—	704				704
Share-based compensation, and related tax benefits			594				594
Common share repurchases	(57)	—	(1,221)	(1,863)			(3,084)
Acquisitions of noncontrolling interests			(11)				(11)
Cash dividends paid on common shares				(820)			(820)
Balance at December 31, 2012	1,019	10	66	30,664	516	(78)	31,178
Net earnings attributable to UnitedHealth Group common shareholders				5,625			5,625
Other comprehensive loss					(462)	(884)	(1,346)
Issuances of common shares, and related tax effects	17	—	431				431
Share-based compensation, and related tax benefits			406				406
Common share repurchases	(48)	—	(984)	(2,186)			(3,170)
Acquisitions of noncontrolling interests, and related tax effects			81				81
Cash dividends paid on common shares				(1,056)			(1,056)
Balance at December 31, 2013	988	$10	$—	$33,047	$54	$ (962)	$32,149

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UnitedHealth Group
Consolidated Statements of Cash Flows

	For the Years Ended December 31,		
(in millions)	2013	2012	2011
Operating activities			
Net earnings	$5,673	$5,526	$5,142
Non-cash items:			
Depreciation and amortization	1,375	1,309	1,124
Deferred income taxes	1	308	59
Share-based compensation	331	421	401
Other, net	(83)	(231)	(67)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(317)	(130)	(267)
Other assets	(838)	(295)	(121)
Medical costs payable	509	101	377
Accounts payable and other liabilities	459	199	146
Other policy liabilities	(221)	(81)	482
Unearned revenues	102	28	(308)
Cash flows from operating activities	6,991		