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RFP Response

State of Vermont
Office of Vermont Health Access
Claims Data Analysis and Post Payment Review
Technical Proposal

January 4, 2008

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Executive Summary

HWT, an Ingenix Company (HWT), is pleased to be submitting this response to the RFP for Claims Data Analysis and Post Payment Review issued by the Office of Vermont Health Access (OVHA). HWT is able to offer OVHA the most complete and in-depth combination of Medicaid overpayment identification services and experience available in the market. As described in greater depth in this response, the HWT solution:

- Is deployed solely in the Medicaid and state health care marketplace and is designed to meet the particular needs of the Medicaid delivery and payment system. Medicaid is fundamentally different from other delivery and payment systems and HWT has the best, most in depth understanding of Medicaid.
- Will be fully customized to meet the needs of OVHA's Program Integrity unit. Because each of the Medicaid plans is unique, cookie cutter solutions are not effective in fighting Medicaid fraud, waste and abuse. HWT will be a true associate to OVHA by designing a program that will be deployed effectively with a goal to maximizing return.
- HWT's will leverage its unparalleled experience working with Medicaid to identify and recover money. HWT has helped 20 states recover \$250 million in provider overpayments. (Other vendors may inflate their numbers by including experience gained in other areas, such as TPL).

HWT gained valuable experience of the Vermont Medicaid claims processing system during a previous contract with the State Auditor and looks forward to bringing that experience to bear for the benefit of OVHA.

SECTION II

II-B Business Organization

- **State the full name and address of the bidder/bidder organization and, if applicable, the branch office or other subordinate element that will perform, or assist in performing, the work described in the bid.**

Company Name/Headquarters

Ingenix, Inc.
12125 Technology Drive
Eden Prairie, MN 553344

Additional Office Locations

HWT, an Ingenix Company
333 S. Des Plaines St. Suite 206
Chicago, IL 60661

HWT, an Ingenix Company
145 Commercial St.
Portland, ME 04101

- **Indicate whether the bidder operates as an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated.**

Ingenix is a Delaware corporation and wholly-owned subsidiary of UnitedHealth Group Corporation. UnitedHealth Group was incorporated in 1977 in the State of Minnesota. As noted in the Executive Summary, this proposal is offered through HWT, which is an Ingenix company, (wholly owned by Ingenix).

- **Indicate whether bidder is licensed to operate in Vermont or agrees to be licensed in the event the bidder is selected as the prevailing bidder, or if licensure in Vermont is required to perform the proposed services.**

Licensure by or within Vermont is not required for the services quoted in this proposal.

-
- **List all subcontractors: include firm name and address, contact person, and complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization, abilities, and commitment to the contract period.**

As the primary contractor and sole owner of this response, Ingenix will not be utilizing the services of any subcontractors.

- **Please provide annual audited financial reports for the past three (3) years for the Bidder and any subcontractor.**

As a UnitedHealth Group company, Ingenix's financial results are included in the consolidated financial statements of UnitedHealth Group. Included as Appendix A are UnitedHealth Groups 10-K reports for 2004, 2005 and 2006.

Annual reports and SEC forms, as well as additional financial information, is available online at http://www.unitedhealthgroup.com/invest/index_invest.htm.

- **Identify all owners and subsidiaries that own more than five (5) percent of the organization.**

Ingenix is a wholly-owned subsidiary of UnitedHealth Group, Inc., a Minnesota (U.S.) corporation whose shares are listed on the New York Stock Exchange (NYSE: UNH).

- **If the Bidder is an affiliate of another organization, submit the financial information for the parent company and describe the relationship.**

Ingenix is a wholly-owned subsidiary of UnitedHealth Group, Inc., a Minnesota (U.S.) corporation whose shares are listed on the New York Stock Exchange (NYSE: UNH).

II-C Location

Indicate the site or sites from which the Bidder will perform the relevant tasks embodied in this proposal. Specifically identify where activities will take place. It is possible that the Contractor may wish to change the site(s) for some of these tasks during the contact term. Please describe the Bidder time line in this regard if applicable.

HWT offices located in Chicago, Illinois and Portland, Maine are the sites at which the majority of the tasks will be performed. Both locations house the subject matter experts with exclusive healthcare identification and verification experience.

In the Portland, Maine location, HWT hosts its Provider Call Center staffed by trained specialists to respond to provider inquiries. When recommendations are approved and accepted by OVHA staff, these services are quickly available.

II-D Affiliations

(This section is proprietary and confidential)

[REDACTED]

[Redacted text block 1]

[Redacted text block 2]

[Redacted text block 3]

[Redacted text block 4]

[Redacted text block 5]

[Redacted text block 6]

[REDACTED]

II-E Relevant Experience

Through its work with 20 state Medicaid programs over almost ten years, HWT has gained a comprehensive level of experience in the detection of Medicaid payment errors due to waste, abuse and fraud. Combining that experience with unique methods and processes for working with Medicaid providers to recovery inappropriate payments, HWT has delivered over \$250 million in recovered revenues and prevention-oriented cost avoidances to its Medicaid clients. The following sections provide more detail on the depth of HWT's experience.

Working collaboratively with our clients, HWT deploys a combination of advanced data warehousing and data mining technologies, healthcare industry expertise, and unique auditing methodologies to dramatically reduce the often-prohibitive amount of time and effort needed by experts to manually investigate and qualify suspected instances of Medicaid overpayment and accounts payable issues.

Using an intensive data-driven approach, HWT achieves a broad and comprehensive level of claims data analysis, post payment review and collections that is simply not achievable using traditional methods. HWT's end-to-end solution includes identification and detection processes, systems and approaches, quality assurance, clinical review of findings where necessary, comprehensive case management tracking systems, “turn-key” collections processes and highly interactive provider relations and adjudication processes.

HWT Experience in Claims Data Analysis & Post Payment Review Consulting Services

Breadth of Experience

Over the last decade, HWT has focused all of its resources on assisting state Medicaid programs use paid claims and other supporting data to identify, recover and prevent inappropriate payments, fraud, waste and abuse, and to develop other data-intensive initiatives to access and use Medicaid data for a variety of other program purposes.

Our breadth of general experience in medical provider reviews for Medicaid programs includes:

- **Revenue Recovery**. HWT's large-scale data analysis uncovers millions in inappropriate payments that are recoverable. OVHA will receive detailed reports on the scope of audit findings and present actionable recommendations for recovery of overpayment from HWT's analysis of data. Initially, HWT proposes to stage its work so that the project focuses on recoveries from what is considered waste - provider billing errors that pass through systems edits and audits. This will allow OVHA to rapidly recover overpayments that providers rarely dispute – providers may disagree with the policy underlying the recoveries; however, they cannot disagree that a payment and billing error has been made. HWT can then increase the scope of its analysis, to include audit suspects (cases requiring desk or on-site audit to gain further information), and legal suspects (cases where criminal intent is suspected).
- **Cost Reduction**. Because HWT deploys a comprehensive, end-to-end solution for identifying and collecting inappropriate payments, our work helps clients reduce costs by managing the increased administrative burdens that detection and recovery efforts can place on staff. In addition, it is our experience that HWT's approach results in a myriad of

other unanticipated but measurable cost reductions from the dramatically improved "business efficiencies" that are introduced through or encouraged by the program.

Such efficiencies can include but aren't limited to:

- Increased provider compliance with proper claiming procedures (because they know better monitoring is in place – the “sentinel effect”).
 - Improved program policies that highlight areas in current policy that need further clarity to provide for appropriate compliance and expenditures.
 - More efficient and faster data-driven answers to questions on areas of program spending and quality that may arise from internal or external (recipients, legislators, Governor's staff) sources.
- **Cost Avoidance**. Through the post-payment review of actual claims paid, HWT's detection programs identify vulnerabilities in the upstream billing instructions and claims payment systems that cause these overpayments to be made. HWT provides recommended policy, procedure, and systems changes that can result in millions of dollars in future overpayment avoidance savings.

HWT's Provider Review Services

In 2006 HWT was able to successfully complete a limited-scope project for the SAO.

The scope of work for that project required HWT to:

- Create a database of paid claims for the time period July 1, 2004 to March 31, 2006
- Quickly develop an understanding of OVHA payment rules
- Modify and deploy a limited set of HWT algorithms focused on institutional, professional and pharmacy claims
- Provide initial quality assurance processes to those results and present the findings to the SAO and to OVHA

The data mining analysis done by HWT identified close to \$900,000 in potential overpayments. Details of the results are described in the tables below:

Table 1 - HWT/SAO Findings – Professional Service and Institutional Claims

Algorithm Name	Date range of paid claims reviewed	Amount of Potential Overpayments Identified
Professional Services Claims Algorithms		
Obstetrical care unbundling—same providers	1/2/04 - 12/30/05	\$4,175
Obstetrical care unbundling—different providers	1/2/04 - 12/30/05	0
Global surgical unbundling	1/2/04 - 12/30/05	0
High anesthesia units	7/1/04 - 12/30/05	257,050
Comprehensive code unbundling (professional services)	7/1/04 - 12/30/05	236,539
Medicare primary payer	7/1/04 - 12/30/05	61,388
Evaluation and management, multiple units of service	7/1/04 - 12/30/05	28,821
Professional services crossover claim duplicates	7/1/04 - 12/30/05	49,893
Total, Professional Services Algorithms		\$637,866
Institutional Claims Algorithms		
Comprehensive code unbundling (institutional)	7/1/04 - 3/31/06	\$151,520
Outpatient radiology overpayments	7/1/04 - 3/31/06	54,977
Outpatient surgical rate unbundling	7/1/04 - 3/31/06	0
Outpatient claims during inpatient stay	7/1/04 - 3/31/06	18,165
Institutional crossover claim duplicates	7/1/04 - 3/31/06	20,821
Total, Institutional Algorithms		\$245,483
TOTAL, ALL ALGORITHMS		\$883,349

Table 2 - HWT/SAO Findings – Pharmacy Claims

No.	Pharmacy Algorithms	Dollars identified	Estimated recovery @ 50/65 percent collection*	60 percent Federal share of recovery	40 percent State of Vermont share
1	Unreasonable Quantity*	\$315,639	\$157,820	\$94,692	\$63,128
2	Unreasonable Quantity (tablets and capsules only)*	\$1,131,831	\$565,916	\$339,550	\$226,366
3	Near Duplicates of Different Providers	\$37,417	\$24,321	\$14,593	\$9,728
4	Near Duplicates of Same Providers	\$364,021	\$236,614	\$141,968	\$94,646
5	Kit Billing Errors	\$49,212	\$31,988	\$19,193	\$12,795
6	Zithromax® Errors	\$33,996	\$22,097	\$13,258	\$8,839
7	Lovenox® Errors	\$109,823	\$71,385	\$42,831	\$28,554
8	Inhaler Errors	\$158,260	\$102,869	\$61,721	\$41,148
	Totals **	\$2,200,199	\$1,213,010	\$727,806	\$485,204

HWT's engagement with the SAO did not require it to participate in the validation of these results for the purpose of pursuing recoveries or implementing other cost containment activities. However, in two final reports issued by the SAO, it did make significant recommendations regarding how the HWT findings could be used to improve Vermont Medicaid's claims payment system and did recommend that the specific HWT findings be further evaluated for overpayment recovery.

In addition to its work for the SAO, HWT has extensive experience on helping state Medicaid programs recover overpayments related to fraud, waste, and abuse, illustrated below:

Table 3 – HWT Experience with State Medicaid Programs

State	Inappropriate Payments			Client Data Tools	Fraud	Payment Reviews	Specialty Data Matches	Drug Rebates
	Detection	Recovery	Prevention					
Alabama	✓	✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut	✓			✓		✓		
Florida	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓		✓	✓	✓	✓		
Kentucky	✓	✓	✓	✓	✓	✓	✓	
Maine	✓			✓		✓		
Missouri								✓
New Mexico	✓	✓	✓	✓	✓	✓		✓
New York	✓	✓	✓	✓	✓	✓		✓
Oklahoma	✓	✓			✓	✓		
Oregon	✓	✓	✓		✓	✓	✓	
Rhode Island	✓	✓				✓		
Texas						✓		
Washington	✓	✓	✓	✓	✓	✓	✓	✓
West Virginia	✓	✓	✓	✓	✓	✓	✓	✓
Wisconsin	✓	✓	✓			✓		✓

- **Detection of Inappropriate Payments.** HWT brings significant technological capacity to the analysis of Medicaid claims data, enabling the identification of random trending behaviors, spiking, multiple claim issuance, shared claims, geographically incongruous

claims, repeat billings, sequentially coded claims, code probing and a variety of other patterns of behavior which can result in excessive or inappropriately paid claims. By reviewing the entire potential universe of claims, patterns across provider types, service areas, individual providers or groups can be identified. The result is an impartial review of all providers and provider types, without the biasing effects of sampling, profiling, or other forms of selectivity, which limit the effectiveness and breadth of other marketplace solutions.

Client Results Achieved: In 2005, through the use of HWT's services, the States of Washington, Colorado, Alabama and West Virginia collectively identified over \$40 million in probable inappropriate provider payments. These inappropriate payments are currently in different stages of review, approval and recovery for each state.

- **Recovery of Inappropriate Payments.** HWT works collaboratively with our clients to design and manage a highly customized recovery process. These services are typically designed to deliver a fully outsourced solution that minimizes a client's time and resources, and include:
 - Notification Process — the recovery process starts with a validated set of overpayment findings, usually generated by HWT's Detection process (see above). HWT generates letters to identified providers, presenting an itemized statement with details on each claim that was inappropriately paid. The itemized statement allows a provider ample opportunity to review individual claims, refer to the explanation of findings on the policy at issue and determine the financial obligation. Working with HWT and leveraging our "what works best" experience, our clients have final say on all written provider communications and each client's specific dispute and escalation procedures are included in the letter.
 - Responding to Inquiries — HWT provides friendly, real time customer service to respond to all requests and communications that occur in response to the letters, as quickly and professionally as possible. Every letter includes a client-specific toll free number for the HWT Provider Help Line. When a provider has an issue to contest or questions about the letter, they can call this number and speak directly to a HWT recovery specialist who, through HWT's recovery management tool iQRMS™, has instantaneous access to the provider's detailed case file.

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- Tracking Recoveries — HWT offers iQRMS™, a web-based recovery tool that allows users to track, manage, measure and report on all stages of collection during the recovery process. With iQRMS™, users have real time access to a provider's billing history, which makes communications with the provider community far more likely to lead to positive resolution. For each provider collection requested, iQRMS™ opens a "case" that contains all necessary provider and recipient data. The case also includes the actual questionable claims lines sent to the provider, so that level of detail can be reviewed and discussed, if necessary. iQRMS™ allows for the capture of notes from provider discussions, as well as contact names and phone numbers to be recorded with the case. Each time a case is accessed, the status can be updated allowing each case to be tracked from the first provider contact through the collection of recovery dollars and case closure. iQRMS™ is deployed to Program Integrity staff to provide a transparent view into the case management process.
 - Managing Collections — HWT offers different options for managing the actual collection of overpayment funds from providers, and customizes the most suitable set of processes and methods for each client. One approach is the creation of a secure lockbox remittance system at either HWT or the client's site. In the overpayment letters, providers are instructed whom to make their checks payable to and where to send them. The bank then provides HWT with a daily e-mail or FTP file of summary information on payments received and processed that HWT uses to update the information in its iQRMS™ system. If providers are unable to make the payment in full, the letters provide alternative methodologies such as the establishment of a payment plan.
 - Expert Testimony — HWT attempts to resolve all appeals through informal resolution. However, as required, HWT provides expert witness testimony to any entities who are conducting investigation or administrative hearings emanating from HWT's recovery work.

Client Results Achieved: In FY2005, the State of Colorado recovered \$3,945,404 from inappropriate payments identified and recovered by HWT. Key areas for recoveries included hospital readmissions, various pharmacy billing & quantity errors and DRG unbundling.

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- **Prevention of Inappropriate Payments.** HWT's detection programs identify vulnerabilities in the upstream billing instructions and claims payment systems that cause these overpayments to be made. HWT provides recommended policy, procedure, and systems changes that can result in millions of dollars in future overpayment avoidance savings.
 - **Client Data Tools.** As part of its typical, contingency fee-based services, HWT provides necessary tools to make sure that our clients have the visibility to and reports on the activities that HWT is conducting on their behalf. The primary tool deployed for this purpose is iQRMS™, HWT's recovery case and accounting system, which tracks and reports on every instance of recovery that HWT initiates on its client's behalf. For several clients, including the States of Washington and West Virginia, HWT has leveraged its capabilities and the state's data it warehouses to extend additional data analysis, reporting and review capabilities – including ad-hoc query, budget analysis, SURS and MARS reporting and ad-hoc report creation and publishing.
 - **Fraud.** HWT provides a unique combination of data-supported investigative services that help state Medicaid programs and their affiliated partners in the pursuit of Medicaid fraud (i.e., the Attorney General Medicaid Fraud Control Units) rapidly identify and qualify suspected or probable instances of Medicaid fraud.
 - **Payment Reviews**. Leveraging HWT staff's unique expertise and experience in the combined review of claims payment data and supporting provider documentation, HWT has provided a range of payment review services for its clients. Among the areas it has worked include provision of nurse case review services for payment and eligibility error determination, secondary audit payment review of prior state contractors, MMIS transition auditing and provider documentation review in support of identified and suspected fraud, waste, abuse and overpayment situations.

Client Results Achieved: For FY2005, HWT completed a “turn-key” operation to help the State of West Virginia Children’s Health Insurance Program participate in the Federal Payment Error Rate Measurement (PERM) program. Submitting the first response received from any of the 25 participating programs and states in FY2005, West Virginia’s CHIP program achieved a payment error rate of 1.72 percent and an eligibility error rate of 0 percent.

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- **Specialty Data Matches.** Through its intensive work with and understanding of Medicaid paid claims and supporting data, HWT has facilitated and implemented specialty programs for its clients involving complex matching of multiple data fields, in order to determine eligibility and payment errors. Some examples of HWT's work include:
 - Assisting state clients with their participation in the federally sponsored Medi-Medi program, which examines a combined set of Medicare and Medicaid data for inappropriate payments that occur across the two programs' payment processes and systems).
 - Implementing a "fuzzy logic" data matching routine to find instances of payment errors and duplicate payments across a variety of Medicaid non-waiver and waiver programs, including certain non-Medicaid social services payment support programs.
 - Using state health statistics to make sure on a long term, ongoing basis that no payments are made for clients after their date of death.
 - Implementing a unique and comprehensive system to examine managed care encounters submitted in standard HIPAA formats against fee for service claims, to find payment errors and duplicates.
 - **Drug Rebates.** Leveraging its experience with Medicaid data and Medicaid pharmacy protocols, HWT has developed and currently provides an array of unique drug rebate recovery services that have proven highly successful to state Medicaid programs. Using a turn-key approach, implementing all end-to-end analyses and operational processes, HWT effects and provides for J-code rebate collections from both single and multiple sources. HWT also provides other comprehensive turn-key services related to the broader Medicaid Drug Rebate program.

Client Results Achieved: In 2005, the State of Florida initiated recovery of over \$13 million in previously unidentified j-code rebates. HWT identified both single and multi-source rebates, using a variety of techniques, including implementing a "look-back" analysis on rebates that had previously been invoiced by the state.

Cost Recovery Results

Successful collection of Medicaid accounts payable is a complex, multi-step process. It begins with a theory of where collections are suspected to exist, and then requires continuous scrutiny and human intervention to turn suspicions into recoverable collections.

In our experience, successful collections programs are a true relationship between HWT and its client. Great results in terms of collections recovered are the outcome of cooperation between HWT and the client organization, as there is work to do on both sides of the relationship.

The following chart illustrates financial savings for several of HWT’s other Medicaid clients:

Table 4 – State Financial Savings

State	Years Worked	Cost Savings (in millions)
Alabama	2004 – 2007	\$7.8
Colorado	2003 - 2007	\$15.5
Florida	2003 – Present	\$17.6
Kentucky	1998 – 2003	\$25.0
Missouri	2004 – 2006	\$3.5
New Mexico	2004 – Present	\$5.1
Oregon	2006 – Present	\$1.5
Washington	2000 – Present	\$40.0
West Virginia	2002 – Present	\$21.2
Wisconsin	2006 – Present	\$2.3

Our team-based approach stands in contrast to vendors who offer automated, lights-out, 100 percent software-based solutions that require little-to-no human intervention. These “drift-net” approaches focus mainly on detection, catching lots of “maybes,” but little that is verifiable or immediately actionable. In our experience, automation is one of many tools and approaches to use, and not the sole means to the intended end of actualized collections.

HWT’s approach to collections has yielded millions of dollars in results for our clients. Below is a summary of our work with the State of Colorado Medicaid Health Care Policy & Finance Department (HCPF) during their fiscal year 2004 (ended Oct 2005). This snapshot covers many mailings to Providers over the course of Colorado’s FY 2004, focusing on Pharmacy, Medical, Institutional, and other types of paid claims.

Table 5 – Colorado Summary

2004 Overpayments Identified	Revisions (from disputes, out of business, etc.)	Final Overpayment After Revisions	Collections To Date	Collections To Go (on-going)
\$8,401,145.98	\$2,778,236.18	\$5,622,909.80	\$5,403,720.91	\$219,188.89
State Fiscal Year Recovery Analysis				
Final overpayments as a % of initial identified				67%
Collections to date as a % of final overpayments				96%

In the chart above, “Overpayments Identified” indicates the full set of provider paid claims identified as *potential* overpayments via our algorithms. This number will shrink due to several factors including provider disputes, provider out of business, revisions due to policy changes, and so on. HWT offers a full-service case review and adjudication process that is staffed by trained healthcare professionals (RNs, Certified CPT coders) to resolve provider disputes in a fair and timely manner. “Final Overpayment” is the amount of dollars valid for collection after revisions. “Collections To Date” is the amount of dollars actually recovered as of the date of this analysis (November 2005). While collections are an on-going process, typically we recover 85 percent of collectable overpayments within the first six months following the mailing of overpayment identification letters.

In the chart below, four different algorithms are outlined that were a part of Colorado’s recoveries in fiscal 2004. From dozens of algorithms run during the year, these examples illustrate the nature and focus of our analyses, and their “yield” (dollars recovered divided by dollars identified). It is typical for HWT and its state client to focus on different medical claim types seasonally throughout the year. For example, pharmacy claims in Q1, physician claims in Q2, and so on.

Table 6 – Colorado Algorithms

Specific Algo Recovery Analysis					
Medical Area of Investigation	Algo Number	Name	Dollars Identified	Dollars Recovered	Dollar Yield (Recovered/Identified)
Hospital	HS024	DRG Readmissions	\$3,081,736.88	\$2,462,190.01	80%
Medical	CC002	Mutually Exclusive Procedure Codes	\$175,776.23	\$172,463.14	98%
Medical	P0012	Multiple Evaluation & Management Codes	\$128,190.91	\$103,286.87	81%
Pharmacy	R0015	Near Duplicate Claims	\$112,025.10	\$82,928.31	74%

Medicaid Laws, Rules and Policies

In order for HWT to confidently provide results that will produce the most efficient return, HWT must thoroughly understand the current environment through policy and procedure review. HWT's trained expert staff has broad, in-depth knowledge of federal and state mandates governing Medicaid services, especially as they pertain to the payments to providers for services and the identification and recovery of overpayments. HWT staff consists of public policy experts who have developed policy for and provided legal counsel to state Medicaid agencies. A number of HWT staff members are former employees of state Medicaid agencies. Their experience and diverse backgrounds in operational aspects of healthcare delivery and third-party payer, managed care, and fee-for-service payment systems in both the public and private sectors allows for a multi-disciplinary approach to analysis and discovery.

HWT policy review staff will conduct a thorough and careful review of all relevant laws, regulations and policies pertaining to claims payments and cost recoveries. Reviews will consist of provider accounts payable, including reimbursement policies, billing instructions, existing/historic claims processing edits and audits, and explanation of benefit (EOB) messages, as well as all federal requirements and guidelines related to Medicaid services and reimbursements and other federal state findings related to these areas. This review is a standard part of HWT's implementation process because HWT understands, based upon its experience working in other states, that in order to be successful, any cost recovery program must be predicated on a detailed understanding of the local landscape and policy based enforcement.

Areas of Related HWT Experience

The following sections detail HWT's experience in a number of areas closely related to the core provider review audit activities that OVHA is seeking to procure. Each section details an area of HWT's experience that highlights the breadth of our experience in healthcare provider reviews, and in some cases, highlights other areas where OVHA may be interested in additional provider review activities outside of the "core" areas identified (hospital, nursing home and pharmacy).

Medicare/Medicaid Specialty Data Matching and Recoveries

HWT understands that the high health care costs of the dually eligible mandates the highest level of payment accuracy in purchasing services. The coordination of benefits between the two programs is a demanding challenge for the states, specifically because the level of effort and time involved in obtaining appropriate data sets and conducting the cross-matching overpayment analysis is enormous. HWT has several different successful client experiences, which have collectively contributed to HWT's extensive knowledge of Medicare and Medicaid coordination of payment and overpayment issues, as described below.

Dual-Eligible Overpayment Recovery

HWT's core Medicare identification, billing and recovery program reduces Medicaid's liability by identifying and recovery Medicaid payments associated with dually eligible Medicare and Medicaid beneficiaries. By examining the State of Washington's Medicaid and Medicare enrollment files, payments, adjustments, voids and the Medicaid agency's initiated claims, HWT constructs the population of dually eligible Medicare and Medicaid beneficiaries, identifies the Medicaid payments associated with periods of Medicare benefits, and recovers payments on the state's behalf

By processing data independently of the state's MMIS and by using supplemental data sources, HWT provides a vital safety net for identifying recovery opportunities that the state might miss during the complex recovery process. HWT has a proven track record recovering not only traditional services, such as inpatient hospital stays, but also non-traditional Part B services frequently mis-billed by providers such as:

- Immunosuppressive drugs.
- Oral anti-cancer drugs.
- Diabetic testing supplies.
- Nebulizer drugs.
- Blood clotting factors.
- Procrit.
- Durable medical equipment.

To begin the process, HWT met with the state to:

- Review the project work plan and schedule.
- Complete project liaison protocols.
- Define appropriate charges to Medicaid.
- Finalize overpayment notice(s) to providers.
- Receive additional guidance and technical documentation.

HWT then worked with the state to secure the data necessary to implement this initiative, including Medicaid paid claims; provider files; recipient eligibility files; diagnosis, procedure code and drug code files; and the Medicare eligibility database (EDB).

After the data was acquired, HWT applied a series of specific algorithms designed to identify at the claim level claims for dual eligible persons that should have been paid by Medicare instead of Medicaid. The results of the algorithms were presented to the State of Washington and were reviewed and validated. The State of Washington then executed a mailing to affected providers to requested repayment of the overpayment. HWT assisted in this process by leveraging its provider relations call center capability to be the “first line” for resolving inquires by providers on the mailing.

HWT has implemented this program in the State of Washington for the past 4.5 years and has been able to successfully identify Medicare coverage and recover more than \$8.8 million Medicaid payments from Medicare.

Medi-Medi Program Participation

In addition to the recoveries described above, for the past year HWT has been the data source for the State of Washington’s participation in the Medi-Medi project. In this role HWT has had to the opportunity to design the data structure and layout that will be used in that project. Medi-Medi is a federally sponsored initiative that allows sharing of data between several states and Medicare for the purpose of finding inappropriate payments to providers participating in both programs.

Participation in Medi-Medi gives HWT a unique opportunity to develop new methodologies for finding overpayments by dual eligibles by actually querying claims across both the Medicaid

and Medicare payment systems. Tried and true HWT algorithms, including algorithms that look for duplicate claims and “time bandits” (providers who bill excessive numbers of claims on a daily basis), will be enhanced by the ability to query across a broader group of claims. The ability to compare billing patterns of providers who participate in both programs and analyze what the incentive may be to bill Medicare differently than Medicaid, will give valuable insight into new algorithms and potential cost avoidance opportunities.

To-date HWT has worked with Washington and CMS to structure a data warehouse suitable for the purposes of this program. HWT has supplied the warehouse with three years of paid claims (and ancillary provider and recipient information). HWT supplies updates to this data on monthly basis.

Other Health Insurance and Financing Programs

In addition to the review activities performed in other areas of interest, HWT has pursued working with other state sponsored health insurance and financing programs as a means of increasing our knowledge of billing errors, fraud, waste and abuse. HWT has worked with other state health insurance programs such as the Children’s Health Insurance Program, Worker’s Compensation Commission and Public Employees Insurance Agency in West Virginia and the Social Service Payment System in Washington State. Below is a brief summary of our experience with each of these payers.

- **Social Service Payment System (SSPS)**. The SSPS system in Washington is used to pay for services that facilitate employment by providing day care services, mileage reimbursement, etc.; increase independence of the elderly and disabled by providing in-home care and residential services; and protect children by providing foster care and counseling services.

More than \$1 billion dollars is paid each year to the more than 83,000 providers who deliver services to more than 185,000 recipients. During fiscal year 2005, HWT was able to identify and begin collections on more than \$1.1 million dollars in inappropriate payments to SSPS providers. Areas the algorithms targeted include:

- Use of mutually exclusive codes for bed holds with non bed hold codes.
- Infant bonus payments exceeding allowed limits.

-
- Services provided after a recipient's death.
 - Duplicate authorizations for residential services.
 - Wrong rates being paid to providers based on child's age and region.
- **State of West Virginia, Workers Compensation Commission (WCC).** HWT constructed a data warehouse with three years of paid claims data for the State of West Virginia's Workers' Compensation Commission, which is the single entity providing workers' compensation insurance to all businesses in the state. Workers' compensation staff has access to canned and ad hoc queries to access data for analysis and review. In addition, HWT conducted post payment review of paid claims and collected overpayment recoveries of more than \$2 million. Algorithms targeted areas such as the multiple surgery rule, medical causality and physical therapy modalities.
 - **State of West Virginia, Public Employee Insurance Agency (PEIA).** Acordia, a third party processing system, processes all PEIA claims for payment. HWT conducted post payment review of paid claims and collected approximately \$390,000 in overpayment recoveries. Algorithms targeted areas such as non-covered professional services, unbundling of lab panels and inappropriate use of new patient codes.
 - **Payment Accuracy Measurement/Payment Error Rate Measurement (PAM/PERM).** West Virginia was one of 27 states awarded grants and participating in two of the four pilot test years of the PERM methodology. Through the competitive bid process, HWT won two one-year contracts with the West Virginia's Children's Health Insurance Program participating in the PAM and PERM Pilot. Providing the full scope of work, HWT developed the random sample within required confidence interval (the first participating year and as required by CMS the second year) and with highly trained and qualified staff performed all medical record review, recipient eligibility review and all quality assurance activities. HWT provided the state with the final calculation of payment error rate that was presented to and accepted by CMS.

Working with Large Agencies

HWT is fully aware of the complexities involved in identifying and recovering provider overpayments. HWT's awareness and experience is largely due to its extensive work with large public payers, including numerous state Medicaid programs.

Because its work is focused exclusively on large public payers, in particular state Medicaid programs, HWT has an excellent understanding of the complexities involved in operating a fraud, waste, abuse and overpayment detection and revenue recovery program for a Medicaid program. HWT understands that no two state agencies are alike and that the information and local expertise necessary for success is always dispersed within the organization across many internal business units. It is not enough to understand only policy or claims processing or program integrity. An effective program must understand all three and how they work in relationship to each other. For optimal success, HWT consults and works closely with agency staff responsible for:

- Program integrity.
- Traditional SURS.
- Provider audit.
- Provider relations.
- Claim processing.
- Policy development and implementation.
- Internal medical (e.g., the agency's medical director) and quality assurance staff.
- Claims processing and MMIS services.
- Rate setting.
- Fraud investigations, including MFCU.
- Financial recovery and accounting staff.

By pulling together the important stakeholders within the organization, HWT is able to develop a plan for revenue recovery that 1) is based on a complete understanding of the local landscape and all of its complexities; and 2) leverages the wealth of knowledge and expertise existing within the agency.

Included below are business references that demonstrate HWT's experience in the offered services. A particular case study of our experience working with a large agency can be found in detail in Section III – Work Statement.

References

HWT has an impressive portfolio of Medicaid programs with whom it has worked in the claims data analysis and post payment review consulting services over the past ten years. The nature of our work varies among our clients, ranging from building data warehouses, creating decision support systems to invoicing manufacturers on drug rebates.

HWT's wide range of services and flexibility allow clients to customize the services uniquely based on their goals intended of the scope of work. The quantity of work is specifically designed to each client as is the work performed. HWT does not base the quantity of work performed by the number of reviews conducted or the time frame of a contract, rather as the number of data analyses and successful algorithms applied to the state specific logic, the amount of overpayment identified, the number of mailings completed to collect the state approved overpayment and the actual dollars returned to the state coffers. Statistics provided in the following pages for the individual clients reflect this approach to "quantity."

Below are references for each of the clients for whom HWT currently performs services similar to what is being proposed to OVHA. We encourage the Office of Vermont Health Access to contact *any* of our current clients to obtain information on our work and results. We would also encourage OVHA to contact Ms. Linda Lambert at the SAO to gauge satisfaction with our prior work for the SAO (contact information below).

NAME OF ORGANIZATION	STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES			
DATES OF CONTRACT	2000 – Present			
PRIMARY CONTACT	MS. PAIGE WALL Payment Review Program Manager Town Square, Bldg. 1, 4 th Floor, MS: 45511 617 8 th Ave SE Olympia, WA 98504-0615 Phone: (360) 725-2117 Email: Wallpg@dshs.wa.gov			
EXTENT OF INTERACTION				
HWT and DSHS’s project teams meet twice each week to discuss and update the status of deliverables and any operational issues. In addition Drew Gattine, HWT’s Client Manager for this engagement and Paige Wall, PRP’s lead, meet weekly to discuss strategic issues.				
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$30MM COLLECTED, \$6MM PENDING COST SAVINGS & AVOIDANCE - \$7MM+			
SERVICE PROVIDED				
<ul style="list-style-type: none"> ▪ Payment Accuracy – Data based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations for provider relations, communications to effect recovery of claims overpayments. ▪ Medicaid Fraud Control Unit – Fraud Referrals ▪ Specialty Data Matches, including Medicaid/Medicare COB, Services After Death, Managed Care, Social Services/Medicaid COB ▪ J-Code Rebates – Single-Source & Multi-Source ▪ Data Warehouse & Decision Support Services for 450+ users 				
FRAUD & ABUSE DATA MINING TOOLS & SOFTWARE PROVIDED				
<table border="0"> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ▪ DSS – Decision Support System ▪ iQSafeguard (to create ad-hoc queries) ▪ iQRMS (Recovery Case Management System) ▪ iQAi (Artificial Intelligence) </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> ▪ iQCase (case management tool) ▪ iQSearch (search engine) ▪ iQPowerUser (direct database connection for advanced users) ▪ iQRebate (rebate collection management) </td> </tr> </table>			<ul style="list-style-type: none"> ▪ DSS – Decision Support System ▪ iQSafeguard (to create ad-hoc queries) ▪ iQRMS (Recovery Case Management System) ▪ iQAi (Artificial Intelligence) 	<ul style="list-style-type: none"> ▪ iQCase (case management tool) ▪ iQSearch (search engine) ▪ iQPowerUser (direct database connection for advanced users) ▪ iQRebate (rebate collection management)
<ul style="list-style-type: none"> ▪ DSS – Decision Support System ▪ iQSafeguard (to create ad-hoc queries) ▪ iQRMS (Recovery Case Management System) ▪ iQAi (Artificial Intelligence) 	<ul style="list-style-type: none"> ▪ iQCase (case management tool) ▪ iQSearch (search engine) ▪ iQPowerUser (direct database connection for advanced users) ▪ iQRebate (rebate collection management) 			
QUANTITY OF WORK PERFORMED TO DATE - based on the total amount of overpayment identified				
MEDICAL	\$5,200,000			
INSTITUTIONAL	\$17,000,000			
PHARMACY	\$28,000,000			
TOTAL	\$50,200,000			

NAME OF ORGANIZATION	STATE OF COLORADO DEPARTMENT OF HEALTHCARE POLICY & FINANCING
DATES OF CONTRACT	2002 – Present
PRIMARY CONTACT	Ms. NANCY DOWNES Program Integrity Reviewer State of Colorado 1570 Grant Street Denver, CO 80203-1818 Phone: (303) 866-5421 Email: nancy.downes@state.co.us
EXTENT OF INTERACTION	Ms. Mohan serves as the primary management liaison between HWT and the State of Colorado Department of Healthcare Policy and Financing. She works cooperatively with HWT to plan overpayment recovery activities and facilitate resolution of provider appeals.
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$ 15MM COLLECTED, \$6MM PENDING COST SAVINGS & AVOIDANCE - \$5MM+
SERVICE PROVIDED	<ul style="list-style-type: none"> ▪ Payment Accuracy – Data based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations to effect recovery of claims overpayments. ▪ Medicaid Fraud Control Unit – Fraud Referrals ▪ J-Code Rebates – Single-Source & Multi-Source
FRAUD & ABUSE DATA MINING TOOL & SOFTWARE PROVIDED	<ul style="list-style-type: none"> ▪ iQRMS (Recovery Case Management System) ▪ iQRbate (rebate collection management)
QUANTITY OF WORK PERFORMED TO DATE - based on the total amount of overpayment identified	
MEDICAL	\$7,800,000
INSTITUTIONAL	\$4,600,000
PHARMACY	\$16,700,000
TOTAL	\$29,100,000

NAME OF ORGANIZATION	STATE OF NEW MEXICO NEW MEXICO HUMAN SERVICES DEPARTMENT
DATES OF CONTRACT	2004- Present
PRIMARY CONTACT	MR. EVERET APODACA New Mexico Project Liaison New Mexico Human Services Department 2025 S. Pacheco Santa Fe, New Mexico 87505 Phone: (505) 827-3195 Email: everet.apodaca@state.nm.us
EXTENT OF INTERACTION	Mr. Onstott serves as the primary management liaison between HWT and the New Mexico Human Services Department. He oversees HWT's overpayment recovery activities and facilitates HWT's access to subject matter experts within the Human Services Department.
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$2.6MM COLLECTED, \$3MM+ PENDING
SERVICE PROVIDED	<ul style="list-style-type: none"> ▪ Medicaid Fraud Control Unit – Fraud Referrals ▪ J-Code Rebates – Single-Source & Multi-Source ▪ Payment Accuracy – Data based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations to effect recovery of claims overpayments.
FRAUD & ABUSE DATA MINING TOOLS & SOFTWARE PROVIDED	<ul style="list-style-type: none"> ▪ iQRMS (Recovery Case Management System) ▪ iQRbate (rebate collection management)
QUANTITY OF WORK PERFORMED TO DATE - based on the total amount of overpayment identified	
MEDICAL	\$800,000
INSTITUTIONAL	\$1,800,000
PHARMACY	\$3,500,000
TOTAL	\$6,100,000

NAME OF ORGANIZATION	STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
DATES OF CONTRACT	2002 – Present
PRIMARY CONTACT	Ms. JEANNE CRESS Director Room 251 350 Capital Street Charleston, WV 25301 Phone: (304) 558-6005 Email: jeannecress@wvdhhr.org
EXTENT OF INTERACTION	Ms. Cress serves as the primary management liaison between HWT and the West Virginia Department of Health and Human Resources. She oversees HWT's overpayment recovery activities and facilitates HWT's access to subject matter experts within the Department of Health and Human Resources.
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$19MM COLLECTED, \$6MM PENDING COST SAVINGS & AVOIDANCE - \$3MM+
SERVICE PROVIDED	<ul style="list-style-type: none"> ▪ Payment Accuracy – Data based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations for provider relations, communications to effect recovery of claims overpayments. ▪ Medicaid Fraud Control Unit – Fraud Referrals ▪ J-Code Rebates – Single-Source & Multi-Source
FRAUD & ABUSE DATA MINING TOOLS & SOFTWARE PROVIDED	<ul style="list-style-type: none"> ▪ iQRMS (Recovery Case Management System) ▪ iQSafeguard (to create ad-hoc queries) ▪ iQRebate (rebate collection management)
QUANTITY OF WORK PERFORMED TO DATE - based on the total amount of overpayment identified	
MEDICAL	\$8,800,000
INSTITUTIONAL	\$10,600,000
PHARMACY	\$13,000,000
TOTAL	\$32,400,000

NAME OF ORGANIZATION	STATE OF OREGON DEPARTMENT OF HUMAN SERVICES
DATES OF CONTRACT	2004 – Present
PRIMARY CONTACT	MR. PAT YOUNG MANAGER, PROVIDER SERVICES SECTION OFFICE OF PAYMENT ACCURACY AND RECOVERY 2575 BITTERN STREET NE SALEM, OR 97309 Phone: 503-947-4288 Email: pat.j.young@state.or.us
EXTENT OF INTERACTION Mr. Young serves as the primary management liaison between HWT and the Oregon Department of Health Services. He oversees HWT's overpayment recovery activities and facilitates HWT's access to subject matter experts within the Department of Health Services.	
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$1.4MM COLLECTED, \$500K PENDING
SERVICE PROVIDED <ul style="list-style-type: none"> ▪ Payment Accuracy – Data-based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations for provider relations, communications to effect recovery of claims overpayments. ▪ Medicaid Fraud Control Unit – Fraud Referrals 	
FRAUD & ABUSE DATA MINING TOOLS & SOFTWARE PROVIDED <ul style="list-style-type: none"> ▪ iQRMS (Recovery Case Management System) 	
QUANTITY OF WORK PERFORMED TO DATE – based on the total amount of overpayment identified	
MEDICAL	\$1,600,000
INSTITUTIONAL	\$350,000
PHARMACY	\$430,000
TOTAL	\$2,380,000

NAME OF ORGANIZATION	STATE OF WISCONSIN DEPARTMENT OF HEALTH & FAMILY SERVICES
DATES OF CONTRACT	2006 – Present
PRIMARY CONTACT	MR. ALAN WHITE DIRECTOR, BUREAU OF HEALTH CARE PROGRAM INTEGRITY 1 W. WILSON STREET P.O BOX 309 MADISON, WI 53701 Phone: (608) 266-7436 Email: whiteas@dhfs.state.wi.us
EXTENT OF INTERACTION Mr. White serves as the primary management liaison between HWT and the Wisconsin Department of Health and Family Services. He oversees HWT's overpayment recovery activities and facilitates HWT's access to subject matter experts within the Department of Health and Family Services.	
FINANCIAL IMPACT TO DATE	REVENUE RECOVERIES – \$1.8MM COLLECTED, \$1MM PENDING
SERVICE PROVIDED <ul style="list-style-type: none"> ▪ Payment Accuracy – Data-based identification of overpayments, fraud, waste, and abuse. ▪ Overpayment Recovery – “Turn-key” operations for provider relations, communications to effect recovery of claims overpayments. ▪ Medicaid Fraud Control Unit – Fraud Referrals ▪ J-Code Rebates – Single-Source & Multi-Source 	
FRAUD & ABUSE DATA MINING TOOLS & SOFTWARE PROVIDED <ul style="list-style-type: none"> ▪ iQRMS (Recovery Case Management System) ▪ iQRbate (rebate collection management) 	
QUANTITY OF WORK PERFORMED TO DATE – based on the total amount of overpayment identified	
MEDICAL	\$1,250,000
INSTITUTIONAL	--
PHARMACY	\$2,000,000
TOTAL	\$3,250,000

NAME OF ORGANIZATION	STATE OF VERMONT OFFICE OF THE STATE AUDITOR
DATES OF CONTRACT	May 2006 – December 2006
PRIMARY CONTACT	Ms. LINDA LAMBERT DIRECTOR, INFORMATION TECHNOLOGY AUDIT VERMONT STATE AUDITOR'S OFFICE 132 STATE STREET MONTPELIER, VT 05633 Phone: (802) 828-0796 Email: Linda.Lambert@state.vt.us
EXTENT OF INTERACTION	Ms. Lambert was the primary management liaison between HWT and the Office of the State Auditor. She oversaw HWT's data mining activities and facilitated HWT's access to subject matter experts within the Office of the State Auditor and the Office of Vermont Health Access.
SERVICE PROVIDED	Perform data mining activities on paid claims to identify and describe possible improper payments. Analyses were focused on specific areas including: pharmacy, hospital outpatient services, psychology, Durable Medical Equipment (DME), and Home & Community-Based Waivers.
RESULTS OF ACTIVITIES	REVENUE RECOVERIES – IDENTIFIED NEARLY \$900,000 IN POTENTIAL OVERPAYMENTS

II-F Contractor Organization and Staffing

HWT is committing a highly experienced team of experts to provide revenue recovery services to OVHA. HWT's team will include a contract manager, subject matter experts (including physicians and pharmacists), technical developers, database administrators, registered nurses, licensed practical nurses, certified billing and coding specialists and technical developers, all of whom are dedicated to providing for the success of OVHA's overpayment recovery initiatives.

As a previous vendor of the State of Vermont, State Auditor's Office, HWT personnel have experience analyzing OVHA data for the purpose of identifying overpayments. As such, HWT comes to the table with significant knowledge regarding OVHA's policies, practices, and preferences pertaining to post-payment claims review services.

The design of the team proposed offer the complement of skills and experience required to successfully complete this project. The structure was organized this way to provide management efficiency and operational accountability throughout the project.

In providing services to its clients, HWT uses a flexible, team-based approach. Maureen Custodio is the designated Contract Manager for OVHA, responsible for the day-to-day supervision and coordinating the timely delivery of high-quality post-payment claims review services. Maureen Custodio will be available to OVHA personnel between the hours of 8 a.m. to 5 p.m., Eastern Time, located at the Chicago office at 333 S. Des Plaines Street, Chicago, IL 60661 and can be reached at 207-523-1011.

HWT will also assign an Executive Project Advisor to provide support and make sure that the project implementation occurs on schedule and in accordance with OVHA requirements. As the Project Advisor, Drew Gattine is a Subject Matter Expert who has extensive experience and expertise in the proposed projects. He will provide ongoing strategic guidance and mentoring to the team. Drew is the enterprise-wide client relations lead for HWT and has overseen all of HWT's successful projects since HWT was founded 1998.

Under Maureen Custodio's direction, HWT personnel will be deployed in various capacities to meet the defined OVHA objectives. For example, HWT's database administrators will make

sure that data are acquired and maintained; HWT developers will execute data mining activities through the use of existing or newly developed algorithms; and HWT provider relations personnel will facilitate letter generation, provider support, and overpayment collection activities.

The Identification Team, Data Operations and Recovery Team bring specific experience to the project areas they manage. They will lead the design and execution of the work plan efficiently coordinating the functions of the project across the entire team. The team will also have analysts and a Medical Director to support and provide the details needed to fully execute the project. This team has complimentary skills and knowledge that has resulted in successful engagements working together. Please refer to Appendix B for examples of resumes of team members.

II-G Technology Requirements

(This section is proprietary and confidential)

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II-H Methodology and Approach

Bidders will be scored, in part, on the methodology and approach proposed in the bid. Be as specific as possible in addressing all of the elements described in each section within Section III, Work Statement, of this RFP. Bidders should include a proposed implementation time line following execution of a contract within the proposal submitted.

Please refer to the response to Section III – Work Statement.

SECTION III - Work Statement

III-A Bidder Response to RFP

HWT understands that like all health insurance programs, Vermont Medicaid has experienced rapid increased in expenditures in recent years, which makes extensive and continuous auditing of paid claims an important function for maintaining the integrity of the program.

In 2007 the Office of the State Auditor contracted with HWT to conduct a limited review of paid claims for an 18-month period ending December 31, 2005. In fulfilling the scope of work for its project with the SAO HWT gained invaluable experience and understanding of the OVHA claims payment environment, the claims data itself and of OVHA's payment rules and policies. Using that experience, HWT is well situated to design and implement a successful and robust post payment review program working directly with OVHA. HWT will be able to leverage its experience working with the SAO so that implementation of work under a contract with OVHA is done quickly and effectively and hence achieve maximum effectiveness.

III-B General Requirements

Through its work with more than 20 state Medicaid programs over ten years, HWT has gained an unparalleled level of experience in the detection of Medicaid payment errors due to waste, abuse and fraud. Combining that experience with unique methods and processes for working with Medicaid providers to recovery inappropriate payments, HWT has delivered over \$250 million in recovered revenues and prevention-oriented cost avoidances to its Medicaid clients. The following sections provide more detail on the depth of HWT's experience.

The key elements of HWT's approach and the factors that distinguish it from other vendors include:

- **Experience-Based Policy & Rules Review.** HWT subject matter experts (SMEs) regularly conduct complete and thorough reviews of all critical claims payment information, including reimbursement policies, billing instructions, existing/historic claims processing edits and audits, and explanation of benefit (EOB) messages, as well as all

federal requirements and guidelines related to Medicaid services and reimbursements and other federal agency findings related to these areas (for example, HHS OIG reports). HWT's SMEs have extensive payer experience in Medicaid policy and procedures, claims processing, reimbursement policy analysis, provider relations and third party liability. In addition, these experts are experienced in operational aspects of healthcare delivery and third-party payer, managed care, and fee-for-service payment systems in both the public and private sectors. The diversity of backgrounds allows for a multi-disciplinary approach to analysis and discovery.

- **Customized Program**. HWT provides a full range of fraud, waste, abuse and overpayment identification and collection tools, along with flexibility with respect to project implementation. We offer pre-existing detection algorithms from a proprietary library of hundreds of algorithms. The library, which is continually updated and modified, reduces the time and investment needed to identify and recover overpayments. We will also work with OVHA's in-house subject matter experts to develop "Vermont specific" algorithms and models tailored to specific payment rules and priorities expressed by OVHA.
- **Accelerated Knowledge Transfer, Experience from Other States**. HWT's past and current work with other states' Medicaid programs has been codified in our proprietary algorithm and analysis library, which we use to "jumpstart" provider reviews in every new client program. Ongoing, HWT rapidly shares and transfers the best and most successful recovery approaches between and among its Medicaid clients, while also assisting them in establishing and maintaining highly productive and successful dialogues among peers in different states.
- **Provider and Other Relationship Management Activities**. As an integral part of its solutions and a key to achieving actual overpayment recoveries, HWT is able to deliver practical solutions for managing relationships with providers and provider associations, legislatures, and the public. HWT staff are also experienced in working with law enforcement agencies, including the State's Attorney General, U.S. Attorneys, the Office of the Inspector General, the Justice State and Medicaid Fraud Control and Surveillance and Utilization Review Units.
- **Highly Experienced Staff**. HWT has assembled a staff of professionals with extensive experience at all levels in public and private payer systems. The team includes

physicians, attorneys, consultants, analysts, nurses, systems administrators, programmers and policy and reimbursement experts, so HWT has the technical, subject matter and project management expertise to successfully meet the requirements of this RFP. Additional evidence of the depth of experience can be seen in the sample resumes of the members of the proposed HWT team.

HWT Experience in Claims Data Analysis & Post Payment Review Consulting Services

Breadth of Experience

For ten years, HWT has focused all of its resources on helping state Medicaid programs use paid claims and other supporting data to identify, recover and prevent inappropriate payments, fraud, waste and abuse, and to develop other data-intensive initiatives to access and use Medicaid data for a variety of other program purposes.

Our breadth of general experience in medical provider reviews for Medicaid programs includes:

- **Revenue Recovery**. HWT's large-scale data analysis uncovers millions in inappropriate payments that are recoverable. OVHA will receive detailed reports on the scope of audit findings and present actionable recommendations for recovery of overpayment from HWT's analysis of data. Initially, HWT proposes to stage its work so that the project focuses on recoveries from what is considered waste - provider billing errors that pass through systems edits and audits. This will allow OVHA to rapidly recover overpayment that providers rarely dispute – providers may disagree with the policy underlying the recoveries; however, they cannot disagree that a payment and billing error has been made. HWT can then increase the scope of its analysis, to include audit suspects (cases requiring desk or on-site audit to gain further information), and legal suspects (cases where criminal intent is suspected).

HWT also proposes that its approach to the project will allow OVHA staff to work much more efficiently, initiate more audit cases and recover more funds. Not only do HWT's service and tools allow for much easier access to and analysis of the claims data, but HWT's whole approach will enable OVHA staff to examine much broader sets of data for potential overpayments in a highly efficient, productive manner.

- **Cost Reduction.** Because HWT deploys a comprehensive, end-to-end solution for identifying and collecting inappropriate payments, our work will help OVHA reduce costs by managing the increased administrative burdens that detection and recovery efforts can place on OVHA staff. In addition, it is our experience that HWT's approach results in a myriad of other unanticipated but measurable cost reductions from the dramatically improved "business efficiencies" that are introduced through or encouraged by the program.

Such efficiencies can include but aren't limited to:

- Increased provider compliance with proper claiming procedures (because they know better monitoring is in place – the “sentinel effect”).
 - Improved program policies that highlight areas in current policy that need further clarity to provide for appropriate compliance and expenditures.
 - More efficient and faster data-driven answers to questions on areas of program spending and quality that may arise from internal or external (recipients, legislators, Governor's staff) sources.
- **Cost Avoidance.** Through the post-payment review of actual claims paid, HWT's detection programs identify vulnerabilities in the upstream billing instructions and claims payment systems that cause these overpayments to be made. HWT provides recommended policy, procedure, and systems changes that can result in millions of dollars in future overpayment avoidance savings.

The following chart illustrates financial savings for several of HWT’s other Medicaid clients:

Table 4 – State Financial Savings

State	Years Worked	Cost Savings (in millions)
Alabama	2004 – 2007	\$7.8
Colorado	2003 - 2007	\$15.5
Florida	2003 – Present	\$17.6
Kentucky	1998 – 2003	\$25.0
Missouri	2004 – 2006	\$3.5
New Mexico	2004 – Present	\$5.1

State	Years Worked	Cost Savings (in millions)
Oregon	2006 – Present	\$1.5
Washington	2000 – Present	\$40.0
West Virginia	2002 – Present	\$21.2
Wisconsin	2006 – Present	\$2.3

Our team-based approach stands in contrast to vendors who offer automated, lights-out, 100 percent software-based solutions that require little-to-no human intervention. These “drift-net” approaches focus mainly on detection, catching lots of “maybes”, but little that is verifiable or immediately actionable. In our experience, automation is one of many tools and approaches to use, and not the sole means to the intended end of actualized collections.

Medicaid Laws, Rules and Policies

In order for HWT to confidently provide results that will produce the most efficient return, HWT must thoroughly understand the current environment through policy and procedure review. HWT policy review staff will conduct a thorough and careful review of all relevant laws, regulations and policies pertaining to claims payments and cost recoveries. Reviews will consist of provider accounts payable, including reimbursement policies, billing instructions, existing/historic claims processing edits and audits, and explanation of benefit (EOB) messages, as well as all federal requirements and guidelines related to Medicaid services and reimbursements and other federal state findings related to these areas.

Working with Large Agencies

HWT is fully aware of the complexities involved in identifying and recovering provider overpayments. HWT’s awareness and experience is largely due to its extensive work with large public payers, including numerous state Medicaid programs. HWT understands that no two state agencies are alike and that the information and local expertise necessary for success is always dispersed within the organization across many internal business units. It is not enough to understand only policy or claims processing or program integrity. An effective program must understand all three and how they work in relationship to each other. To ensure optimal success, HWT consults and works closely with all divisions of the agency staff, from traditional SURS, claims processing, policy development to rate

setting and financial recovery and accounting staff. Of particular interest, one example of HWT's work with large agencies is described in detail below.

Washington Project Overview

During the course of its seven year engagement with the State of Washington, HWT has successfully brought together various key stakeholders throughout the organization for the purpose of optimizing successful detection and recovery efforts.

On April 1, 2000, HWT commenced work with the Department of Social and Health Services (DSHS) in Washington State, providing a full-scale overpayment detection system. DSHS has recently renewed this contract for an additional period of 42 months (through December 31, 2008). The goals of this project are:

- Identify and seek recovery on Medicaid and SSPS (social service) claims that have been overpaid using HWT's library of proprietary algorithms.
- Deliver actionable leads to fraud investigators and auditors using HWT's advanced models.
- Provide over 450+ investigators, auditors and MFCU staff desktop access to a decision support system (DSS) containing over seven years of MMIS data and six years of SSPS data maintained by HWT in a specially constructed data warehouse designed to be queried for fraud, waste and abuse.
- Supplement the state's drug rebate program but identifying single and multi-source pharmacy products for which the state may seek rebates.
- Enhance the state's TPL program by identifying claims paid by Medicaid that should have been paid by Medicare and seeking recoveries of payment for those claims from providers (primarily hospitals, physicians and pharmacies).
- Identify and facilitate implementation of cost avoidance opportunities, including policy changes, system edits and audits and appropriate modifications in provider fee schedules.

HWT goals to exceed the state's expectation has resulted to saving DSHS over \$34 million including rebate recoveries and documented cost avoidances. DSHS measures recoveries based upon dollars actually collected (not only on amounts identified) using HWT's algorithms. This amount does not include the million of dollars in recoveries

obtained by auditors and investigators using the results of HWT's models, results derived directly from queries run by users against the DSS or restitution and judgments obtained by MFCU using HWT results. HWT algorithms have resulted in collections from a broad range of provider types include but not limited to:

- Hospitals (both inpatient and outpatient claims).
- Physicians (both individual and large practice groups).
- Pharmacies (individual providers and large national chains).
- DME and medical supply providers (including oxygen providers).
- Dentists.
- Rural health centers.
- Laboratories (free standing and facility-based).
- Managed care providers.
- Radiology.

In addition to the results described above, HWT has delivered 25 advanced models using its iQAI product designed to give investigator, auditors and criminal prosecutors the tools they need to find fraud. Each of these models focuses on a different provider area (i.e., pharmacy, physician, hospital) or potential "scheme" (i.e., pharmacy claims for nursing home clients, over-utilization of home-based services). These models are designed to unearth billing patterns and other provider activities that cannot be seen using linear queries.

Using both the MMIS claims data, as well as eligibility information obtained directly from CMS, HWT has been able to refer to collection \$9.3 million in claims that should have been paid by Medicare. This includes \$4.2 million in expensive inpatient hospital claims as well as \$3 million in claims by pharmacies for expensive transplant-related drugs.

Over 450 Washington users have desktop access to over seven years of MMIS and six years of SSPS data. Data is updated on a weekly basis. Auditors, investigators, prosecutors and other program staff use a variety of HWT's desktop applications to mine the data for actionable overpayments, abuse and fraud. HWT also provides several DSHS "power users" direct access to the data warehouse using standard developer tools such as PL/SQL. DSHS users also use the system for a variety of other program support

functions such as rate-setting, policy analysis, budgeting and quality of care analysis. Although undoubtedly significant, DSHS does not measure the financial benefit of the DSS for the purposes of evaluating HWT's performance under this contract.

It is important to note that the documented recoveries achieved annually under this contract far exceed the fee paid by DSHS to HWT. In essence, DSHS receives a return on investment of greater than 2:1 as measured solely by the benefit of HWT's algorithms yet also receives the additional benefit of the advanced models and a DSS that supports the work of over 450 people.

HWT's success in Washington is in many ways attributable to HWT's ability to forge strong working relationships across the broad Medicaid agency. In Washington, HWT has implemented a number of successful protocols:

- Executive Steering Committee. On a quarterly basis, HWT participates in a meeting of DSHS executive leadership chartered with overseeing and directing HWT's recovery efforts.
- Algorithm Workshops. On a regular basis, HWT facilitates workshops that bring together in one room all relevant stakeholders and local experts for the purpose of discussing particular recovery efforts and algorithms. These workshops provide an opportunity for HWT to present its own ideas and initiatives it has used in other states for the purpose of determining whether they would be feasible in Washington. They also provide an excellent opportunity for state staff to bring forward ideas they have for discussion with the larger group including peers with whom they may not often meet.
- Algorithm Core Group. On a weekly basis HWT coordinates a conference call to report on the progress of on-going recovery efforts and discuss where the focus of these efforts should be.
- Weekly Algorithm Call. HWT facilitates a weekly call with its primary client contacts to discuss in significant detail each particular recovery initiative. These initiatives are formally tracked and reported on.
- Subject Matter Expert (SME) Meetings. When an algorithm is developed or deployed for the first time it receives internal scrutiny by a particularized group of internal subject matter experts.

Projected Timeline

Over the course of the three-year contract, HWT will maintain a data warehouse, implement claims data analyses (mutually agreed upon algorithm and model results) and provide the state with recommendations based on the findings. Below is a brief description of the expected milestones:

- **Acquire Data.** HWT will be able to leverage the experience it gained working with the OVHA claims data during its project with the OSA. This will give HWT a significant head start in creating the technical infrastructure needed to commence work for OVHA. HWT anticipates that data will in production for this project within 30 to 60 days of the contract signing date, assuming that EDS can get necessary data to HWT on a mutually agreed to schedule.
- **Kick-off Meeting/Validation Workshop.** Contemporaneous with the data acquisition phase, HWT will commence other critical project kick-off activities with OVHA. Ideally (subject to OVHA's availability) HWT will hold a Validation Workshop with critical OVHA stakeholders for the purpose of 1) educating HWT as much as necessary about the payment and provider landscape; and 2) analyzing in depth the various HWT algorithms and models for the purpose of determining which would be the most beneficial to deploy for OVHA.
- **Detailed Roadmap.** Based on the results of the Validation Workshop HWT will deliver to OVHA a detailed roadmap, including a proposed monthly deliverable schedule for algorithm results and models. Once this roadmap is agreed upon by OVHA production will begin.
- **Delivering the Results.** Based upon the above, HWT believes it can begin delivering results to OVHA within 90 days of contract signing.

As part of the kick-off process HWT will create, subject to OVHA's approval, a more detailed project plan tailored to meet the needs of this project.

III-C Global Commitment and OVHA Programs

As OVHA implements the "Global Commitment," HWT will customize the claims data analysis processes to take into account Vermont's fluid Medicaid landscape.

The HWT algorithms and models are not off-the-shelf, “cookie cutter” tools but are individually designed and reformatted to meet the particular nuances of the payment environment in which they are deployed. For each of its clients, HWT subject matter experts complete a thorough review of provider reimbursement policies, eligibility criteria, billing instructions, existing/historic accounts payable edits and audits, and explanation of benefit (EOB) messages.

As a precursor to its data mining activities, HWT will:

- Gain an in depth understanding of the client’s overall business and operational environment related to the processing and payment of healthcare claims. Specific areas of interest include the client’s benefit offerings, medical policy administration, reimbursement mechanisms, payment practices, and system edits.
- Assess the extent to which other client initiatives will or will not be successful in this particular environment.
- Consulting with client personnel to tap their expertise regarding program vulnerabilities, aberrant provider behaviors, or other claims review/overpayment recovery opportunities and customizing the data mining activities to specific state rules, policies and procedures.

Only after familiarizing itself with the client’s existing infrastructure, understanding the client’s perspective regarding vulnerabilities, and with an awareness of initiatives that have proven successful in other states, is HWT prepared to initiate its claims data analyses activities.

III-D Communication and Collaboration with OVHA Staff

HWT prides itself on its ability to foster strong client relationships. The best HWT implementations are those where HWT has been able to develop a team based approach to overpayment identification and recovery. HWT measures the success of its relationships on the credibility of these relationships and would encourage OVHA to contact HWT’s current and former clients as references.

As an integral part of HWT’s work, we will employ a strong emphasis on preventing, anticipating, resolving, and managing any issues that arise during the course of the project. Following are key elements of HWT’s project planning and management process:

Project Work Plan

At the outset of each project, HWT will develop a detailed draft Project Work Plan that identifies the tasks and timeframe for deliverables for the duration of the project. The work plan will be validated, refined, and modified during project planning discussions with OVHA to make sure that the resources and plan are adequate to meet OVHA requirements.

The Project Work Plan will serve as the measurement template and coordination for multiple concurrent tasks for the project. Specific goals and objectives will be measured against the timeframes contained in the work plan. The HWT Contract Manager maintains vigilant oversight over all project activities to make sure the timely completion of all tasks and all project milestones are met.

Project Management

Working in close collaboration with OVHA representatives and other OVHA contractors, the Contract Manager will provide overall management for the project. HWT's project management includes all the processes necessary to provide timely project completion with outcomes that meet or exceed OVHA expectations. These processes include seamless project integration, scope management, time and resource allocation, communications, procurement, and quality assurance.

Project Status Reports

A regular project status report will be created by HWT and delivering to OVHA the specific requirements on a mutually agreeable schedule. The purposes of this report include:

- Providing a regular update on progress for the clients.
- Capturing progress against key milestones, important issues and risks, project metrics, project financials, and external dependencies.
- Communicating scope change requests and decisions.

Project Meetings

HWT will determine with OVHA an appropriate schedule of regular status meetings.

These typically include:

- Regular Meetings/Conference Calls – Typically conducted as brief conference calls, containing pertinent information on the current phase(s) of a project, identify milestones on target, issues and provide for overall estimates of the point to date success of the project.
- Quarterly and Annual Meetings – These regularly scheduled briefings will constitute reports that define a project in terms of its projected goals and milestones.

Customer Service to the State

HWT's key customer service goals in working with OVHA include:

- Respond to all inquiries promptly.
- Communicate status, issue and concerns in a timely and clear fashion.
- Creating, updating and managing a project plan (as described above) for the course of all work during the project.

HWT's goal is to exceed OVHA expectations of customer service focusing on all OVHA needs and promptly delivering the intended results.

III-E Audit Procedures

Data Mining and Analysis

HWT has established key data mining activities that have proven to build a solid foundation prior to commencing post payment review activities. HWT completes several preliminary tasks, all of which are designed to make sure that the data mining process is focused, targeted, effective, and productive. Much of the information in this section of the proposal reflects the way in which HWT's activities and processes were previously administered on behalf of the SAO. Because HWT's approach to working with the SAO is well tested and effective, the information in this section reflects HWT's proposals and recommendations regarding the optimal delivery of post-payment claims review services to OVHA.

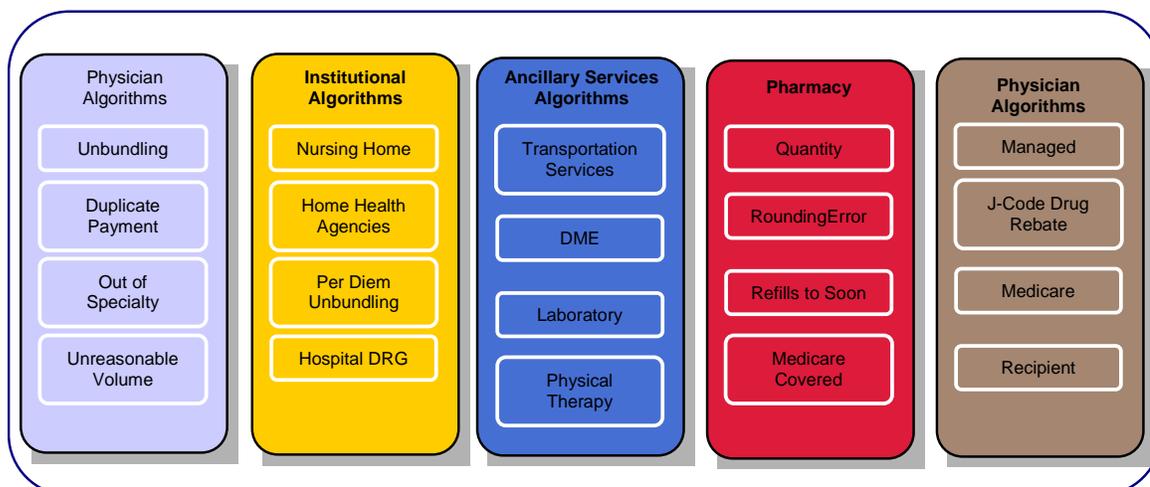
In Section II-G, HWT describes the prerequisites necessary to the commencement of data mining activity. The following describes HWT’s work process once those steps are completed.

The HWT Algorithms

The key to detecting inappropriate payments is the ability to ask questions (via various data mining and analysis techniques) of the data, and to communicate the results in meaningful reports for detailed investigative purposes. HWT utilizes an algorithmic approach to data mining. An algorithm is simply a finite list of well defined instructions that specify the exact manner in which the data mining is to occur (or: Algorithms are a rules-based, expert-driven approach that can be either statistical or linear in nature). HWT’s algorithms can be very general in nature, or they can be highly structured and very specific, depending on the topic being investigated. Often, particularly for new topics, it is reasonable to first query the data using a very broad algorithm, i.e., one that helps define the overall magnitude of the issue, both financially and in terms of volume. Subsequent queries may then use a more specific algorithm that provides more detailed insight into the topic, e.g., number of providers affected, types of providers involved, etc. It is not unusual for each query of the data to become progressively more detailed, particularly when each query result serves to modify the question itself.

HWT has created an extensive library of algorithms, addressing all types of claims and identifying both recoveries and other cost savings.

Table 6 – HWT Algorithm Library



Examples of types of patterns that are included in the algorithm library are:

- Looking at a single claim line transaction – All of HWT's algorithms identify potential payment appropriateness and the ability to drill down to the single claim line transaction.
- Relationships based on the history of a patient or overall provider practice patterns – With each analysis, the patient and/or provider's history is examined to determine unexpected trends. These types of analyses enable HWT to generate utilization comparisons of providers with their peer groups or timed billing patterns.
- Volume and nature of services delivered by one provider to one patient – HWT's algorithms identify both unreasonable volume (for example, double billing, improbable frequencies, or quantities) and medical necessity.
- Waste, abuse, and overpayment trends within one practice group – Among HWT's suite of reports is a Full Practice Review that summarizes indicators of excessive dollars or claims for each provider type. This enables a client to view potential fraud and abuse patterns per provider practice or by type of provider (for example, multiple new office visits).
- Interdependent Services – HWT enables users to look at billing patterns where one would expect to see interdependent services such as an ambulance charge with a related medical service or a home health charge with an associated physician charge.
- Institutional Billing Patterns – HWT has developed specific algorithms to examine excessive or inappropriate billing among labs, DME, hospitals, emergency rooms, nursing homes, home health, and adult day health. Examples of patterns detected among institutions include: Per diem services (DME, pharmacy) billed separately as mutually exclusive services, duplicate billings and physical therapy billed by multiple institutional entities.
- Pharmacy Billing Errors – HWT has had enormous success in identifying a range of pharmacy billing errors including: quantity errors, unreasonable quantities, rounding errors and decimal billing errors, abuse of prior authorization codes, drugs covered by Medicare, refills too soon and aberrant recipient patterns such as excessive use of street drugs.

-
- Claim unbundling – A variety of HWT's algorithms specifically address the issue of claim unbundling and comprehensive coding as per CMS's Correct Coding Initiative. For example: dental fillings, hospital DRG, emergency department services and global surgical unbundling
 - Billing patterns suggestive of fraud and abuse – A recent result found providers inappropriately inflating charges for drugs being administered in the physician's office. Another example is hit and run scams where DME dealers set up shop, bill excessive amounts and then leave town.
 - A limited number of procedures that account for high percentages of paid claims – targeting specific areas which are susceptible to high dollar, low volume claims (for example, DME codes and miscellaneous procedure codes) and regular billings that are \$1 under the acceptable limit set by a state.
 - Instances of modifier misuse – identifying instances where claims for the same service were double billed both with and without a modifier. We also look at services where a modifier was excluded in order to obtain higher "global" reimbursement such as for the professional or technical component of radiology or laboratory services. We also look at instances where providers are billing for separately identifiable procedures and using a modifier to "upcode" a service that should have been included in a global fee.
 - E&M churning – There are several ways that HWT investigates this issue. One analysis is to look within a medical group or IPA to identify multiple physicians who are sharing a single patient ID. Another is to profile individual physician's utilization patterns of office visit codes and identify those outliers who seem to consistently be using the most time intensive codes. Another common billing practice that we have identified is the submission of claims of multiple office visits for the same recipient, same provider for the same date of service. For example, an office visit may be classified as a low-complexity, medium-complexity, or high-complexity visit. HWT identified numerous cases where providers were reimbursed for all three types of office visits for the same recipients on the same dates of service.
 - Falsification of procedures and diagnoses – HWT routinely looks for certain procedure codes that should be billed together. For example a recent analysis of nerve block procedures indicated that the expected fluoroscopy service that should have also been billed was not, indicating questionable billing behavior. Another way HWT identifies

false procedures is to "match" provider specialties with procedure and diagnosis codes to determine if providers are billing out of their specialty. Yet another way we've identified false codes is to identify providers who consistently bill for the same procedures.

Algorithm Research and Development

In addition to its existing algorithm library, HWT has personnel dedicated to expanding the library through focused research and development (R & D) activities. Through these activities, HWT is able to proactively address the ever-changing nature of healthcare fraud, waste, and abuse. Also, HWT's R & D process is an excellent mechanism for addressing especially complex topics that require more in-depth review.

Technical Perspective

HWT's algorithms are executed by HWT programming and development personnel using industry-standard database query tools, e.g., SQL. HWT personnel are highly experienced in using these query tools, and the tools themselves are exceptionally flexible. By using the logic defined in one or more HWT algorithm (existing or new), HWT's developers can mine OVHA's data and produce preliminary results.

Internal Validation of Algorithm Results

Once HWT's technical developers complete the data mining activities associated with a particular algorithm or group of algorithms, the initial iteration of the result set is subject to numerous quality assurance and validation steps within HWT. All HWT personnel involved with the algorithm, including the developers and the project manager, are responsible for reviewing and insuring the accuracy of the algo results. As necessary, HWT's Medical Director and other clinical resources are involved to assess the clinical integrity of the algorithm results

Presentation of Algorithm Results to Client and Client Validation

Once HWT is confident of the algorithm's accuracy, the results are presented to designated client representatives for review and validation. Typically, HWT presents algorithm results in detailed Microsoft Access reports, all of which are available in both electronic and hard-copy formats. These reports are communicated to the client using a secure file transfer protocol (FTP) site, or via encrypted media, in order to comply with

HIPAA requirements. The reports provide an organized presentation of all relevant information, and are designed to facilitate the client's quality assurance and validation processes. Though designs can vary, HWT's reports most often reflect claim-level information segregated by provider – with relevant summary information, e.g., total number of claims, total amount of reimbursed dollars, total overpayment amounts, etc. Results are usually presented in one report, but HWT can readily produce separate reports, or sub-reports, particularly if the result set is large or complex. Because all result set information is also provided in electronic format, the client is free to manipulate, massage, and query the data, as needed, to facilitate review and validation.

Client Validation of Algorithm Results

HWT has learned that the client's validation of algorithm results is a critical step in the overall post-payment claims review process. While HWT makes every effort to prospectively address all relevant factors within its algorithm designs, the client's perspective regarding the actual algorithm results is invaluable. Typically it is not necessary for the client to review all claims in the result set, but rather a representative sample. As part of the algorithm validation, HWT clients are typically asked to consider questions such as specific exclusions, overpayment calculation logic and specific data elements.

Often, the first iteration of the algorithm results provides a partial answer to the question at hand, and illustrates the need for a subtle change in the algorithm's criteria. Frequently, multiple iterations of the algorithm are executed and reviewed by HWT and the client. This iterative process is normal, and it is completed as often as necessary until both HWT and the client are satisfied with the results.

Overpayment Calculation (As a Component of Algorithm Results)

One especially important element of the algorithm results is the calculation of the financial overpayment. The financial overpayment varies from algorithm to algorithm and from provider to provider; it represents the maximum amount of money that HWT and the client believe may be recouped from any subsequent recovery process. Overpayments most often occur when services are billed and paid in a manner that is not consistent with Medicaid policy and/or instructions in the provider manual.

HWT algorithms include very specific formulas, all of which are approved by the client, for calculating suspected provider overpayments. Overpayment calculation formulas can be straightforward or relatively complex, depending upon the subject of the algorithm and the payment methodology.

Payment Recovery Operations

HWT has proposed Recovery Operations as a separate service in its Cost Proposal. This section describes in detail the elements of these operations.

If accepted, HWT will work closely with OVHA to tailor this process to their specific needs, requirements and concerns. If not accepted HWT will provide OVHA with detailed recommendations regarding the next steps with respect to the results of HWT algorithms

Validated claims analyses are generally separated into the following general categories:

- **Immediate Recovery.** Waste and abuse overpayments that have been inappropriately paid according to OVHA rules and policies.
- **Audit Suspects.** Cases requiring on-site audit to gain further information. These are cases that formula driven algorithms identify or where medical necessity is questionable. HWT will work with OVHA to determine appropriate next steps on these cases. (Providers who score high on the HWT iQAI models, described below, generally fall into this category.)
- **Legal Suspects.** Cases where criminal intent is suspected. These are a combination of occurrences and dollar amounts that indicate an investigation of intent may be warranted. HWT will refer these instances to OVHA to transition any findings to the state's Medicaid Fraud Control Unit, or through other disposition as decided by OVHA.
- **Cost Avoidance and Prevention Opportunities.** Throughout the project, through the course of looking for potential fraud, waste, abuse and overpayments, HWT will discover and provide to OVHA recommendations on vulnerabilities in current payment policies that could result in edit, audit and payment policy changes to prevent future losses.

Recovery Process Overview

Highlighted below is HWT's recovery process consisting of the following four areas of process/operation.

Table 7 – HWT Recovery Process

Process Area	Brief Description
Provider Notifications	Typically done in letter format to the healthcare providers (doctors, clinics, hospitals, etc) for whom overpayments were identified, verified and authorized for collections to commence by OVHA. The letter will outline the policy under which the overpayment is being collected, and a detailed report specific to that provider, providing comprehensive detail on the Overpayments being claimed.
Informal Adjudication by HWT Staff	This process will consist of direct inquires written and/or verbal communications (a toll free phone number is set up just for OVHA providers to contact HWT) with the provider. HWT staff will review documentation submitted by providers challenging the recovery results and finalize a fair outcome for OVHA and the provider within a reasonable time from receipt of documents from the provider.
Recovery Case Management	HWT's proprietary tool iQRMS will be used throughout the recovery process. iQRMS is a full-function, browser-based case management tool which will be used jointly by HWT and OVHA during the course of the contract to track and manage every provider contact and communication, and document all collections case results
Financial Operations	Revenue recovery will result in providers either sending payments or agreeing to recoupments from future payments that OVHA owes them for services rendered. Financial Operations are established between HWT and OVHA to ascertain that appropriate controls and accounting are in place

Avoiding Overlap with Past and Current State Activities

HWT recognizes that OVHA conducts its own post-payment claims review activities internally and utilizes other vendors in select areas. Working collaboratively with OVHA (and the PBM, MMIS and other contractor staff as authorized by OVHA), HWT will be responsible for obtaining the necessary information on providers and/or other overpayment recoveries that should be excluded from HWT's recovery efforts. HWT will

establish effective processes to make sure that its review activities do not overlap or conflict with those of another entity.

Artificial Intelligence Tools – HWT’s iQAI Models

In addition to algorithmic analysis for fraud and abuse, HWT uses an artificial intelligence tool, iQAI. iQAI is a data-driven product that combines advanced statistics, applied human expertise and the "lessons learned" from HWT's algorithms to create models to detect and analyze what would otherwise pass as undetected patterns.

These reports use advanced statistics to create profiles of service categories (examples: Nursing Facility Services, Pharmacy Utilization). Providers are ranked on numerous attributes that profile their behavior when compared to their peers. A provider's score expresses an individual's ranking in terms of the number of standard deviations that the score lays above or below the mean.

iQAI provides a variety of customized models such as the one shown below. Every iQAI analysis report provides drill-down capability, enabling users to easily access additional details down to the individual claim level on suspect claims. In addition, all reports can be sorted and rank-ordered according to user-defined criteria, such as fraud score or potential dollars lost.

Table 7 – Sample Report Screen

The screenshot shows the HWT iQAI Portal interface. At the top, there is a navigation bar with links for 'home', 'customize', and 'logout'. Below this is a secondary navigation bar with tabs for various analysis types: 'IQSafeguard 7', 'IQSafeguard 8', 'IQBudget', 'IQRMS', 'iQAI' (selected), 'IQSample', 'IQSearch', 'AMS', 'IQCase', and 'IQPortal Admin'. The main content area features the HWT logo and the iQAI logo. Below the logos, it states 'Application last modified: November 30, 2004'. A table of analysis reports is displayed, with columns for Analysis, Time Frame, Published Date, Description, and Methodology. The table lists various analyses such as 'ESA Authorization Trends', 'Hospital Inpatient Analysis', 'Medical Provider 2004', 'Dental', 'Pharmacy Analysis', and 'ESA Mini-model'.

Analysis	Time Frame	Published Date	Description	Methodology
WA				
ESA Authorization Trends	FY2005	07/19/2005	ESA Authorization Trends	
Hospital Inpatient Analysis	CY2000-2003	06/13/2005	Inpatient Hospital Billings	Outlier Analysis
Medical Provider 2004	CY2004	06/13/2005	CY2004 Medical Provider Analysis	Outlier Analysis
Dental	CY2003	05/08/2005	Dental Provider Model Description	Outlier Analysis
Pharmacy Analysis	CY2003	05/02/2005	CY2003 Pharmacy Analysis	Outlier Analysis
ESA Mini-model	FY2003	11/30/2004	ESA Mini-model	
Pharmacy Analysis	CY2002	11/30/2004	CY2002 Pharmacy Analysis	Outlier Analysis
Dental	CY2002	10/14/2004	Dental Provider Model Description	
Medical Provider 2003	CY2003	10/14/2004	CY2003 Medical Provider Analysis	Outlier Analysis
Hospital Inpatient Analysis	CY2000-2002	06/17/2004	Inpatient Hospital Billings	Outlier Analysis
Medical Provider 2002	CY2002	01/12/2004	CY2002 Medical Provider Analysis	Outlier Analysis

With flexibility, depth and uniqueness, iQAI offers the following benefits:

- Comprehensive - iQAI scrutinizes large quantities of claims, provider and patient historical data to detect a range of suspicious patterns, including complex patterns that have eluded detection and new schemes. Comprehensive profiling considers the data of multiple entities including pharmacies, prescribers, patients, and providers to better detect fraud. This comprehensive approach provides superior detection power.
- Practical and Easy-to-Use - iQAI's output generates a fraud risk score with percent of certainty for each category being analyzed as well as Reason Codes to further explain each score and help guide investigators in further analysis of the suspect claims.

Once an iQAI model is complete, HWT works closely with its clients to make sure that the model is understood and can be easily used on an ongoing basis by the appropriate client staff members.

III-F Analysis and Reporting

As a result of the audit process described above, HWT will provide OVHA with readily available reports in an agreed upon format of claims paid incorrectly and the impact of over/underpayment identified. HWT has significant experience and is routinely able to account for and separate out for analysis claims that are subject to different rules, such as claims where Medicare and other insurance is primary.

As part of the work of this contract, HWT will deliver on a regular or as-needed basis the following reports:

- Analytical reports (for each category of service, provider, or provider type, drug or class of drug as applicable, etc) needed to perform an efficient and effective review for cost recoveries of Medicaid payments, clearly displaying the impact of claim error.
- Reports showing potential cost recovery, identified with a minimum of: (1) client name, (2) claim number, date and amount, and, (3) name, address and telephone number of the healthcare provider to whom or which the overpayment was made and from whom or which HWT would be prepared to seek repayment.
- If collection is authorized by OVHA, HWT will provide a report identifying the name of the healthcare providers from whom collection is made, date and amount collected.

-
- Monthly summary reports of potential, realized cost recoveries and trends identified to date.

Please see Appendix C for an analytical report sample.

Customized Reporting Capabilities

Delivery of HWT's core business services require all staff to have both a deep knowledge of Medicaid collections and recoveries processes, as well as an extensive understanding and familiarity with all of the detailed data that underlies all of its collections efforts.

With these skills in hand, along with a expertly trained and experienced technical staff, HWT can easily and quickly respond to any customized reporting request of query that may arise during the course of the contract.

As needed and requested, HWT's staff regularly work with our existing clients to: define and implement customized data queries and build and deploy any particular format and content in an electronic or hard copy format.

These capabilities will be made available to OVHA on an as-needed basis during the execution of the collections obligations under this contract.

Methods of Delivering Reports

Reports that are developed for and delivered to OVHA in execution of this contract can be delivered in many ways at the convenience to OVHA. HWT has extensive experience and capabilities providing reports in every conceivable format, including but not limited to: Adobe PDF, Crystal Reports/Crystal Viewer, Microsoft Office products, any "raw" data format – including comma delimited, character delimited, flat ASCII files.

Additionally reports can be presented in a variety of contexts including provider perspective, recipient perspective and institutional perspective. Reports can include graphs, charts, statistical analysis, or frequency distributions to support and focus the investigation.

All of HWT's reporting can be deployed using web-based technology (access, print and download reports via an Internet browser), or easily downloaded (via direct access, email or FTP) in any format compatible to OVHA.

One of HWT's strong recommendations and preferred activities with all clients is to set-up and maintain a dedicated secure FTP server, where both HWT and state staff can post, store and exchange any sort of documents needed during the course of the contract.

Importantly, any reports that HWT prepares can be developed so they are easily compatible with OVHA current reporting tools.

III-G Staffing and Time Requirements

HWT is committing a team of experts that include a Contract Manager, medical directors, subject matter experts, database administrators and registered nurses to provide timely execution and successful ongoing operations. The team members selected to perform the work for the State of Vermont, Office of Vermont Health Access under the 'Claims Data Analysis and Post Payment Review' RFP are highly experienced individuals with a broad range of expertise. In addition, the team brings nationwide experience performing similar work in multiple states.

In providing services to its clients, HWT uses a flexible, team-based approach. The design of the team proposed offer the complement of skills and experience required to successfully complete this project. The structure was organized this way to provide the management efficiency and operational accountability throughout the project.

Maureen Custodio is the designated Contract Manager for OVHA, responsible for the day-to-day supervision and coordinating the timely delivery of high-quality post-payment claims review services. Maureen Custodio will be available to OVHA personnel between the hours of 8 a.m. to 5 p.m. Eastern Time, located from the Chicago office and can be reached at 207-523-1011 and via email: mcustodio@hwtc.com.

Drew Gattine will serve as the Executive Project Advisor will provide support and make sure that the project implementation occurs on schedule and in accordance with OVHA requirements. Drew has overall responsibility for HWT client implementations and has been involved in all of HWT's implementations. He will provide ongoing strategic guidance and mentoring to the team.

HWT personnel will be deployed in various capacities to meet the defined OVHA objectives. HWT's database administrators will make sure that data are acquired and

maintained. HWT developers will execute data mining activities through the use of existing or newly developed algorithms. HWT provider relations personnel will facilitate letter generation, provider support, and overpayment collection activities.

The Identification Team, Data Operations and Recovery Team bring specific experience to the project areas they manage. They will lead the design and execution of the work plan efficiently coordinating the functions of the project across the entire team. The team will also have analysts and a Medical Director to support and provide the details needed to fully execute the project. Resumes describing the educational and work experiences for each of the key staff assigned to this complete this work is included in Appendix B.

HWT Contract Managers typically make several on-site client visits each year. These visits are helpful in establishing positive working relationships. In addition, they provide an excellent opportunity to evaluate the status of the program's shared objectives and to plan future activities. Additional HWT personnel are also available to make on-site client visits as needed, e.g., to complete on-site provider reviews, or to participate in appeal hearings.

III-H Disaster Recovery

(This section is proprietary and confidential)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

III-I Post Implementation

HWT leverages over 20 full-time professionals in support of our technical processing environment. Their skills include the full range of qualified and tested expertise needed to run, maintain and support all aspects of operations described in the Work Statement over the term of the contract on a 24/7/365 basis.

Based on work already completed under a previous contract with The State of Vermont, Office of the State Auditor, HWT’s technical team will update and present to OVHA routine procedures and processes to maintain a secure, customized, HIPAA-compliant data warehouse in order to commence its claims data analysis and post payment review activities.

HWT will continue to receive and load the monthly extracts with updated claims and related data on a monthly basis, or as necessary to accommodate changes that OVHA or

EDS make to their operations and systems. Once the data exchange operations are established, it is expected that HWT will have to complete no additional work to continue its regular and current receipt and loading of the monthly claims data updates.

III-J Required Reports

As a measure to support decision making, HWT will provide OVHA standard reports on a regular basis. As requested by OVHA, HWT will also provide ad hoc reports in a timely manner upon the receipt of any such request made by the state. HWT has extensive capabilities and experience in providing a wide variety of ad hoc reports and other deliverables, as noted above in the Analysis and Reporting section.

At a minimum, HWT will deliver the following reports on a regular or as-needed basis:

- Analytical reports by claim type, category of service, provider type, service detail (e.g., drug at the NDC level or drug class) identifying numbers and percentage of claims paid incorrectly and dollar amount of potential costs/savings.
- Detailed data sets of claims requiring adjustments, reversals, recoupments and/or recovery that would quantify amounts paid incorrectly. Fields included in these data sets will be determined by a discussion with OVHA.

A sample of the format can be found in Appendix C. Additional reports are available upon OVHA request.

III-K Performance Standards

(This section is proprietary and confidential)

[Redacted content]

[Redacted]

[Redacted]

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

FORM 10-K

(Mark One)

- ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2005**
- TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission file number: **1-10864**

UNITEDHEALTH GROUP INCORPORATED

(Exact name of registrant as specified in its charter)

MINNESOTA
(State or other jurisdiction of
incorporation or organization)

41-1321939
(I.R.S. Employer
Identification No.)

**UNITEDHEALTH GROUP CENTER
9900 BREN ROAD EAST
MINNETONKA, MINNESOTA**
(Address of principal executive offices)

55343
(Zip Code)

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

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

COMMON STOCK, \$.01 PAR VALUE
(Title of each class)

NEW YORK STOCK EXCHANGE, INC.
(Name of each exchange on which registered)

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

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

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

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

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

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

Large accelerated filer Accelerated filer Non-accelerated filer

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

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2005, was approximately \$65,178,318,867 (based on the last reported sale price of \$52.14 per share on June 30, 2005, on the New York Stock Exchange).*

As of February 15, 2006, there were 1,356,292,073 shares of the registrant's Common Stock, \$.01 par value per share, issued and outstanding.

Note that in Part III of this report on Form 10-K, we "incorporate by reference" certain information from our Definitive Proxy Statement for the Annual Meeting of Shareholders to be held on May 2, 2006. This document will be filed with the Securities and Exchange Commission (SEC) within the time period permitted by the SEC. The SEC allows us to disclose important information by referring to it in that manner. Please refer to such information.

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

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PART I

ITEM 1. BUSINESS

INTRODUCTION

UnitedHealth Group is a diversified health and well-being company, serving approximately 65 million Americans. We are focused on improving the American health care system and how it works for multiple, distinct constituencies. We provide individuals with access to quality, cost-effective health care services and resources through more than 500,000 physicians and other care providers and 4,600 hospitals across the United States. During 2005, we managed approximately \$68 billion in aggregate annual health care spending on behalf of the constituents and consumers we served. Our primary focus is on improving health care systems by simplifying the administrative components of health care delivery, promoting evidence-based medicine as the standard for care, and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions. Through our diversified family of businesses, we leverage core competencies in advanced technology-based transactional capabilities; health care data, knowledge and information; and health care resource organization and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

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

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

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

On December 20, 2005 we acquired PacifiCare Health Systems, Inc. PacifiCare offers managed care and other health insurance products to employer groups, individuals and Medicare beneficiaries, with approximately 3.1 million health plan members, including 2.4 million commercial members and 750,000 senior members, and approximately 12 million specialty plan members nationwide. PacifiCare’s commercial and senior plans are primarily offered in the Western United States and are designed to deliver quality health care and customer service cost effectively. PacifiCare operates one of the largest Medicare Advantage programs in the United States as measured by membership under its Secure Horizons brand. PacifiCare’s specialty plan operations include behavioral health, dental, vision and complete pharmacy benefit management (PBM) services, through its subsidiary Prescription Solutions.

UnitedHealth Group Incorporated is a Minnesota corporation incorporated in January 1977. The terms “we,” “our” or the “company” refer to UnitedHealth Group Incorporated and our subsidiaries. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300. You can access our Web site at www.unitedhealthgroup.com to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, along with amendments to

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

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

DESCRIPTION OF BUSINESS SEGMENTS

UNIPRISE

Uniprise delivers health care and well-being services nationwide to large national employers, individual consumers and other health care organizations through three related business units: Uniprise Strategic Solutions (USS), Definity Health and Exante Financial Services (Exante). Each business unit works with other UnitedHealth Group businesses to deliver a complementary and integrated array of services. USS delivers strategic health and well-being solutions to large national employers. Definity Health provides consumer-driven health plans and services to employers and their employees. As of December 31, 2005, USS and Definity Health served approximately 10.5 million individuals. Exante delivers health-care-focused financial services for consumers, employers and providers. Most Uniprise products and services are delivered through its affiliates. Uniprise provides administrative and customer care services for certain other businesses of UnitedHealth Group. Uniprise also offers transactional processing services to various intermediaries and health care entities.

Uniprise specializes in large-volume transaction management, large-scale benefit design and innovative technology solutions that simplify complex administrative processes and promote improved health outcomes. Uniprise processes approximately 240 million medical benefit claims each year and responds to approximately 50 million service calls annually. Uniprise provides comprehensive operational services for independent health plans and third-party administrators, as well as the majority of the commercial health plan consumers served by UnitedHealthcare. Uniprise maintains Internet-based administrative and financial applications for physician inquiries and transactions, customer-specific data analysis for employers, and consumer access to personal health care information and services.

USS

USS provides comprehensive and customized administrative, benefits and service solutions for large employers and other organizations with more than 5,000 employees in multiple locations. USS customers generally retain the risk of financing the medical benefits of their employees and their dependents and USS provides coordination and facilitation of medical services; transaction processing; consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals for a fixed service fee per individual served. As of December 31, 2005, USS served approximately 380 employers, including approximately 160 of the *Fortune* 500 companies.

Definity Health

Definity Health provides innovative consumer health care solutions that enable consumers to take ownership and control of their health care benefits. Definity Health's products include high-deductible consumer-driven benefit plans coupled with health reimbursement accounts (HRAs) or health savings accounts (HSAs), and discount cards for services generally not covered by high-deductible health plans. Definity Health is a national leader in consumer-driven health benefit programs. As of December 31, 2005, Definity Health provided health benefits to 83 employers, including 23 of the *Fortune* 500, under self-funded benefit plan arrangements.

Exante

Exante Financial Services provides health-based financial services for consumers, employers and providers. These financial services are delivered through Exante Bank, a Utah-chartered industrial bank. These financial services include HSAs that consumers can access using a debit card. Exante's health benefit card programs

include electronic systems for verification of benefit coverage and eligibility and administration of Flexible Spending Accounts (FSAs) and HRAs. Exante also provides extensive electronic payment and statement services for health care providers and payers.

HEALTH CARE SERVICES

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

UnitedHealthcare

UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for small and mid-sized employers, and individuals nationwide. UnitedHealthcare provides health care services on behalf of more than 14 million Americans as of December 31, 2005. With its risk-based product offerings, UnitedHealthcare assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically at a fixed rate for a one-year period. UnitedHealthcare also provides administrative and other management services to customers that self-insure the medical costs of their employees and their dependents, for which UnitedHealthcare receives a fixed service fee per individual served. These customers retain the risk of financing medical benefits for their employees and their dependents, while UnitedHealthcare provides coordination and facilitation of medical services, customer and care provider services and access to a contracted network of physicians, hospitals and other health care professionals. Small employer groups are more likely to purchase risk-based products because they are generally unable or unwilling to bear a greater potential liability for health care expenditures.

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

UnitedHealthcare arranges for discounted access to care through more than 500,000 physicians and other care providers, and 4,600 hospitals across the United States. The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare to contract for cost-effective access to a large number of conveniently located care providers. Directly or through UnitedHealth Group's family of companies, UnitedHealthcare offers:

- A broad range of benefit plans integrating medical, ancillary and alternative care products so customers can choose benefits that are right for them;
- Affordability through a broad product line from basic benefit plans to full benefit plans, all of which offer access to our broad-based proprietary network with economic benefits reflective of the aggregate purchasing capacity of tens of millions of people;
- Access to broad and diverse numbers of physicians and other care providers;
- Innovative clinical outreach programs—built around an extensive longitudinal clinical data set and the principles of evidence-based medicine—that promote care quality and patient safety and provide incentives for physicians who demonstrate consistency of clinical care against best practice standards;
- Access to quality and cost information for physicians and hospitals in a variety of specialties through the UnitedHealth Premium program;

- Care facilitation services that use proprietary predictive technology to identify individuals with significant gaps in care and unmet needs or risk for potential health problems and then facilitate timely and appropriate interventions;
- Unique disease and condition management programs to help individuals address significant, complex disease states;
- Convenient self-service for customer transactions, pharmacy services and health information; and
- Clinical information that physicians can use to better serve their patients as well as improve their practices.

UnitedHealthcare's regional and national access to broad, affordable and quality networks of care has advanced significantly in the past 24 months with acquisitions and/or expansions enhancing services throughout the United States, including California, Oregon, Washington, Oklahoma, Texas, Arizona, Colorado, Nevada, Indiana, Florida, Connecticut, Delaware, Maryland, New Jersey, New York, Pennsylvania and Wisconsin. UnitedHealthcare has also organized health care alliances with select regional not-for-profit health plans to facilitate greater customer access and affordability.

We believe that UnitedHealthcare's innovation distinguishes its product offerings from the competition. Its consumer-oriented health benefits and services value individual choice and control in accessing health care. UnitedHealthcare has programs that provide health education, admission counseling before hospital stays, care advocacy to help avoid delays in patients' stays in the hospital, support for individuals at risk of needing intensive treatment and coordination of care for people with chronic conditions. UnitedHealthcare offers comprehensive and integrated pharmaceutical management services that achieve lower costs by using formulary programs that drive better unit costs for drugs, benefit designs that encourage consumers to use drugs that offer the best value and outcomes, and physician and consumer programs that support the appropriate use of drugs based on clinical evidence.

UnitedHealthcare's distribution system consists primarily of insurance producers in the small employer group market and producers and other consultant-based or direct sales for large employer and public sector groups. UnitedHealthcare's direct distribution operations are relatively limited and apply only in the Maryland, Washington, D.C. and Virginia markets, as well as to portions of the large employer commercial market (which is generally self-funded) and to cross-selling of specialty products to existing customers. UnitedHealthcare's external distribution network includes national benefits consultants and local insurance producers.

Ovations

Ovations provides health and well-being services for individuals age 50 and older, addressing their unique needs for preventative and acute health care services as well as for services dealing with chronic disease and other specialized issues for older individuals. Ovations is one of few enterprises fully dedicated to this market segment, providing products and services in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the Northern Mariana Islands through affiliates. Ovations' wide array of products and services includes Medicare Supplement and Medicare Advantage health benefit coverage, and stand-alone prescription drug coverage and prescription drug discount cards, as well as disease management and chronic care programs.

Ovations has extensive capabilities and experience with distribution, including direct marketing to consumers on behalf of its key clients—AARP, state and U.S. government agencies and employer groups. Ovations also has distinct marketing, pricing, underwriting and clinical program management, and marketing capabilities dedicated to senior and geriatric risk-based health products and services.

Medicare Reform Legislation

The Medicare Modernization Act represents a significant change to the Medicare program. The Centers for Medicare & Medicaid Services (CMS) is overseeing a multiyear implementation of these changes, including the recent introduction of a prescription drug benefit (Part D) and a greater diversity in Medicare's product offerings. We believe that these changes create and expand opportunities for well-organized and focused companies to better serve older Americans. We believe that Ovation is well-positioned to respond to these opportunities.

In November 2005, Ovation began enrollment into its Medicare Part D program, in preparation for offering prescription drug coverage to Medicare beneficiaries nationwide. Ovation provides the only Medicare prescription drug coverage plan branded by AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over. Ovation is also offering Part D drug coverage through its Medicare Advantage program and Special Needs Plans.

Ovation participates nationally in the Medicare program across the broad spectrum of Medicare products—offering Medigap products that supplement traditional fee-for-service coverage, more traditional health plan-type programs under Medicare Advantage, prescription drug coverage and discount card offerings, and special offerings for chronically ill and Medicare and Medicaid dual-eligible beneficiaries. Ovation will continue to explore new market opportunities in a disciplined manner.

Ovation Insurance Solutions

Ovation offers a range of health insurance products and services to AARP members, and has expanded the scope of services and programs offered over the past several years. Ovation operates the nation's largest Medicare Supplement business, providing Medicare supplement and hospital indemnity insurance from its insurance company affiliates to approximately 3.8 million AARP members. Additional Ovation services include an expanded AARP Nurse Healthline service, which provides 24-hour access to health information from nurses for certain lines of business. Ovation also developed a lower cost Medicare Supplement offering that provides consumers with a hospital network and 24-hour access to health care information. Ovation also offers an AARP-branded health insurance program focused on persons between 50 and 64 years of age.

Ovation Pharmacy Solutions

Ovation Pharmacy Solutions addresses one of the most significant cost problems facing older Americans—prescription drug costs. With approximately 1.9 million users on December 31, 2005, Ovation's discount card and pharmacy services programs provide access to discounted retail and mail order pharmacy services, and a complimentary health and well-being catalog offering. Ovation also offers three different Medicare-endorsed discount drug cards under the Medicare Modernization Act. These cards offer cost savings for retail and mail order prescription drugs. The Medicare endorsed card programs end on May 15, 2006.

In November 2005, Ovation began enrollment into its Medicare Part D program. As of December 31, 2005, including PacifiCare, Ovation had enrolled 3.9 million members in the Part D program, including 2.8 million in the stand-alone prescription drug plans and 1.1 million in Medicare Advantage plans incorporating Part D coverage.

Prescription Solutions®

Prescription Solutions, a subsidiary of PacifiCare, offers integrated PBM services (including mail order pharmacy services) to approximately 6.0 million people, including approximately 800,000 seniors, as of December 31, 2005. Prescription Solutions offers a broad range of innovative programs, products and services designed to enhance clinical outcomes with appropriate financial results for employers and members. The fulfillment capabilities of Prescription Solutions are an important strategic component in serving PacifiCare's legacy commercial and senior business, as well as PacifiCare's Part D enrollees.

Ovations Secure Horizons

The Ovations Secure Horizons division provides health care coverage for the seniors market primarily through the Medicare Advantage program administered by CMS. Ovations offers Medicare Advantage HMO, PPO, Special Needs Plans and Private-Fee-for-Service plans. Under the Medicare Advantage programs, Ovations provides health insurance coverage to eligible Medicare beneficiaries in exchange for a fixed monthly premium per member from CMS that varies based on the geographic areas in which members reside. Products are offered under the Secure Horizons and UnitedHealthcare Medicare Complete brand names. In 2005, Ovations Secure Horizons expanded its program to 16 new regional markets and offered Medicare Advantage in 35 markets nationwide. In addition, Ovations Secure Horizons offers Private-Fee-for-Service plans in 24 states. As of December 31, 2005, Ovations had more than 1.1 million enrolled individuals in its Medicare Advantage products. Beginning January 1, 2006, Secure Horizons will offer a regional PPO in 3 markets.

Evercare

Through its Evercare division, Ovations is one of the nation's leaders in offering complete, individualized care planning and care benefits for aging, disabled and chronically ill individuals. Evercare serves approximately 80,000 people across the nation in long-term care settings including nursing homes, community-based settings and private homes, as well as through hospice and palliative care. Evercare offers services through innovative care management and clinical programs. In 2005, Evercare expanded its programs and now offers services in 23 states.

Evercare offers a variety of federally sponsored products that provide enhanced medical coverage to frail, elderly and chronically ill populations in both nursing homes and community settings. These services are provided primarily through nurse practitioners, nurses and care managers. Evercare also offers a Medicaid long-term health care product for elderly, physically disabled and other vulnerable individuals in five states. Evercare Connections is a comprehensive eldercare service program providing service coordination, consultation, claim management and information resources nationwide. Proprietary, automated medical record software enables Evercare geriatric care teams to capture and track patient data and clinical encounters in nursing home, hospital and home care settings. Evercare has begun extending its complex care management services to end-of-life situations and now offers community-based hospice programs in four states.

AmeriChoice

AmeriChoice provides network-based health and well-being services to beneficiaries of state Medicaid, Children's Health Insurance Programs (CHIP), and other government-sponsored health care programs through its affiliates. AmeriChoice provides health insurance coverage to eligible Medicaid beneficiaries in exchange for a fixed monthly premium per member from the applicable state. AmeriChoice provides services to nearly 1.3 million individuals in 13 states across the country. The individuals AmeriChoice serves generally live in areas that are medically underserved and where a consistent relationship with the medical community or a care provider is less likely. The population served by AmeriChoice also tends to face significant social and economic challenges. AmeriChoice offers government agencies a broad menu of separate management services—including clinical care, consulting and management, pharmacy benefit services and administrative and technology services—to help them effectively administer their distinct health care delivery systems for individuals in these programs.

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

cardiovascular disease, asthma, sickle cell disease, diabetes, cancer and high-risk pregnancy. Several of these programs have been developed by AmeriChoice with the help of leading researchers and clinicians at academic medical centers and medical schools.

For physicians, the AmeriChoice Personal Care Model means assistance with coordination of their patients' care. AmeriChoice utilizes sophisticated technology to monitor preventive care interventions and evidence-based treatment protocols to support care management. AmeriChoice uses state-of-the-art telemedicine tools that enable nurses and physicians to monitor vital signs, check medication use, assess patient status and facilitate overall care. AmeriChoice utilizes advanced and unique pharmacy services—including benefit design, generic drug incentive programs, drug utilization review and preferred drug list development—to help optimize the use of pharmaceuticals and concurrently contain pharmacy expenditures to levels appropriate to the specific clinical situations. For state customers, the AmeriChoice Personal Care Model means increased access to care and improved quality, in a measurable system that reduces their administrative burden and lowers their costs.

AmeriChoice considers a variety of factors in determining in which state programs to participate, including the state's experience and consistency of support for its Medicaid program in terms of service innovation and funding, the population base in the state, the willingness of the physician/provider community to participate with the AmeriChoice Personal Care Model, and the presence of community-based organizations that can partner with AmeriChoice to meet the needs of its members. Using these criteria, AmeriChoice entered one new market in 2005, signed an agreement to enter another new market in 2006, and is examining several others. Conversely, during the past three years, AmeriChoice has exited several markets because of reimbursement issues or lack of consistent direction and support from the sponsoring states.

SPECIALIZED CARE SERVICES

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

Specialized Care Services' products are marketed under several different brands to employers, government programs, health insurers and other intermediaries, and individual consumers, and through affiliates such as Ovations, UnitedHealthcare, AmeriChoice and Uniprise. SCS also distributes products on a private-label basis, allowing unaffiliated health plans, insurance companies, third-party administrators and similar institutions to deliver products and services to their customers under their brands. Specialized Care Services offers its products both on an administrative fee basis, where it manages and administers benefit claims for self-insured customers in exchange for a fixed service fee per individual served, and a risk-based basis, where Specialized Care Services assumes responsibility for health care and income replacement costs in exchange for a fixed monthly premium per individual served. Specialized Care Services' simple, modular service designs can be easily integrated to meet varying health plan, employer and consumer needs at a wide range of price points. Approximately 55% of consumers served by Specialized Care Services receive their major medical health benefits from a source other than a UnitedHealth Group affiliate.

The SCS companies are divided into three operating groups: Specialized Health Solutions; Dental and Vision; and Group Insurance Services.

Specialized Health Solutions

The Specialized Health Solutions operating group provides services and products for benefits commonly found in comprehensive medical benefit plans, as well as a continuum of individualized specialty health and wellness solutions from health information to case and disease management for complex, chronic and rare medical conditions.

United Behavioral Health (UBH) and its subsidiaries provide behavioral health care, substance abuse programs and psychiatric disability benefit management services. UBH's customers buy its care management services and access its large national network of 77,000 clinicians and counselors. UBH serves 29 million individuals.

LifeEra offers employee assistance, work life and other products to assist individuals in managing personal issues while seeking to increase employee productivity. LifeEra serves nearly 16 million consumers through programs developed in consultation with employers, government agencies and other affinity plans.

ACN Group (ACN) and its affiliates provide benefit administration, and clinical and network management for chiropractic, physical therapy, occupational therapy and other complementary and alternative care services. ACN's national networks of contracted health professionals serves more than 22 million consumers.

Through Optum, Specialized Care Services delivers personalized care and condition management, health assessments, longitudinal care management, disease management, and health information assistance, support and related services including wellness services. Utilizing evidence-based medicine, technology and specially trained nurses, Optum facilitates effective and efficient health care delivery by helping its 28 million consumers address daily living concerns, make informed health care decisions, and become more effective health care purchasers.

United Resource Networks (URN) provides support services and access to "Centers of Excellence" networks for individuals in need of organ transplantation and those diagnosed with complex cancer, congenital heart disease, kidney disease, infertility and neonatal care issues. URN provides these services to approximately 48 million individuals through more than 3,000 payers. United Resource Networks negotiates competitive rates with medical centers that have been designated as "Centers of Excellence" based on satisfaction of clinical standards, including patient volumes and outcomes, medical team credentials and experience, and support services.

Dental and Vision

Spectera and its affiliates administer vision benefits for 11 million people enrolled in employer-sponsored benefit plans. Spectera works to build productive relationships with vision care professionals, retailers, employer groups and benefit consultants. Spectera's national network includes approximately 31,000 vision professionals.

UnitedHealth Dental (UHD) and its affiliates provide dental benefit management and related services to 6 million individuals through a network of approximately 90,000 dentists. UHD's products are distributed to commercial and government markets, both directly and through unaffiliated insurers and its UnitedHealth Group affiliates.

Group Insurance Services

Group Insurance Services distributes life, critical illness, and short-term and long-term disability insurance, along with cost management products and services for health plans and employers through its affiliates. Unimerica Workplace Benefits provides integrated short-term disability, critical illness and group life insurance products to employers' benefit programs. National Benefit Resources (NBR) distributes and administers medical stop-loss insurance covering self-funded employer benefit plans. Through a network of third-party administrators, brokers and consultants, NBR markets stop-loss insurance throughout the United States. NBR also distributes products and services on behalf of its SCS affiliates, URN and Optum.

INGENIX

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a nationwide and international

basis. Ingenix's customers include more than 3,000 hospitals, 250,000 physicians, 2,000 payers and intermediaries, more than 150 *Fortune* 500 companies, and more than 180 pharmaceutical and biotechnology companies, as well as other UnitedHealth Group businesses. Ingenix is engaged in the simplification of health care administration by providing products and services that help customers accurately and efficiently document, code and bill for reimbursement for the delivery of care services. Ingenix is a leader in contract research services, medical education services, publications, and pharmacoconomics, outcomes, safety and epidemiology research through its i3 businesses.

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

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

Information Services

Ingenix's diverse product offerings help clients strengthen health care administration and advance health care outcomes. These products include health care utilization reporting and analytics, physician clinical performance benchmarking, clinical data warehousing, analysis and management responses for medical cost trends, decision-support portals for evaluation of health benefits and treatment options and claims management tools for administrative error and cost reduction. Ingenix uses proprietary software applications that manage clinical and administrative data across diverse information technology environments. Ingenix also uses proprietary predictive algorithmic applications to help clients detect and act on repetitive health care patterns in large data sets.

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

Pharmaceutical Services

Ingenix's i3 division helps to coordinate and manage clinical trials for pharmaceutical products in development for pharmaceutical, biotechnology and medical device manufacturers. Ingenix's focus is to help pharmaceutical and biotechnology customers effectively and efficiently get drug and medical device data to appropriate regulatory bodies and to improve health outcomes through integrated information, analysis and technology. Ingenix capabilities and efforts focus on the entire range of product assessment, through commercialization of life-cycle management services—pipeline assessment, market access and product positioning, clinical trials, economic, epidemiology, safety and outcomes research, and medical education. Ingenix services include global contract research services, protocol development, investigator identification and training, regulatory assistance, project management, data management, biostatistical analysis, quality assurance, medical writing and staffing resource services. Ingenix's pharmaceutical contract research operations are in 45 countries and are therapeutically focused on oncology, the central nervous system, and respiratory and infectious diseases. Ingenix uses comprehensive, science-based evaluation and analysis and benchmarking services to support pharmaceutical, biotechnology and medical device development. Ingenix has developed an advanced drug registry tool, i3 Aperio, that utilizes Ingenix's proprietary research database to assist pharmaceutical manufacturers and regulatory agencies in detecting potential safety issues from newly marketed drugs earlier than other available surveillance methods. Ingenix also helps educate providers about pharmaceutical products through medical symposia, product communications and scientific publications.

GOVERNMENT REGULATION

Most of our health and well-being services are regulated. This regulation can vary significantly from jurisdiction to jurisdiction. Federal and state regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and regulations are continually being considered, and the interpretation of existing laws and rules also may change periodically.

Federal Regulation

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

State Regulation

All of the states in which our subsidiaries offer insurance and health maintenance organization products regulate those products and operations. These states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state Departments of Insurance and the filing of reports that describe capital structure, ownership, financial condition, certain inter-company 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. In addition, some of our business and related activities may be subject to preferred provider organization (PPO), managed care organization (MCO) or third-party administrator-related regulations and licensure requirements. These regulations differ from state to state, but may contain network, contracting, product and rate, financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, payment of claims, fraud prevention, protection of consumer health information and covered benefits and services. We believe we are in compliance in all material respects with the applicable laws and regulations.

As typically occurs in connection with a transaction of this size, in connection with the PacifiCare transaction, certain of our subsidiaries entered into various commitments with state regulatory departments, principally in California. We believe that none of these commitments will materially affect our operations.

HIPAA

The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations promulgated pursuant to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. We believe that we are in compliance in all material respects with these regulations. New standards for national provider and employer identifiers are currently being implemented by regulators. We have been and intend to remain in compliance in all material respects with these regulations. Additionally, different approaches to HIPAA's provisions and varying enforcement philosophies in the different states may adversely affect our ability to standardize our products and services across state lines.

ERISA

The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and

regulations subject to periodic interpretation by the United States Department of Labor as well as the federal courts. ERISA places controls on how our business units may do business with employers who sponsor employee benefit health plans, particularly those that maintain self-funded plans. We believe that we are in compliance in all material respects with applicable ERISA regulations.

Audits and Investigations

We typically have and are currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits, and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including loss of licensure or exclusion from participation in government programs. We do not believe the results of any of the current investigations, audits or reviews, individually or in the aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

International Regulation

Some of our business units have limited international operations. These international operations are subject to different legal and regulatory requirements in different jurisdictions, including various tax, tariff and trade regulations, as well as employment, intellectual property and investment rules and laws. We believe we are in compliance in all material respects with applicable laws.

COMPETITION

As a diversified health and well-being services company we operate in highly competitive markets. Our competitors include managed health care companies, insurance companies, third-party administrators and business services outsourcing companies, health care providers that have formed networks to directly contract with employers, specialty benefit providers, government entities, and various health information and consulting companies. For our Uniprise and Health Care Services businesses, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., and WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and other enterprises concentrated in more limited geographic areas. Our Specialized Care Services and Ingenix business segments also compete with a number of other businesses. New entrants into the markets in which we compete, as well as consolidation within these markets, also contribute to a competitive environment. We believe the principal competitive factors that can impact our businesses relate to the sales and pricing of our products and services; product innovation; consumer satisfaction; the level and quality of products and services; care delivery; network capabilities; market share; product distribution systems; efficiency of administration operations; financial strength and marketplace reputation.

EMPLOYEES

As of December 31, 2005, we employed approximately 55,000 individuals. We believe our employee relations are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

<u>Name</u>	<u>Age</u>	<u>Position</u>	<u>First Elected as Executive Officer</u>
William W. McGuire, M.D.	57	Chairman of the Board and Chief Executive Officer	1988
Stephen J. Hemsley	53	President, Chief Operating Officer and Director	1997
Patrick J. Erlandson	46	Chief Financial Officer	2001
David J. Lubben	54	General Counsel and Secretary	1996
Richard H. Anderson	50	Executive Vice President, UnitedHealth Group and Chief Executive Officer, Ingenix	2005
Tracy L. Bahl	43	Chief Executive Officer, Uniprise	2004
William A. Munsell	54	Chief Executive Officer, Specialized Care Services	2004
Lois E. Quam	44	Chief Executive Officer, Ovations	1998
Robert J. Sheehy	48	Chief Executive Officer, UnitedHealthcare	2001
David S. Wichmann	43	President and Chief Operating Officer, UnitedHealthcare, and Senior Vice President, UnitedHealth Group	2004

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

Dr. McGuire is the Chairman of the Board of Directors and Chief Executive Officer of UnitedHealth Group. Dr. McGuire joined UnitedHealth Group as Executive Vice President in November 1988 and became its Chairman and Chief Executive Officer in 1991. Dr. McGuire also served as UnitedHealth Group's Chief Operating Officer from May 1989 to June 1995 and as its President from November 1989 until May 1999.

Mr. Hemsley is the President and Chief Operating Officer of UnitedHealth Group and has been a member of the Board of Directors since February 2000. Mr. Hemsley joined UnitedHealth Group in May 1997 as Senior Executive Vice President. He became Chief Operating Officer in September 1998 and was named President in May 1999.

Mr. Erlandson joined UnitedHealth Group in 1997 as Vice President of Process, Planning and Information Channels. He became Controller and Chief Accounting Officer in September 1998 and was named Chief Financial Officer in January 2001.

Mr. Lubben joined UnitedHealth Group in October 1996 as General Counsel and Secretary. Prior to joining UnitedHealth Group, he was a partner in the law firm of Dorsey & Whitney LLP.

Mr. Anderson joined UnitedHealth Group in November 2004 as Executive Vice President and was named Chief Executive Officer, Ingenix in January 2005. From April 2001 until November 2004, Mr. Anderson served as the Chief Executive Officer of Northwest Airlines Corporation. Mr. Anderson served in various other capacities at Northwest Airlines from 1990 until April 2001.

Mr. Bahl joined UnitedHealth Group in August 1998 and was named Chief Executive Officer, Uniprise in March 2004. From January 2003 until March 2004, Mr. Bahl was UnitedHealth Group's Chief Marketing Officer, and from August 1998 until December 2002, he was the President of Uniprise Strategic Solutions.

Mr. Munsell joined UnitedHealth Group in 1997 and was named Chief Executive Officer, Specialized Care Services in November 2004. From February 2003 to June 2004, Mr. Munsell served as the Chief Administrative Officer, UnitedHealthcare, after serving as Chief Operating Officer, UnitedHealthcare since February 2000. From August 1997 to January 2000, Mr. Munsell served as Chief Financial Officer, UnitedHealthcare.

Ms. Quam joined UnitedHealth Group in 1989 and became the Chief Executive Officer of Ovation in April 1998. Prior to April 1998, Ms. Quam served in various capacities with UnitedHealth Group.

Mr. Sheehy joined UnitedHealth Group in 1992 and became Chief Executive Officer of UnitedHealthcare in January 2001. From April 1998 to December 2000, he was President of UnitedHealthcare. Prior to April 1998, Mr. Sheehy served in various capacities with UnitedHealth Group.

Mr. Wichmann joined UnitedHealth Group in 1998 and became President and Chief Operating Officer, UnitedHealthcare in July 2004. From June 2003 to July 2004, Mr. Wichmann served as the Chief Executive Officer, Specialized Care Services. From 2001 to June 2003, he was President and Chief Operating Officer, Specialized Care Services. From March 1998 to July 2004, Mr. Wichmann also served as Senior Vice President of Corporate Development.

ITEM 1A. RISK FACTORS

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

As of December 31, 2005, we leased approximately 10.1 million aggregate square feet of space and owned approximately 1.9 million aggregate square feet of space in the United States and Europe. Our leases expire at various dates through May 31, 2025. Our various segments use this space exclusively for their respective business purposes and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

See Item 7—“Legal Matters” and Item 8—Note 12 “Commitments and Contingencies”— “Government Regulation,” which are incorporated by reference herein.

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

None.

PART II

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

Market Prices

Our common stock is traded on the New York Stock Exchange under the symbol UNH. On February 15, 2006, there were 14,741 registered holders of record of our common stock. The high and low common stock prices per share were as follows:

	<u>High</u>	<u>Low</u>
<i>2006</i>		
First quarter (through 2/15/06)	\$62.93	\$56.00
<i>2005</i>		
First quarter	\$48.33	\$42.63
Second quarter	\$53.64	\$44.30
Third quarter	\$56.66	\$47.75
Fourth quarter	\$64.61	\$53.84
<i>2004</i>		
First quarter	\$32.25	\$27.73
Second quarter	\$34.25	\$29.31
Third quarter	\$37.38	\$29.67
Fourth quarter	\$44.38	\$32.31

Dividend Policy

Our Board of Directors established our dividend policy in August 1990. Pursuant to our dividend policy, the Board reviews our financial statements following the end of each fiscal year and decides whether to declare a dividend on the outstanding shares of common stock. Shareholders of record on April 1, 2005 received an annual dividend for 2005 of \$0.015 per share and shareholders of record on April 1, 2004 received an annual dividend for 2004 of \$0.008 per share. On January 31, 2006, the Board approved an annual dividend of \$0.03 per share, which will be paid on April 17, 2006 to shareholders of record on April 3, 2006.

Issuer Purchases of Equity Securities

Issuer Purchases of Equity Securities ⁽¹⁾ Fourth Quarter 2005

<u>For the Month Ended</u>	<u>Total Number of Shares Purchased</u>	<u>Average Price Paid per Share</u>	<u>Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs</u>	<u>Maximum Number of Shares that may yet be purchased under the plans or programs</u>
October 31, 2005	250,000	\$56.50	250,000	59,545,100
November 30, 2005	200,000	\$60.40	200,000	59,345,100
December 31, 2005	<u>3,800,000</u>	\$63.31	<u>3,800,000</u>	55,545,100
TOTAL	<u>4,250,000</u>	\$62.77	<u>4,250,000</u>	

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

ITEM 6. SELECTED FINANCIAL DATA

Financial Highlights

<u>(in millions, except per share data)</u>	<u>For the Year Ended December 31,</u>				
	<u>2005¹</u>	<u>2004¹</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>
Consolidated Operating Results					
Revenues	\$45,365	\$37,218	\$28,823	\$25,020	\$23,454
Earnings From Operations	\$ 5,373	\$ 4,101	\$ 2,935	\$ 2,186	\$ 1,566
Net Earnings	\$ 3,300	\$ 2,587	\$ 1,825	\$ 1,352	\$ 913
Return on Shareholders' Equity	27.2%	31.4%	39.0%	33.0%	24.5%
Basic Net Earnings per Common Share ²	\$ 2.61	\$ 2.07	\$ 1.55	\$ 1.12	\$ 0.73
Diluted Net Earnings per Common Share ²	\$ 2.48	\$ 1.97	\$ 1.48	\$ 1.06	\$ 0.70
Common Stock Dividends per Share ²	\$ 0.015	\$ 0.015	\$ 0.008	\$ 0.008	\$ 0.008
Consolidated Cash Flows From (Used For)					
Operating Activities	\$ 4,326	\$ 4,135	\$ 3,003	\$ 2,423	\$ 1,844
Investing Activities	\$ (3,489)	\$ (1,644)	\$ (745)	\$ (1,391)	\$ (1,138)
Financing Activities	\$ 593	\$ (762)	\$ (1,126)	\$ (1,442)	\$ (585)
Consolidated Financial Condition					
(As of December 31)					
Cash and Investments	\$14,982	\$12,253	\$ 9,477	\$ 6,329	\$ 5,698
Total Assets	\$41,374	\$27,879	\$17,634	\$14,164	\$12,486
Debt	\$ 7,111	\$ 4,023	\$ 1,979	\$ 1,761	\$ 1,584
Shareholders' Equity	\$17,733	\$10,717	\$ 5,128	\$ 4,428	\$ 3,891
Debt-to-Total-Capital Ratio	28.6%	27.3%	27.8%	28.5%	28.9%

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

¹ UnitedHealth Group acquired PacifiCare Health Systems, Inc. (PacifiCare) in December 2005 for total consideration of approximately \$8.8 billion, Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately \$5.0 billion and Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately \$2.7 billion. These acquisitions affect the comparability of 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates. See Note 3 to the consolidated financial statements for a detailed discussion of these acquisitions.

² In May 2005, our board of directors declared a two-for-one stock split. All share and per share amounts have been restated to reflect the stock split.

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

Business Overview

UnitedHealth Group is a diversified health and well-being company, serving approximately 65 million Americans. Our focus is on improving the American health care system by simplifying the administrative components of health care delivery; promoting evidence-based medicine as the standard for care; and providing relevant, actionable data that physicians, health care providers, consumers, employers and other participants in health care can use to make better, more informed decisions.

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

2005 Financial Performance Highlights

UnitedHealth Group had a very strong year in 2005. The company achieved diversified growth across its business segments and generated net earnings of \$3.3 billion, representing an increase of 28% over 2004. Other financial performance highlights include:

- Diluted net earnings per common share of \$2.48, an increase of 26% over 2004.
- Revenues of \$45.4 billion, a 22% increase over 2004. Excluding the impact of acquisitions, revenues increased 11% over 2004.
- Earnings from operations of \$5.4 billion, up 31% over 2004.
- Operating margin of 11.8%, up from 11.0% in 2004.

UnitedHealth Group acquired PacifiCare Health Plans, Inc. (PacifiCare) in December 2005 for total consideration of approximately \$8.8 billion, Oxford Health Plans, Inc. (Oxford) in July 2004 for total consideration of approximately \$5.0 billion and Mid Atlantic Medical Services, Inc. (MAMSI) in February 2004 for total consideration of approximately \$2.7 billion. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates.

2005 Results Compared to 2004 Results

Consolidated Financial Results

Revenues

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

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers' health care services and related administrative costs. Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. For both

premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; customer, consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals.

Consolidated revenues in 2005 increased by \$8.1 billion, or 22%, to \$45.4 billion. Excluding the impact of businesses acquired since the beginning of 2004, consolidated revenues increased by approximately 11% in 2005 primarily as a result of rate increases on premium-based and fee-based services and growth in individuals served across business segments. Following is a discussion of 2005 consolidated revenue trends for each of our three revenue components.

Premium Revenues Consolidated premium revenues totaled \$41.1 billion in 2005, an increase of \$7.6 billion, or 23%, over 2004. Excluding the impact of acquisitions, consolidated premium revenues increased by approximately 11% over 2004. This increase was primarily driven by premium rate increases and a modest increase in the number of individuals served by our risk-based products.

UnitedHealthcare premium revenues increased by \$5.1 billion, or 24%, over 2004. Excluding premium revenues from businesses acquired since the beginning of 2004, UnitedHealthcare premium revenues increased by approximately 9% over 2004. This increase was primarily due to average net premium rate increases of approximately 8% to 9% on UnitedHealthcare's renewing commercial risk-based products. In addition, Ovation's premium revenues increased by \$1.8 billion, or 24%, over 2004. Excluding the impact of acquisitions, Ovation's premium revenues increased by approximately 20% over 2004, driven primarily by an increase in the number of individuals served by Medicare Advantage products and by Medicare supplement products provided to AARP members, as well as rate increases on these products. Premium revenues from AmeriChoice's Medicaid programs increased by approximately \$270 million, or 9%, over 2004 driven primarily by premium rate increases. The remaining premium revenue increase is due mainly to strong growth in the number of individuals served by several Specialized Care Services businesses under premium-based arrangements.

Service Revenues Service revenues in 2005 totaled \$3.8 billion, an increase of \$473 million, or 14%, over 2004. The increase in service revenues was driven primarily by aggregate growth of 8% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2005, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased by more than 20% due to growth in the health information and clinical research businesses as well as businesses acquired since the beginning of 2004.

Investment and Other Income Investment and other income totaled \$499 million, representing an increase of \$111 million over 2004. Interest income increased by \$126 million in 2005, principally due to the impact of increased levels of cash and fixed-income investments during the year due to the acquisitions of Oxford and MAMSI as well as higher yields on fixed-income investments. Net capital gains on sales of investments were \$4 million in 2005, a decrease of \$15 million from 2004.

Medical Costs

The combination of pricing, benefit designs, consumer health care utilization and comprehensive care facilitation efforts is reflected in the medical care ratio (medical costs as a percentage of premium revenues). The consolidated medical care ratio decreased from 80.6% in 2004 to 79.7% in 2005. Excluding the AARP business¹,

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

the medical care ratio decreased from 79.5% in 2004 to 78.6% in 2005. These medical care ratio decreases resulted primarily from changes in product, business and customer mix and an increase in favorable medical cost development related to prior periods.

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

On an absolute dollar basis, 2005 medical costs increased \$5.7 billion, or 21%, over 2004. Excluding the impact of acquisitions, medical costs increased by approximately 9% driven primarily by a 7% to 8% increase in medical cost trend due to both inflation and a slight increase in health care consumption as well as organic growth.

Operating Costs

The operating cost ratio (operating costs as a percentage of total revenues) for 2005 was 15.0%, down from 15.4% in 2004. This decrease was primarily driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. Operating costs as a percentage of premium revenues are generally considerably lower than operating costs as a percentage of fee-based revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for 2005 increased \$1.1 billion, or 19%, over 2004. Excluding the impact of acquisitions, operating costs increased by approximately 11%. This increase was driven by an 8% increase in total individuals served by Health Care Services and Uniprise during 2005, excluding the impact of acquisitions, growth in Specialized Care Services and Ingenix and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

Depreciation and Amortization

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

Income Taxes

Our effective income tax rate was 35.7% in 2005, compared to 34.9% in 2004. The increase was mainly driven by favorable settlements of prior year tax returns during 2004. Excluding these settlements, the 2004 effective tax rate would have been approximately the same as the 2005 effective tax rate.

Business Segments

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

<u>Revenues</u>	<u>2005</u>	<u>2004</u>	<u>Percent Change</u>
Health Care Services	\$40,019	\$32,673	22%
Uniprise	3,850	3,365	14%
Specialized Care Services	2,806	2,295	22%
Ingenix	794	670	19%
Intersegment Eliminations	(2,104)	(1,785)	nm
Consolidated Revenues	<u>\$45,365</u>	<u>\$37,218</u>	<u>22%</u>

<u>Earnings From Operations</u>	<u>2005</u>	<u>2004</u>	<u>Percent Change</u>
Health Care Services	\$ 3,815	\$ 2,810	36%
Uniprise	799	677	18%
Specialized Care Services	582	485	20%
Ingenix	177	129	37%
Consolidated Earnings From Operations	<u>\$ 5,373</u>	<u>\$ 4,101</u>	<u>31%</u>

nm - not meaningful

Health Care Services

The Health Care Services segment is composed of the UnitedHealthcare, Ovations and AmeriChoice businesses. UnitedHealthcare offers a comprehensive array of consumer-oriented health benefit plans and services for local, small and mid-sized employers and individuals nationwide. Ovations provides health and well-being services to individuals age 50 and older, including the administration of supplemental health insurance coverage on behalf of AARP. AmeriChoice provides network-based health and well-being services to state Medicaid, Children's Health Insurance Program and other government-sponsored health care programs and the beneficiaries of those programs.

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

Health Care Services earnings from operations in 2005 were \$3.8 billion, representing an increase of \$1.0 billion, or 36%, over 2004. This increase primarily resulted from revenue growth and improved gross margins on UnitedHealthcare's risk-based products, increases in the number of individuals served by UnitedHealthcare's commercial fee-based products, and the acquisitions of Oxford and MAMSI during 2004. UnitedHealthcare's commercial medical care ratio decreased to 78.2% in 2005 from 79.0% in 2004 mainly due to changes in product, business and customer mix. Health Care Services' 2005 operating margin was 9.5%, an

increase from 8.6% in 2004. This increase was driven mainly by the lower commercial medical care ratio as well as changes in business and customer mix.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31¹:

<u>(in thousands)</u>	<u>2005²</u>	<u>2004</u>
Commercial		
Risk-based	7,765	7,655
Fee-based	3,895	3,305
Total Commercial	11,660	10,960
Medicare	395	330
Medicaid	1,250	1,260
Total Health Care Services	<u>13,305</u>	<u>12,550</u>

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

² Excludes commercial risk-based membership of approximately 2.3 million, commercial fee-based membership of approximately 100,000 and Medicare membership of approximately 750,000 related to the December 2005 acquisition of PacifiCare. These amounts have been excluded since the impact of PacifiCare on our 2005 consolidated financial results is not significant.

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

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

Uniprise

Uniprise provides network-based health and well-being services, business-to-business transaction processing services, consumer connectivity and technology support services nationwide to large employers and health plans, and provides health-related consumer and financial transaction products and services. Uniprise revenues in 2005 were \$3.9 billion, representing an increase of \$485 million, or 14%, over 2004. Excluding the impact of acquisitions, Uniprise revenues increased approximately 12% over 2004. This increase was driven primarily by growth of 7% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 10.5 million individuals and 9.9 million individuals as of December 31, 2005 and 2004, respectively.

Uniprise earnings from operations in 2005 were \$799 million, representing an increase of \$122 million, or 18%, over 2004. Operating margin for 2005 improved to 20.8% from 20.1% in 2004. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction

processing and customer service, billing and enrollment functions. Additionally, Uniprise's infrastructure can be scaled efficiently, allowing its business to grow revenues at a proportionately higher rate than the associated growth in operating expenses.

Specialized Care Services

Specialized Care Services offers a comprehensive platform of specialty health, wellness and ancillary benefits, networks, services and resources to specific customer markets nationwide. Specialized Care Services revenues of \$2.8 billion increased by \$511 million, or 22%, over 2004. This increase was principally driven by an 11% increase in the number of individuals served by its specialty benefit businesses, excluding the impact of acquisitions, and rate increases related to these businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 of \$582 million increased \$97 million, or 20%, over 2004. Specialized Care Services' operating margin was 20.7% in 2005, down from 21.1% in 2004. This decrease was due to a business mix shift toward higher revenue, lower margin products, partially offset by continued gains in quality initiatives and operating cost efficiencies.

Ingenix

Ingenix offers database and data management services, software products, publications, consulting services, outsourced services and pharmaceutical development and consulting services on a national and international basis. Ingenix 2005 revenues of \$794 million increased by \$124 million, or 19%, over 2004. This was driven primarily by growth in the health information and contract research businesses as well as businesses acquired since the beginning of 2004.

Earnings from operations in 2005 were \$177 million, up \$48 million, or 37%, from 2004. Operating margin was 22.3% in 2005, up from 19.3% in 2004. The increase in earnings from operations and operating margin was primarily due to growth in the health information and contract research businesses, improving gross margins due to effective cost management and businesses acquired since the beginning of 2004.

2004 Results Compared to 2003 Results

Consolidated Financial Results

Revenues

Consolidated revenues increased by \$8.4 billion, or 29%, in 2004 to \$37.2 billion, primarily as a result of revenues from businesses acquired since the beginning of 2003. Excluding the impact of these acquisitions, consolidated revenues increased by approximately 8% in 2004 as a result of rate increases on premium-based and fee-based services and growth across business segments. Following is a discussion of 2004 consolidated revenue trends for each of our three revenue components.

Premium Revenues Consolidated premium revenues in 2004 totaled \$33.5 billion, an increase of \$8.0 billion, or 32%, over 2003. Excluding the impact of acquisitions, premium revenues increased by approximately 8% in 2004. This increase was due in part to average net premium rate increases of approximately 9% on UnitedHealthcare's renewing commercial risk-based business, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products and changes in the commercial product benefit and customer mix. In addition, Ovations' premium revenues increased largely due to increases in the number of individuals it serves through Medicare Advantage products and changes in product mix related to Medicare supplement products, as well as rate increases on all of these products. Premium revenues from AmeriChoice's Medicaid programs and Specialized Care Services' businesses also increased due to advances in the number of individuals served by those businesses.

Service Revenues Service revenues in 2004 totaled \$3.3 billion, an increase of \$217 million, or 7%, over 2003. The increase in service revenues was driven primarily by aggregate growth of 4% in the number of individuals served by Uniprise and UnitedHealthcare under fee-based arrangements during 2004, excluding the impact of acquisitions, as well as annual rate increases. In addition, Ingenix service revenues increased due to new business growth in the health information and clinical research businesses.

Investment and Other Income Investment and other income totaled \$388 million, representing an increase of \$131 million over 2003. Interest income increased by \$134 million in 2004, principally due to the impact of increased levels of cash and fixed-income investments during the year from the acquisitions of Oxford, MAMSI and Golden Rule Financial Corporation (Golden Rule), which was acquired in November 2003. Net capital gains on sales of investments were \$19 million in 2004, a decrease of \$3 million from 2003.

Medical Costs

The consolidated medical care ratio decreased from 81.4% in 2003 to 80.6% in 2004. Excluding the AARP business, the medical care ratio decreased from 80.0% in 2003 to 79.5% in 2004. The medical care ratio decrease resulted primarily from net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in product, business and customer mix.

Each period, our operating results include the effects of revisions in medical cost estimates related to all prior periods. Changes in medical cost estimates related to prior fiscal years that are identified in the current year are included in total medical costs reported for the current fiscal year. Medical costs for 2004 include approximately \$210 million of favorable medical cost development related to prior fiscal years. Medical costs for 2003 include approximately \$150 million of favorable medical cost development related to prior fiscal years.

On an absolute dollar basis, 2004 medical costs increased \$6.3 billion, or 30%, over 2003 principally due to the impact of the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, medical costs increased by approximately 8% driven primarily by medical cost inflation and a moderate increase in health care consumption.

Operating Costs

The operating cost ratio for 2004 was 15.4%, down from 16.9% in 2003. This decrease was driven by revenue mix changes, with premium revenues growing at a faster rate than service revenues largely due to recent acquisitions. The existence of premium revenues within our risk-based products cause them to have lower operating cost ratios than fee-based products, which have no premium revenues. Additionally, the decrease in the operating cost ratio reflects productivity gains from technology deployment and other cost management initiatives.

On an absolute dollar basis, operating costs for 2004 increased \$868 million, or 18%, over 2003 primarily due to the acquisitions of Oxford, MAMSI and Golden Rule. Excluding the impact of acquisitions, operating costs increased by approximately 3%. This increase was driven by a more than 3% increase in the total number of individuals served by Health Care Services and Uniprise in 2004, excluding the impact of acquisitions, and general operating cost inflation, partially offset by productivity gains from technology deployment and other cost management initiatives.

Depreciation and Amortization

Depreciation and amortization in 2004 was \$374 million, an increase of \$75 million, or 25%, over 2003. Approximately \$42 million of this increase is related to intangible assets acquired in business acquisitions in 2004. The remaining increase is due primarily to additional depreciation and amortization from higher levels of computer equipment and capitalized software as a result of technology enhancements, business growth and businesses acquired since the beginning of 2003.

Income Taxes

Our effective income tax rate was 34.9% in 2004, compared to 35.7% in 2003. The decrease was driven mainly by favorable settlements of prior year income tax returns during 2004.

Business Segments

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

<u>Revenues</u>	<u>2004</u>	<u>2003</u>	<u>Percent Change</u>
Health Care Services	<u>\$32,673</u>	\$24,807	32%
Uniprise	<u>3,365</u>	3,107	8%
Specialized Care Services	<u>2,295</u>	1,878	22%
Ingenix	<u>670</u>	574	17%
Intersegment Eliminations	<u>(1,785)</u>	(1,543)	nm
Consolidated Revenues	<u>\$37,218</u>	<u>\$28,823</u>	<u>29%</u>

<u>Earnings From Operations</u>	<u>2004</u>	<u>2003</u>	<u>Percent Change</u>
Health Care Services	<u>\$ 2,810</u>	\$ 1,865	51%
Uniprise	<u>677</u>	610	11%
Specialized Care Services	<u>485</u>	385	26%
Ingenix	<u>129</u>	75	72%
Consolidated Earnings From Operations	<u>\$ 4,101</u>	<u>\$ 2,935</u>	<u>40%</u>

nm - not meaningful

Health Care Services

Health Care Services had revenues of \$32.7 billion in 2004, representing an increase of \$7.9 billion, or 32%, over 2003, driven primarily by acquisitions since the beginning of 2003. Excluding the impact of acquisitions, Health Care Services revenues increased by approximately \$1.9 billion, or 8%, over 2003. UnitedHealthcare accounted for approximately \$850 million of this increase, driven by average premium rate increases of approximately 9% on renewing commercial risk-based business and growth in the number of individuals served by fee-based products, partially offset by a slight decrease in the number of individuals served by UnitedHealthcare's commercial risk-based products. Ovations contributed approximately \$770 million to the revenue advance over 2003 driven by growth in the number of individuals served by Ovations' Medicare Advantage products and changes in product mix related to Medicare supplement products it provides to AARP members, as well as rate increases on all of these products. The remaining increase in Health Care Services revenues is attributable to growth in the number of individuals served by AmeriChoice's Medicaid programs and Medicaid premium rate increases.

Health Care Services earnings from operations in 2004 were \$2.8 billion, representing an increase of \$945 million, or 51%, over 2003. This increase primarily resulted from Ovations' and UnitedHealthcare's revenue growth, improved gross margins on UnitedHealthcare's commercial risk-based products and the impact of the acquisitions of Oxford, MAMSI and Golden Rule. UnitedHealthcare's commercial medical care ratio decreased to 79.0% in 2004 from 80.0% in 2003. The decrease in the commercial medical care ratio was primarily driven by net premium rate increases that slightly exceeded overall medical benefit cost increases and changes in business and customer mix. Health Care Services' 2004 operating margin was 8.6%, an increase of 110 basis

points over 2003. This increase was principally driven by a combination of the improved commercial medical care ratio and changes in business and customer mix.

The following table summarizes the number of individuals served by Health Care Services, by major market segment and funding arrangement, as of December 31¹:

<u>(in thousands)</u>	<u>2004</u>	<u>2003</u>
Commercial		
Risk-based	7,655	5,400
Fee-based	3,305	2,895
Total Commercial	<u>10,960</u>	<u>8,295</u>
Medicare	330	230
Medicaid	<u>1,260</u>	<u>1,105</u>
Total Health Care Services	<u>12,550</u>	<u>9,630</u>

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

The number of individuals served by UnitedHealthcare's commercial business as of December 31, 2004, increased by nearly 2.7 million, or 32%, over the prior year. Excluding the 2004 acquisitions of Oxford, MAMSI and a smaller regional health plan, the number of individuals served by UnitedHealthcare's commercial business increased by 245,000. This included an increase of 285,000 in the number of individuals served with fee-based products, driven by new customer relationships and existing customers converting from risk-based products to fee-based products, partially offset by a decrease of 40,000 in the number of individuals served with risk-based products resulting primarily from customers converting to self-funded, fee-based arrangements and a competitive commercial risk-based pricing environment.

Excluding the impact of the Oxford acquisition, the number of individuals served by Ovations' Medicare Advantage products increased by 30,000, or 13%, from 2003. AmeriChoice's Medicaid enrollment increased by 155,000, or 14%, due to organic growth in the number of individuals served and the acquisition of a Medicaid health plan in Michigan in February 2004, resulting in the addition of approximately 95,000 individuals served.

Uniprise

Uniprise revenues in 2004 were \$3.4 billion, representing an increase of 8% over 2003. This increase was driven primarily by growth of 4% in the number of individuals served by Uniprise, excluding the impact of acquisitions, and annual service fee rate increases for self-insured customers. Uniprise served 9.9 million individuals and 9.1 million individuals as of December 31, 2004 and 2003, respectively.

Uniprise earnings from operations in 2004 were \$677 million, representing an increase of 11% over 2003. Operating margin for 2004 improved to 20.1% from 19.6% in 2003. Uniprise has expanded its operating margin through operating cost efficiencies derived from process improvements, technology deployment and cost management initiatives that have reduced labor and occupancy costs in its transaction processing and customer service, billing and enrollment functions.

Specialized Care Services

Specialized Care Services revenues during 2004 of \$2.3 billion increased by \$417 million, or 22%, over 2003. This increase was principally driven by an increase in the number of individuals served by its behavioral health benefits business, its dental services business and its vision care benefits business; rate increases related to these businesses; and incremental revenues related to businesses acquired since the beginning of 2003 of approximately \$100 million.

Earnings from operations in 2004 of \$485 million increased \$100 million, or 26%, over 2003. Specialized Care Services' operating margin increased to 21.1% in 2004, up from 20.5% in 2003. This increase was driven primarily by operational and productivity improvements within Specialized Care Services' businesses and consolidation of the production and service operation infrastructure to enhance productivity and efficiency and to improve the quality and consistency of service, partially offset by a business mix shift toward higher revenue, lower margin products.

Ingenix

Ingenix revenues in 2004 of \$670 million increased by \$96 million, or 17%, over 2003. This was driven primarily by new business growth in the health information and contract research businesses. Earnings from operations in 2004 were \$129 million, up \$54 million, or 72%, from 2003. Operating margin was 19.3% in 2004, up from 13.1% in 2003. The increase in earnings from operations and operating margin was primarily due to growth and improving gross margins in the health information and clinical research businesses.

Financial Condition, Liquidity and Capital Resources at December 31, 2005

Liquidity and Capital Resources

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

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

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

Cash flows generated from operating activities, our primary source of liquidity, are principally from net earnings, prior to depreciation and amortization. As a result, any future decline in our profitability may have a negative impact on our liquidity. The level of profitability of our risk-based insured business depends in large part on our ability to accurately predict and price for health care and operating cost increases. This risk is partially mitigated by the diversity of our other businesses, the geographic diversity of our risk-based business and our disciplined underwriting and pricing processes, which seek to match premium rate increases with future health care costs. In 2005, a hypothetical unexpected 1% increase in commercial insured medical costs would have reduced net earnings by approximately \$130 million.

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

Cash and Investments

Cash flows from operating activities were \$4.3 billion in 2005, an increase over \$4.1 billion in 2004. The increase in operating cash flows resulted primarily from an increase of \$834 million in net income prior to depreciation, amortization and other noncash items partially offset by a decrease of \$643 million in cash flows generated from working capital changes. We generated operating cash flows from working capital changes of \$406 million in 2005 and \$1,049 million in 2004. The year-over-year decrease primarily resulted from the Company receiving only eleven monthly Medicare premium payments during 2005 from the Centers for Medicare and Medicaid Services (CMS) rather than the twelve monthly payments received in 2004, negatively impacting the change in reported operating cash flows by \$375 million. Additionally, there was reduced growth in medical payables during 2005 compared to 2004 due in part to an increase in electronic claim submissions and other disbursement process efficiencies.

We maintained a strong financial condition and liquidity position, with cash and investments of \$15.0 billion at December 31, 2005. Total cash and investments increased by \$2.7 billion since December 31, 2004, primarily due to cash and investments acquired through businesses acquired since the beginning of 2005, strong operating cash flows and cash received from debt issuances, partially offset by common stock repurchases, cash paid for business acquisitions and capital expenditures.

As further described under Regulatory Capital and Dividend Restrictions, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. At December 31, 2005, approximately \$270 million of our \$15.0 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use, including acquisitions and share repurchases.

Financing and Investing Activities

In addition to our strong cash flows generated by operating activities, we use commercial paper and debt to maintain adequate operating and financial flexibility. As of December 31, 2005 and 2004, we had commercial paper and debt outstanding of approximately \$7.1 billion and \$4.0 billion, respectively. Our debt-to-total-capital ratio was 28.6% and 27.3% as of December 31, 2005 and December 31, 2004, respectively. We believe the prudent use of debt leverage optimizes our cost of capital and return on shareholders' equity, while maintaining appropriate liquidity.

On December 20, 2005, the company acquired PacifiCare. Under the terms of the agreement, PacifiCare shareholders received 1.1 shares of UnitedHealth Group common stock and \$21.50 in cash for each share of PacifiCare common stock they owned. Total consideration issued for the transaction was approximately \$8.8 billion, composed of approximately 99.2 million shares of UnitedHealth Group common stock (valued at approximately \$5.3 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of July 6, 2005), approximately \$2.1 billion in cash, \$960 million cash paid to retire PacifiCare's existing debt and UnitedHealth Group vested common stock options with an estimated fair value of approximately \$420 million issued in exchange for PacifiCare's outstanding vested common stock options.

On February 24, 2006, our Health Care Services business segment acquired John Deere Health Care, Inc. (John Deere Health). Under the terms of the purchase agreement, we paid approximately \$500 million in cash in exchange for all of the outstanding equity of John Deere Health. We issued commercial paper to finance the John Deere Health purchase price.

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

On December 10, 2004, our Uniprise business segment acquired Definity Health Corporation (Definity). Under the terms of the purchase agreement, we paid \$305 million in cash in exchange for all of the outstanding stock of Definity. We used available cash and issued commercial paper to finance the Definity purchase price.

On July 29, 2004, our Health Care Services business segment acquired Oxford. Under the terms of the purchase agreement, Oxford shareholders received 1.2714 shares of UnitedHealth Group common stock and \$16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately \$5.0 billion, composed of approximately 104.4 million shares of UnitedHealth Group common stock (valued at approximately \$3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately \$1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of \$240 million issued in exchange for Oxford's outstanding vested common stock options.

On February 10, 2004, our Health Care Services business segment acquired MAMSI. Under the terms of the purchase agreement, MAMSI shareholders received 1.64 shares of UnitedHealth Group common stock and \$18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately \$2.7 billion, composed of 72.8 million shares of UnitedHealth Group common stock (valued at \$1.9 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and approximately \$800 million in cash.

In November and December 2005, we issued \$2.6 billion of commercial paper primarily to finance the cash portion of the purchase price of the PacifiCare acquisition described above and to retire a portion of the PacifiCare debt at the closing of the acquisition, as well as to refinance current maturities of long-term debt. As of December 31, 2005, our outstanding commercial paper had interest rates ranging from 4.2% to 4.4%.

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

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

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

To more closely align interest costs with the floating interest rate received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from a fixed rate to a variable rate. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of \$3.4 billion with variable rates that are benchmarked to the London Interbank Offered Rate (LIBOR). At December 31, 2005, the rate used to accrue interest expense on these agreements ranged from 4.3% to 5.0%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations.

In December 2005, we amended and restated our \$1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the capacity to \$1.3 billion and extended the maturity date to December 2010. In October 2005, we executed a \$3.0 billion 364-day revolving credit facility to support a \$3.0 billion increase in our commercial paper program. As of December 31, 2005, we had no amounts outstanding under either of these credit facilities.

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

governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest mandatory redemption date, plus a pro rata share of \$1 million. On January 31, 2006, approximately 91% of the convertible notes were tendered pursuant to the offer, for which we issued 4.8 million shares of UnitedHealth Group common stock and cash of \$99 million.

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

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

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During the year ended December 31, 2005, we repurchased 53.6 million shares at an average price of approximately \$48 per share and an aggregate cost of approximately \$2.6 billion. As of December 31, 2005, we had board of directors' authorization to purchase up to an additional 55.5 million shares of our common stock. Our common stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares because we believe it is a prudent use of capital. A decision by the company to discontinue share repurchases would significantly increase our liquidity and financial flexibility.

We currently have a \$4.0 billion universal S-3 shelf registration statement (for common stock, preferred stock, debt securities and other securities) which has been declared effective by the SEC. In addition, we are considered a "well known seasoned issuer" under the Securities Offering Reform Act that became effective in December 2005. We have not yet issued any securities under this shelf registration statement. We may publicly offer securities from time to time at prices and terms to be determined at the time of offering. We intend to issue debt securities during the first quarter of 2006 to refinance some or all of the commercial paper currently outstanding. Under our S-4 acquisition shelf registration statement, we have remaining issuing capacity of 48.6 million shares of our common stock in connection with acquisition activities. We filed separate S-4 registration statements for the 72.8 million shares issued in connection with the February 2004 acquisition of MAMSI, the 104.4 million shares issued in connection with the July 2004 acquisition of Oxford and the 99.2 million shares issued in connection with the December 2005 acquisition of PacifiCare described previously.

Contractual Obligations, Off-Balance Sheet Arrangements And Commitments

The following table summarizes future obligations due by period as of December 31, 2005, under our various contractual obligations, off-balance sheet arrangements and commitments (in millions):

	<u>2006</u>	<u>2007 to 2008</u>	<u>2009 to 2010</u>	<u>Thereafter</u>	<u>Total</u>
Debt and Commercial Paper ¹	\$3,261	\$1,450	\$ 700	\$1,700	\$ 7,111
Interest on Debt and Commercial Paper ²	194	299	191	302	986
Operating Leases	167	287	183	172	809
Purchase Obligations ³	151	45	6	—	202
Future Policy Benefits ⁴	120	305	280	1,176	1,881
Other Long-Term Obligations ⁵	—	56	—	302	358
Total Contractual Obligations	<u>\$3,893</u>	<u>\$2,442</u>	<u>\$1,360</u>	<u>\$3,652</u>	<u>\$11,347</u>

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

² Calculated using stated rates from the debt agreements and related interest rate swap agreements and assuming amounts are outstanding through their contractual term. For variable-rate obligations, we used the rates in place as of December 31, 2005 to estimate all remaining contractual payments.

³ Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements which are cancelable with the payment of an early termination penalty. Excludes agreements that are cancelable without penalty and also excludes liabilities to the extent recorded on the Consolidated Balance Sheet at December 31, 2005.

⁴ Estimated payments required under life and annuity contracts. Under our reinsurance arrangement with OneAmerica Financial Partners, Inc. (OneAmerica) these amounts are payable by OneAmerica but we remain primarily liable to the policyholders if they are unable to pay (see Note 3 of the consolidated financial statements).

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

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

AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings were approximately \$4.9 billion in 2005, \$4.5 billion in 2004 and \$4.1 billion in 2003.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member services expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. As further described in Note 11 to the consolidated financial statements, the RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

Medicare Part D Pharmacy Benefits Contract

The Company has contracted with the Centers for Medicare & Medicaid Services to serve as a Prescription Drug Plan sponsor offering Medicare Part D prescription drug insurance coverage to eligible Medicare beneficiaries, beginning January 1, 2006. This product is either offered as a stand-alone product or as an element of the Medicare Advantage products.

As a result of this contract and the December 2005 acquisition of PacifiCare, premium revenues from Medicare-related programs, which have historically been approximately 10% of total premium revenues, are expected to increase to approximately 25% in 2006.

Regulatory Capital and Dividend Restrictions

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the "A" range, we maintain an aggregate statutory capital level for our regulated subsidiaries that is significantly higher than the minimum level regulators require. As of December 31, 2005, our regulated subsidiaries had aggregate statutory capital of approximately \$6.4 billion, which is significantly more than the aggregate minimum regulatory requirements.

Critical Accounting Policies and Estimates

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

Medical Costs

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

Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the

period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Historically, the net impact of estimate developments has represented less than 1% of annual medical costs, less than 5% of annual earnings from operations and less than 4% of medical costs payable.

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

	Favorable Development	Net Impact on Medical Costs(a)	Medical Costs		Earnings from Operations	
			As Reported	As Adjusted(b)	As Reported	As Adjusted(b)
2002	\$ 70	(\$ 80)	\$18,192	\$18,112	\$2,186	\$2,266
2003	\$150	(\$ 60)	\$20,714	\$20,654	\$2,935	\$2,995
2004	\$210	(\$190)	\$27,000	\$26,810	\$4,101	\$4,291
2005	\$400	(c)	\$32,725	(c)	\$5,373	(c)

- (a) The amount of favorable development recorded in the current year pertaining to the prior year less the amount of favorable development recorded in the subsequent year pertaining to the current year.
- (b) Represents reported amounts adjusted to reflect the net impact of medical cost development.
- (c) Not yet determinable as the amount of prior period development recorded in 2006 will change as our December 31, 2005 medical costs payable estimate develops throughout 2006.

Our estimate of medical costs payable represents management's best estimate of the company's liability for unpaid medical costs as of December 31, 2005, developed using consistently applied actuarial methods. Management believes the amount of medical costs payable is reasonable and adequate to cover the company's liability for unpaid claims as of December 31, 2005; however, actual claim payments may differ from established estimates. The increase in favorable medical cost development in 2005 was driven primarily by lower than anticipated medical costs as well as growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004. Assuming a hypothetical 1% difference between our December 31, 2005 estimates of medical costs payable and actual costs payable, excluding the AARP business, 2005 earnings from operations would increase or decrease by \$63 million and diluted net earnings per common share would increase or decrease by \$0.03 per share.

Contingent Liabilities

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

Goodwill, Intangible Assets and Other Long-Lived Assets

As of December 31, 2005, we had long-lived assets, including goodwill, other intangible assets, property, equipment and capitalized software, of \$19.9 billion. We review our goodwill for impairment annually at the

reporting unit level, and we review our remaining long-lived assets for impairment when events and changes in circumstances indicate we might not recover their carrying value. To determine the fair value of our long-lived assets and assess their recoverability, we must make assumptions about a wide variety of internal and external factors including estimated future utility and estimated future cash flows, which in turn are based on estimates of future revenues, expenses and operating margins. If these estimates or their related assumptions change in the future, we may be required to record impairment charges for these assets that could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs.

Revenues

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

Investments

As of December 31, 2005, we had approximately \$9.6 billion of investments, primarily held in marketable debt securities. Our investments are principally classified as available for sale and are recorded at fair value. We exclude unrealized gains and losses on investments available for sale from earnings and report them together, net of income tax effects, as a separate component in shareholders' equity. We continually monitor the difference between the cost and fair value of our investments. As of December 31, 2005, our investments had gross unrealized gains of \$105 million and gross unrealized losses of \$53 million. If any of our investments experience a decline in fair value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in our Consolidated Statements of Operations. Management judgment is involved in evaluating whether a decline in an investment's fair value is other than temporary. New information and the passage of time can change these judgments. We revise impairment judgments when new information becomes known and record any resulting impairment charges at that time. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

Inflation

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

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

Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates, including PacifiCare, in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and the Racketeer Influenced Corrupt Organization Act (RICO) in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. Through a series of motions and appeals, all direct claims against us have been compelled to arbitration. A trial date has been set for September 2006. The trial court has ordered that the trial be split into separate liability and damage proceedings. In August 2005, the capitation-related claims were dismissed from litigation. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare. A March 14, 2006 hearing date has been scheduled for our summary judgment motion.

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

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

Quantitative and Qualitative Disclosures About Market Risks

Market risk represents the risk of changes in the fair value of a financial instrument caused by changes in interest rates or equity prices. The company's primary market risk is exposure to changes in interest rates that could impact the fair value of our investments and long-term debt.

Approximately \$14.7 billion of our cash equivalents and investments at December 31, 2005 were debt securities. Assuming a hypothetical and immediate 1% increase or decrease in interest rates applicable to our fixed-income investment portfolio at December 31, 2005, the fair value of our fixed-income investments would decrease or increase by approximately \$345 million. We manage our investment portfolio to limit our exposure to any one issuer or industry and largely limit our investments to U.S. Government and Agency securities, state and municipal securities, and corporate debt obligations that are investment grade.

To mitigate the financial impact of changes in interest rates, we have entered into interest rate swap agreements to more closely match the interest rates of our long-term debt with those of our cash equivalents and short-term investments. Including the impact of our interest rate swap agreements, approximately \$6.2 billion of our commercial paper and debt had variable rates of interest and approximately \$0.9 billion had fixed rates as of December 31, 2005. A hypothetical 1% increase or decrease in interest rates would not be material to the fair value of our commercial paper and debt.

At December 31, 2005, we had \$261 million of equity investments, a portion of which were held by our UnitedHealth Capital business in various public and non-public companies concentrated in the areas of health care delivery and related information technologies. Market conditions that affect the value of health care or technology stocks will likewise impact the value of our equity portfolio.

Concentrations of Credit Risk

Investments in financial instruments such as marketable securities and accounts receivable may subject UnitedHealth Group to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our board of directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. Government and Agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups that constitute our customer base. As discussed more fully in Note 3 to the consolidated financial statements, we have a \$1.8 billion reinsurance receivable resulting from the sale of our life and annuity business. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery. As of December 31, 2005, there were no other significant concentrations of credit risk.

Cautionary Statements

The statements 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 Securities and Exchange Commission, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words or phrases “believes,” “anticipates,” “expects,” “plans,” “seeks,” “intends,” “will likely result,” “estimates,” “projects” or similar expressions are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed in the forward-looking statements.

The following discussion contains certain cautionary statements regarding our business that investors and others should consider. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this 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. Actual future results may vary materially from expectations expressed in our prior communications.

We must effectively manage our health care costs.

Under our risk-based product arrangements, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based products (excluding AARP) have typically comprised approximately 75% to 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our risk-based products depends in large part on our ability to predict, price for, and effectively manage health care costs. Total health care costs are affected by the number of individual services rendered and the cost of each service. Our premium revenue is typically fixed in price for a 12-month period and is generally priced one to four months before the contract commences. We base the premiums we charge on our estimate of future health care costs over the fixed premium period; however, inflation, regulations and other factors may cause actual costs to exceed what was estimated and reflected in premiums. These factors may include increased use of services, increased cost of individual services, catastrophes, epidemics, the introduction of new or costly treatments and technology, new mandated benefits or other regulatory changes, insured population characteristics and seasonal changes in the level of health care use. As a measure of the impact of medical cost on our financial results, relatively small differences between predicted and actual medical costs as a percentage of premium revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for UnitedHealthcare's commercial insured products, our annual net earnings for 2005 would have been reduced by approximately \$130 million. In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. If these estimates prove too high or too low, the effect of the change in estimate will be included in future results. That change can be either positive or negative to our results.

We face competition in many of our markets and customers have flexibility in moving between competitors.

Our businesses compete throughout the United States and face competition in all of the geographic markets in which they operate. For our Uniprise and Health Care Services segments, competitors include Aetna Inc., Cigna Corporation, Coventry Health Care, Inc., Humana Inc., and WellPoint, Inc., numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross Blue Shield Association and enterprises that serve more limited geographic areas. Our Specialized Care Services and Ingenix segments also compete with a number of businesses. The addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. In particular markets, competitors may have capabilities or resources that give them a competitive advantage. Greater market share, established reputation, superior supplier or provider arrangements, existing business relationships, and other factors all can provide a competitive advantage to our businesses or to their competitors. In addition, significant merger and acquisition activity has occurred in the industries in which we operate, both as to our competitors and suppliers in these industries. Consolidation may make it more difficult for us to retain or increase customers, to improve the terms on which we do business with our suppliers, or to maintain or advance profitability.

Our relationship with AARP is important.

Under our 10-year contract with AARP, which commenced in 1998, we provide Medicare supplement and hospital indemnity health insurance and other products to AARP members. As of December 31, 2005, our portion of AARP's insurance program represented approximately \$4.9 billion in annual net premium revenue from approximately 3.8 million AARP members. The AARP contract may be terminated early by us or AARP under certain circumstances, including a material breach by either party, insolvency of either party, a material

adverse change in the financial condition of either party, and by mutual agreement. The success of our AARP arrangement depends, in part, on our ability to service AARP and its members, develop additional products and services, price the products and services competitively, and respond effectively to federal and state regulatory changes.

Some of the favorable and unfavorable effects of changes in Medicare remain uncertain.

The changes in Medicare as a result of the Medicare Modernization Act of 2003 (MMA) are complex and wide-ranging and continue to affect our businesses. We have taken advantage of new opportunities to partner with the federal government created by the MMA, including Medicare Part D prescription drug coverage, Medicare Advantage Regional PPOs, and Special Needs Plans for chronically ill Medicare beneficiaries. We have invested considerable resources in creating new Medicare product offerings for these initiatives and in analyzing how to best address uncertainties and risks associated with these new programs and other changes arising from the MMA. In particular, the Part D program presents challenges because of the size and scope of the new program. Our ability to successfully participate in the Part D program depends in part on coordination of information and information systems between us, CMS and state governments. We have been working with CMS to correct systems issues that they have experienced with respect to certain low income people eligible to participate in Part D. The inability to receive correct information due to systems issues by the federal government, the applicable state government or us could adversely affect our business. Additionally, our participation in the Part D program is based upon certain assumptions regarding enrollment, utilization, pharmaceutical costs and other factors. In the event any of these assumptions are materially incorrect, either as a result of unforeseen changes to the Part D program or otherwise, our results could be materially affected. Any positive or negative results of the Part D program are likely to have a significant impact on us as a result of the size of our enrollment in our Part D program.

We are subject to funding risks with respect to revenue received from participation in Medicare and Medicaid programs.

We participate as a payer in Medicare Advantage, Part D, and Medicaid programs and receive revenues from the Medicare and Medicaid programs to provide benefits under these programs. Revenues for these programs are dependent upon annual funding from the federal government or applicable state governments. Funding for these programs is dependent upon many factors outside of our control including general economic conditions at the federal or applicable state level and general political issues and priorities. An unexpected reduction in government funding for these programs may adversely affect our revenues and financial results.

Our business is subject to routine government scrutiny, and we must respond quickly and appropriately to frequent changes in government regulations.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. We must obtain and maintain regulatory approvals to market many of our products, to increase prices for certain regulated products and to complete certain acquisitions and dispositions. Delays in obtaining approvals or our failure to obtain or maintain these approvals could reduce our revenue or increase our costs.

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

State legislatures and Congress continue to focus on health care issues. Legislative and regulatory proposals at state and federal levels may affect certain aspects of our business, including contracting with physicians, hospitals and other health care professionals; physician reimbursement methods and payment rates; coverage determinations; claim payments and processing; drug utilization and patient safety efforts; use and maintenance of individually identifiable health information; medical malpractice litigation; and government-sponsored programs. We cannot predict if any of these initiatives will ultimately become binding law or regulation, or, if enacted, what their terms will be, but their enactment could increase our costs, expose us to expanded liability, require us to revise the ways in which we conduct business or put us at risk for loss of business.

We typically are involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services.

Relationships with physicians, hospitals and other health care providers are important to our business.

We contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers, and other health care providers for competitive prices. Our results of operations and prospects are substantially dependent on our continued ability to maintain these competitive prices. A number of organizations are advocating for legislation that would exempt certain of these physicians and health care professionals from federal and state antitrust laws. In any particular market, these physicians and health care professionals could refuse to contract, demand higher payments, or take other actions that could result in higher health care costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician/hospital organizations or multispecialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part.

In addition, we have capitation arrangements with some physicians, hospitals and other health care providers. Under the typical arrangement, the provider receives a fixed percentage of premium to cover all the medical costs provided to the capitated member. Under some capitated arrangements, the provider may also receive additional compensation from risk sharing and other incentive arrangements. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the provider. To the extent that a capitated 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 are the responsibility of the capitated provider and for which we have already paid the provider under the capitation arrangement.

The nature of our business exposes us to litigation risks.

Periodically, we become a party to the types of legal actions that can affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, and intellectual property-related litigation. In addition, because of the nature of our business, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. These matters include, among others, claims related to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices. In 1999, a number of class action lawsuits were filed against UnitedHealthcare and PacifiCare and virtually all major entities in the health benefits business, although all claims against PacifiCare have been dismissed. The suits are

purported class actions on behalf of physicians for alleged breaches of federal statutes, including ERISA and RICO . In March 2000, the American Medical Association filed a lawsuit against us in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. Although the expenses we have incurred to date in defending the 1999 class action lawsuits and the American Medical Association lawsuit have not been material to our business, we will continue to incur expenses in the defense of these lawsuits and other matters, even if they are without merit.

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

Our businesses providing pharmacy benefit management (PBM) services face regulatory and other risks associated with the pharmacy benefits management industry that may differ from the risks of providing managed care and health insurance products.

In connection with the PacifiCare merger, we acquired a pharmacy benefits management business, Prescription Solutions. We also provide pharmacy benefits management services through UnitedHealth Pharmaceutical Solutions. Prescription Solutions and UnitedHealth Pharmaceutical Solutions are subject to federal and state anti-remuneration and other laws that govern their relationships with pharmaceutical manufacturers, customers and consumers. Federal and state legislatures are considering new regulations for the industry that could adversely affect current industry practices, including the receipt of rebates from pharmaceutical companies. In addition, if a court were to determine that our PBM business acts as a fiduciary under the Employee Retirement Income Security Act, or ERISA, we could be subject to claims for alleged breaches of fiduciary obligations in implementation of formularies, preferred drug listings and therapeutic intervention programs, contracting network practices, speciality drug distribution and other transactions. Our PBM also conducts business as a mail order pharmacy, which subjects it to extensive federal, state and local laws and regulations, as well as risks inherent in the packaging and distribution of pharmaceuticals and other health care products. The failure to adhere to these laws and regulations could expose our PBM subsidiary to civil and criminal penalties. We also face potential claims in connection with purported errors by our mail order pharmacy.

Our businesses depend on effective information systems and the integrity of the data in our information systems.

Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to accurately report our financial results depends on the integrity of the data in our information systems. As a result of our acquisition activities, we have acquired additional systems. We have been taking steps to reduce the number of systems we operate and have upgraded and expanded our information systems capabilities. If the information we rely upon to run our businesses were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, have problems in determining medical cost estimates and establishing appropriate pricing, have disputes with customers, physicians and other health care providers have regulatory problems, have increases in operating expenses or suffer other adverse consequences.

The value of our intangible assets may become impaired.

Due largely to our recent acquisitions, goodwill and other intangible assets represent a substantial portion of our assets. Goodwill and other intangible assets were approximately \$18.2 billion as of December 31, 2005, representing approximately 44% of our total assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our books. We periodically evaluate our goodwill and other intangible

assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to earnings may be necessary. Any future evaluations requiring an asset impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

Our knowledge and information-related businesses depend on our ability to maintain proprietary rights to our databases and related products.

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

We must comply with restrictions on patient privacy and information security, including taking steps to ensure that our business associates who obtain access to sensitive patient information maintain its confidentiality.

The use of individually identifiable data by our businesses is regulated at the international, federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and disclosure of individually identifiable health data. Most are derived from the privacy and security provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996, (HIPAA). HIPAA also imposes guidelines on our business associates (as this term is defined in the HIPAA regulations). Even though we provide for appropriate protections through our contracts with our business associates, we still have limited control over their actions and practices. Compliance with these proposals, requirements, and new regulations may result in cost increases due to necessary systems changes, the development of new administrative processes, and the effects of potential noncompliance by our business associates. They also may impose further restrictions on our use of patient identifiable data that is housed in one or more of our administrative databases.

The anticipated benefits of acquiring PacifiCare may not be realized.

We acquired PacifiCare with the expectation that the merger will result in various benefits including, among others, benefits relating to a stronger and more diverse network of doctors and other health care providers, expanded and enhanced affordable health care services, enhanced revenues, a strengthened market position for UnitedHealth Group in the Western United States, cross-selling opportunities, technology, cost savings and operating efficiencies. Achieving the anticipated benefits of the merger is subject to a number of uncertainties, including whether UnitedHealth Group integrates PacifiCare in an efficient and effective manner and general competitive factors in the marketplace. Failure to achieve these anticipated benefits could result in increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially impact our business, financial condition and operating results.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The information called for by this Item is incorporated herein by reference to Item 7 of this report under the heading "Quantitative and Qualitative Disclosures about Market Risk."

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

UnitedHealth Group
Consolidated Statements of Operations

<u>(in millions, except per share data)</u>	<u>For the Year Ended December 31,</u>		
	<u>2005</u>	<u>2004</u>	<u>2003</u>
Revenues			
Premiums	\$41,058	\$33,495	\$25,448
Services	3,808	3,335	3,118
Investment and Other Income	499	388	257
Total Revenues	<u>45,365</u>	<u>37,218</u>	<u>28,823</u>
Medical and Operating Costs			
Medical Costs	32,725	27,000	20,714
Operating Costs	6,814	5,743	4,875
Depreciation and Amortization	453	374	299
Total Medical and Operating Costs	<u>39,992</u>	<u>33,117</u>	<u>25,888</u>
Earnings From Operations	5,373	4,101	2,935
Interest Expense	(241)	(128)	(95)
Earnings Before Income Taxes	5,132	3,973	2,840
Provision for Income Taxes	(1,832)	(1,386)	(1,015)
Net Earnings	<u>\$ 3,300</u>	<u>\$ 2,587</u>	<u>\$ 1,825</u>
Basic Net Earnings per Common Share	<u>\$ 2.61</u>	<u>\$ 2.07</u>	<u>\$ 1.55</u>
Diluted Net Earnings per Common Share	<u>\$ 2.48</u>	<u>\$ 1.97</u>	<u>\$ 1.48</u>
Basic Weighted-Average Number of Common Shares Outstanding	1,265	1,252	1,178
Dilutive Effect of Common Stock Equivalents	65	58	56
Diluted Weighted-Average Number of Common Shares Outstanding	<u>1,330</u>	<u>1,310</u>	<u>1,234</u>

See Notes to Consolidated Financial Statements.

UnitedHealth Group
Consolidated Balance Sheets

<u>(in millions, except per share data)</u>	<u>As of December 31,</u>	
	<u>2005</u>	<u>2004</u>
Assets		
Current Assets		
Cash and Cash Equivalents	\$ 5,421	\$ 3,991
Short-Term Investments	590	514
Accounts Receivable, net of allowances of \$105 and \$101	1,290	906
Assets Under Management	1,825	1,930
Deferred Income Taxes	645	353
Other Current Assets	869	547
Total Current Assets	<u>10,640</u>	<u>8,241</u>
Long-Term Investments	8,971	7,748
Property, Equipment, and Capitalized Software, net of accumulated depreciation and amortization of \$966 and \$660	1,647	1,139
Goodwill	16,206	9,470
Other Intangible Assets, net of accumulated amortization of \$192 and \$103	2,020	1,205
Other Assets	1,890	76
Total Assets	<u>\$41,374</u>	<u>\$27,879</u>
Liabilities and Shareholders' Equity		
Current Liabilities		
Medical Costs Payable	\$ 7,301	\$ 5,540
Accounts Payable and Accrued Liabilities	3,301	2,107
Other Policy Liabilities	1,824	1,933
Commercial Paper and Current Maturities of Long-Term Debt	3,261	673
Unearned Premiums	957	1,076
Total Current Liabilities	<u>16,644</u>	<u>11,329</u>
Long-Term Debt, less current maturities	3,850	3,350
Future Policy Benefits for Life and Annuity Contracts	1,761	1,669
Deferred Income Taxes and Other Liabilities	1,386	814
Commitments and Contingencies (Note 12)		
Shareholders' Equity		
Common Stock, \$0.01 par value - 3,000 shares authorized; 1,358 and 1,286 shares outstanding	14	13
Additional Paid-In Capital	6,921	3,088
Retained Earnings	10,765	7,484
Accumulated Other Comprehensive Income:		
Net Unrealized Gains on Investments, net of tax effects	33	132
Total Shareholders' Equity	<u>17,733</u>	<u>10,717</u>
Total Liabilities and Shareholders' Equity	<u>\$41,374</u>	<u>\$27,879</u>

See Notes to Consolidated Financial Statements.

UnitedHealth Group

Consolidated Statements of Changes in Shareholders' Equity

(in millions)	Common Stock		Additional Paid-in Capital	Retained Earnings	Net Unrealized Gains on Investments	Total Shareholders' Equity	Comprehensive Income
	Shares	Amount					
Balance at December 31, 2002	1,198	\$12	\$ 164	\$ 4,104	\$148	\$ 4,428	
Issuances of Common Stock, and related tax benefits	34	—	490	—	—	490	
Common Stock Repurchases	(66)	—	(602)	(1,005)	—	(1,607)	
Comprehensive Income							
Net Earnings	—	—	—	1,825	—	1,825	\$1,825
Other Comprehensive Income							
Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	—	—	—	—	1	1	<u>1</u>
Comprehensive Income							<u>\$1,826</u>
Common Stock Dividend	—	—	—	(9)	—	(9)	
Balance at December 31, 2003	1,166	12	52	4,915	149	5,128	
Issuances of Common Stock, and related tax benefits	223	2	6,481	—	—	6,483	
Common Stock Repurchases	(103)	(1)	(3,445)	—	—	(3,446)	
Comprehensive Income							
Net Earnings	—	—	—	2,587	—	2,587	\$2,587
Other Comprehensive Income							
Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	—	—	—	—	(17)	(17)	<u>(17)</u>
Comprehensive Income							<u>\$2,570</u>
Common Stock Dividend	—	—	—	(18)	—	(18)	
Balance at December 31, 2004	1,286	13	3,088	7,484	132	10,717	
Issuances of Common Stock, and related tax benefits	126	1	6,390	—	—	6,391	
Common Stock Repurchases	(54)	—	(2,557)	—	—	(2,557)	
Comprehensive Income							
Net Earnings	—	—	—	3,300	—	3,300	\$3,300
Other Comprehensive Income							
Adjustments:							
Change in Net Unrealized Gains on Investments, net of tax effects	—	—	—	—	(99)	(99)	<u>(99)</u>
Comprehensive Income							<u>\$3,201</u>
Common Stock Dividend	—	—	—	(19)	—	(19)	
Balance at December 31, 2005	<u>1,358</u>	<u>\$14</u>	<u>\$6,921</u>	<u>\$10,765</u>	<u>\$ 33</u>	<u>\$17,733</u>	

See Notes to Consolidated Financial Statements.

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Year Ended December 31,		
	2005	2004	2003
Operating Activities			
Net Earnings	\$ 3,300	\$ 2,587	\$ 1,825
Noncash Items			
Depreciation and Amortization	453	374	299
Deferred Income Taxes and Other	167	125	91
Net Change in Other Operating Items, net of effects from acquisitions, and changes in AARP balances:			
Accounts Receivable and Other Current Assets	(83)	(30)	(46)
Medical Costs Payable	193	322	276
Accounts Payable and Other Accrued Liabilities	580	623	547
Unearned Premiums	(284)	134	11
Cash Flows From Operating Activities	4,326	4,135	3,003
Investing Activities			
Cash Paid for Acquisitions, net of cash assumed and other effects	(2,562)	(2,225)	(590)
Cash Transferred on Sale of Business	(363)	—	—
Purchases of Property, Equipment and Capitalized Software	(509)	(350)	(352)
Purchases of Investments	(5,876)	(3,190)	(2,583)
Maturities and Sales of Investments	5,821	4,121	2,780
Cash Flows Used For Investing Activities	(3,489)	(1,644)	(745)
Financing Activities			
Proceeds from (Payments of) Commercial Paper, net	2,556	194	(382)
Proceeds from Issuance of Long-Term Debt	500	2,000	950
Payments for Retirement of Long-Term Debt	(400)	(150)	(350)
Common Stock Repurchases	(2,557)	(3,446)	(1,607)
Proceeds from Common Stock Issuances	423	583	268
Dividends Paid	(19)	(18)	(9)
Other	90	75	4
Cash Flows From (Used For) Financing Activities	593	(762)	(1,126)
Increase in Cash and Cash Equivalents	1,430	1,729	1,132
Cash and Cash Equivalents, Beginning of Period	3,991	2,262	1,130
Cash and Cash Equivalents, End of Period	\$ 5,421	\$ 3,991	\$ 2,262
Supplemental Schedule of Noncash Investing and Financing Activities			
Common Stock Issued for Acquisitions	\$ 5,696	\$ 5,557	\$ —

See Notes to Consolidated Financial Statements.

Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (also referred to as “UnitedHealth Group,” “the company,” “we,” “us,” and “our”) is a diversified health and well-being company dedicated to making health care work better. Through strategically aligned, market-defined businesses, we design products, provide services and apply technologies that improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable.

2. Summary of Significant Accounting Policies

Basis of Presentation

We have prepared the consolidated financial statements according to accounting principles generally accepted in the United States of America and have included the accounts of UnitedHealth Group and its subsidiaries. We have eliminated all significant intercompany balances and transactions.

Use of Estimates

These consolidated financial statements include certain amounts that are based on our best estimates and judgments. These estimates require us to apply complex assumptions and judgments, often because we must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to medical costs, medical costs payable, contingent liabilities, intangible asset valuations, asset impairments and revenues. We adjust these estimates each period, as more current information becomes available. The impact of any changes in estimates is included in the determination of earnings in the period in which the estimate is adjusted.

Revenues

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is fixed, typically for a one-year period, and we assume the economic risk of funding our customers’ health care services and related administrative costs. We recognize premium revenues in the period in which eligible individuals are entitled to receive health care services. We record health care premium payments we receive from our customers in advance of the service period as unearned premiums.

Service revenues consist primarily of fees derived from services performed for customers that self-insure the medical costs of their employees and their dependents. Under service fee contracts, we recognize revenue in the period the related services are performed based upon the fee charged to the customer. The customers retain the risk of financing medical benefits for their employees and their employees’ dependents, and we administer the payment of customer funds to physicians and other health care providers from customer-funded bank accounts. Because we do not have the obligation for funding the medical expenses, nor do we have responsibility for delivering the medical care, we do not recognize gross revenue and medical costs for these contracts in our consolidated financial statements.

For both premium risk-based and fee-based customer arrangements, we provide coordination and facilitation of medical services; transaction processing; customer, consumer and care provider services; and access to contracted networks of physicians, hospitals and other health care professionals.

Medical Costs and Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers but for which we have either not yet received or processed claims,

and for liabilities for physician, hospital and other medical cost disputes. We develop estimates for medical costs incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, care provider contract rate changes, medical care consumption and other medical cost trends. We estimate liabilities for physician, hospital and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, we re-examine previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that generally have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments. Investments with maturities of less than one year are classified as short-term. We may sell investments classified as long-term before their maturities to fund working capital or for other purposes. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. We classify these investments as held to maturity and report them at amortized cost. All other investments are classified as available for sale and reported at fair value based on quoted market prices.

We exclude unrealized gains and losses on investments available for sale from earnings and report it, net of income tax effects, as a separate component of shareholders' equity. We continually monitor the difference between the cost and estimated fair value of our investments. If any of our investments experiences a decline in value that is determined to be other than temporary, based on analysis of relevant factors, we record a realized loss in Investment and Other Income in our Consolidated Statements of Operations. To calculate realized gains and losses on the sale of investments, we use the specific cost or amortized cost of each investment sold.

Assets Under Management

We administer certain aspects of AARP's insurance program (see Note 11). Pursuant to our agreement, AARP assets are managed separately from our general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at our discretion, within investment guidelines approved by AARP. We do not guarantee any rates of return on these investments and, upon transfer of the AARP contract to another entity, we would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with the AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. As such, they are not included in our earnings.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software is stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development.

We calculate depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are: from three to seven years for furniture, fixtures and equipment; from 35 to 40 years for buildings; the shorter of the useful life or remaining

lease term for leasehold improvements; and from three to nine years for capitalized software. The weighted-average useful life of property, equipment and capitalized software at December 31, 2005 was approximately five years. The net book value of property and equipment was \$876 million and \$543 million as of December 31, 2005 and 2004, respectively. The net book value of capitalized software was \$771 million and \$596 million as of December 31, 2005 and 2004, respectively.

Goodwill and Other Intangible Assets

Goodwill represents the amount by which the purchase price of businesses we have acquired exceed the estimated fair value of the net tangible assets and separately identifiable intangible assets of these businesses. Goodwill and intangible assets with indefinite useful lives are not amortized, but are tested at least annually for impairment. Intangible assets with discrete useful lives are amortized on a straight-line basis over their estimated useful lives.

Long-Lived Assets

We review long-lived assets, including property, equipment, capitalized software and intangible assets, for events or changes in circumstances that would indicate we might not recover their carrying value. We consider many factors, including estimated future utility and cash flows associated with the assets, to make this decision. An impairment charge is recorded for the amount by which an asset's carrying value exceeds its estimated fair value. We record assets held for sale at the lower of their carrying amount or fair value, less any costs for the final settlement.

Other Policy Liabilities

Other policy liabilities include the RSF associated with the AARP program (see Note 11), customer balances related to experience-rated insurance products and the current portion of future policy benefits for life insurance and annuity contracts. Customer balances represent excess customer payments and deposit accounts under experience-rated contracts. At the customer's option, these balances may be refunded or used to pay future premiums or claims under eligible contracts.

Income Taxes

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

Future Policy Benefits for Life and Annuity Contracts and Reinsurance Receivables

Future policy benefits for life insurance and annuity contracts represent account balances that accrue to the benefit of the policyholders, excluding surrender charges, for universal life and investment annuity products. As a result of the October 2005 sale of the life and annuity business within our subsidiary Golden Rule Financial Corporation (Golden Rule) under an indemnity reinsurance arrangement described in Note 3, we have maintained a liability associated with the reinsured contracts, as we remain primarily liable to the policyholders, and have recorded a corresponding reinsurance receivable due from the purchaser on the Consolidated Balance Sheet as of December 31, 2005. We regularly evaluate the financial condition of the reinsurer and only record the reinsurance receivable to the extent that the amounts are deemed probable of recovery.

Policy Acquisition Costs

For our health insurance contracts, costs related to the acquisition and renewal of customer contracts are charged to expense as incurred. Our health insurance contracts typically have a one-year term and may be cancelled upon 30 days notice by either the company or the customer.

Stock-Based Compensation

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

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

<u>(in millions, except per share data)</u>	<u>For the Year Ended</u> <u>December 31,</u>		
	<u>2005</u>	<u>2004</u>	<u>2003</u>
Net Earnings			
As Reported	\$3,300	\$2,587	\$1,825
Compensation Expense, net of tax effect	(160)	(132)	(122)
Pro Forma	<u>\$3,140</u>	<u>\$2,455</u>	<u>\$1,703</u>
Basic Net Earnings Per Common Share			
As Reported	\$ 2.61	\$ 2.07	\$ 1.55
Pro Forma	\$ 2.48	\$ 1.96	\$ 1.45
Diluted Net Earnings Per Common Share			
As Reported	\$ 2.48	\$ 1.97	\$ 1.48
Pro Forma	\$ 2.36	\$ 1.87	\$ 1.38
Weighted-Average Fair Value Per Share of			
Options Granted	\$ 13	\$ 10	\$ 6

Information on our stock-based compensation plans and data used to calculate compensation expense in the table above are described in more detail in Note 9.

As discussed more fully within Note 9, FAS No. 123 (revised 2004), "Share Based Payment," (FAS 123R) was effective during the first quarter of 2006, and requires us to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. We adopted this standard on a retrospective restatement basis as of January 1, 2006 and the adoption did not result in any change to the pro forma compensation expense amounts historically disclosed under FAS 123.

Net Earnings Per Common Share

We compute basic net earnings per common share by dividing net earnings by the weighted-average number of common shares outstanding during the period. We determine diluted net earnings per common share using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares that might be issued upon the exercise of common stock options or the conversion of convertible subordinated debentures.

Derivative Financial Instruments

As part of our risk management strategy, we enter into interest rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and

recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations. Our existing interest rate swap agreements convert a majority of our interest rate exposure from a fixed to a variable rate and are accounted for as fair value hedges. Additional information on our existing interest rate swap agreements is included in Note 7.

Recently Issued Accounting Standards

In November 2005, the FASB issued Staff Position No. 115-1, "The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments" (FSP 115-1). FSP 115-1 provides accounting guidance for evaluating and recording other-than-temporary impairment losses on certain debt and equity investments. FSP 115-1 nullifies certain provisions of Emerging Issues Task Force Issue No. 03-1 while retaining its disclosure requirements, which had already been adopted. The Company has adopted FSP 115-1 and its adoption did not have any impact on our consolidated financial position or results of operations.

In June 2005, the FASB issued an exposure draft of a proposed standard entitled "Business Combinations — a replacement of FASB Statement No. 141." The proposed standard, if adopted, would provide new guidance for evaluating and recording business combinations and would be effective on a prospective basis for business combinations whose acquisition dates are on or after January 1, 2007. Upon issuance of a final standard, the Company will evaluate the impact of this new standard and its effect on the process for recording business combinations.

3. Acquisitions and Divestitures

On December 20, 2005, the company acquired PacifiCare Health Systems, Inc. (PacifiCare). PacifiCare provides health care and benefit services to individuals and employers, principally in markets in the Western United States. This merger significantly strengthened our resources by enhancing our capabilities on the Pacific Coast and in other Western states and broadening the scope of our product offerings for a host of specialized services. The operations of PacifiCare reside primarily within our Health Care Services and Specialized Care Services segments. Under the terms of the agreement, PacifiCare shareholders received 1.1 shares of UnitedHealth Group common stock and \$21.50 in cash for each share of PacifiCare common stock they owned. Total consideration issued for the transaction was approximately \$8.8 billion, composed of approximately 99.2 million shares of UnitedHealth Group common stock (valued at approximately \$5.3 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of July 6, 2005), approximately \$2.1 billion in cash, \$960 million cash paid to retire PacifiCare's existing debt and UnitedHealth Group vested common stock options with an estimated fair value of approximately \$420 million issued in exchange for PacifiCare's outstanding vested common stock options. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately \$7.1 billion. Pending completion of an independent valuation analysis, we have preliminarily allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of \$1.0 billion and associated deferred tax liabilities of \$392 million, and goodwill of approximately \$6.5 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 13 years. The acquired goodwill is not deductible for income tax purposes. Our preliminary estimate of acquired net tangible assets and liabilities are categorized as follows: cash and cash equivalents of \$810 million; investments of \$2.4 billion; accounts receivable and other current assets of \$750 million; property, equipment and capitalized software and other assets of \$380 million; medical costs payable of \$1.4 billion and other liabilities of \$1.2 billion.

On February 24, 2006, our Health Care Services business segment acquired John Deere Health Care, Inc. (John Deere Health). John Deere Health serves employers primarily in central and eastern Iowa, western Illinois, eastern Tennessee and southwestern Virginia. This acquisition will strengthen our market position in these areas. We paid approximately \$500 million in cash in exchange for all of the outstanding equity of John Deere Health. Due to the timing of the acquisition, management is still in the process of estimating the acquired net tangible assets, intangible assets and goodwill resulting from this acquisition.

On September 19, 2005, our Health Care Services business segment acquired Neighborhood Health Partnership (NHP). NHP serves local employers primarily in South Florida. This acquisition strengthened our market position in this region and provided expanded distribution opportunities for our other UnitedHealth Group businesses. We paid approximately \$185 million in cash in exchange for all of the outstanding equity of NHP. The results of operations and financial condition of NHP have been included in our consolidated financial statements since the acquisition date. The pro forma effects of the NHP acquisition on our consolidated financial statements were not material.

On December 10, 2004, our Uniprise business segment acquired Definity Health Corporation (Definity). Definity is a national market leader in consumer-driven health benefit programs. This acquisition strengthened our position in the emerging consumer-driven health benefits marketplace. We paid \$305 million in cash in exchange for all of the outstanding stock of Definity. The purchase price and costs associated with the acquisition exceeded the preliminary estimated fair value of the net tangible assets acquired by approximately \$263 million. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of \$34 million and associated deferred tax liabilities of \$13 million, and goodwill of approximately \$242 million. The finite-lived intangible assets consist primarily of customer contracts and trademarks, with an estimated weighted-average useful life of 13 years. The acquired goodwill is not deductible for income tax purposes. The results of operations and financial condition of Definity have been included in our consolidated financial statements since the acquisition date. The pro forma effects of the Definity acquisition on our consolidated financial statements were not material. Acquired net tangible assets of \$42 million consisted mainly of cash, cash equivalents, accounts receivable, property and equipment and other assets partially offset by current liabilities.

On July 29, 2004, our Health Care Services business segment acquired Oxford Health Plans, Inc. (Oxford). Oxford provides health care and benefit services for individuals and employers, principally in New York City, northern New Jersey and southern Connecticut. This merger strengthened our market position in this region and provided substantial distribution opportunities in this region for our other UnitedHealth Group businesses. Under the terms of the purchase agreement, Oxford shareholders received 1.2714 shares of UnitedHealth Group common stock and \$16.17 in cash for each share of Oxford common stock they owned. Total consideration issued was approximately \$5.0 billion, composed of approximately 104.4 million shares of UnitedHealth Group common stock (valued at approximately \$3.4 billion based upon the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of April 26, 2004), approximately \$1.3 billion in cash and UnitedHealth Group vested common stock options with an estimated fair value of \$240 million issued in exchange for Oxford's outstanding vested common stock options. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately \$4.2 billion. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of approximately \$600 million and associated deferred tax liabilities of approximately \$225 million, and goodwill of approximately \$3.8 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 16 years. The acquired goodwill is not deductible for income tax purposes. Acquired net tangible assets and liabilities are categorized as follows: cash, cash equivalents and investments of \$1.7 billion; accounts receivable and other current assets of \$162 million; property, equipment and capitalized software and other assets of \$37 million; medical costs payable of \$713 million and other current liabilities of \$334 million.

On February 10, 2004, our Health Care Services business segment acquired Mid Atlantic Medical Services, Inc. (MAMSI). MAMSI offers a broad range of health care coverage and related administrative services for individuals and employers in the mid-Atlantic region of the United States. This merger strengthened UnitedHealthcare's market position in the mid-Atlantic region and provided substantial distribution opportunities for our other UnitedHealth Group businesses in this region. Under the terms of the purchase agreement, MAMSI

shareholders received 1.64 shares of UnitedHealth Group common stock and \$18 in cash for each share of MAMSI common stock they owned. Total consideration issued was approximately \$2.7 billion, comprised of 72.8 million shares of UnitedHealth Group common stock (valued at \$1.9 billion based on the average of UnitedHealth Group's share closing price for two days before, the day of and two days after the acquisition announcement date of October 27, 2003) and approximately \$800 million in cash. The purchase price and costs associated with the acquisition exceeded the estimated fair value of the net tangible assets acquired by approximately \$2.1 billion. Based on management's consideration of fair value, which included an independent valuation analysis, we have allocated the excess purchase price over the fair value of the net tangible assets acquired to finite-lived intangible assets of approximately \$280 million and associated deferred tax liabilities of approximately \$100 million, and goodwill of approximately \$1.9 billion. The finite-lived intangible assets consist primarily of member lists, health care physician and hospital networks and trademarks, with an estimated weighted-average useful life of 17 years. The acquired goodwill is not deductible for income tax purposes. Acquired net tangible assets and liabilities are categorized as follows: cash, cash equivalents and investments of \$736 million; accounts receivable and other current assets of \$228 million; property, equipment and capitalized software and other assets of \$57 million; medical costs payable of \$283 million and other current liabilities of \$140 million.

The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in our consolidated financial statements since the respective acquisition dates. The unaudited pro forma financial information presented below assumes that the acquisitions occurred as of the beginning of the respective periods. The pro forma adjustments include the pro forma effect of UnitedHealth Group shares issued in the acquisitions, the amortization of finite-lived intangible assets arising from the purchase price allocations, interest expense related to financing the cash portion of the purchase price and the associated income tax effects of the pro forma adjustments. The following unaudited pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the acquisitions been consummated at the beginning of the periods presented.

<u>(in millions, except per share data)</u>	<u>For the Year Ended December 31, 2005</u>	<u>For the Year Ended December 31, 2004</u>
	<u>Pro forma - unaudited</u>	
Revenues	\$59,426	\$53,051
Net Earnings	\$ 3,568	\$ 3,012
Earnings Per Share:		
Basic	\$ 2.62	\$ 2.12
Diluted	\$ 2.48	\$ 2.02

In October 2005, we sold the life insurance and annuity business within Golden Rule to OneAmerica Financial Partners, Inc. (OneAmerica) through an indemnity reinsurance arrangement. Under the arrangement, OneAmerica assumes the risks associated with the future policy benefits for the life and annuity contracts. We remain liable for claims if OneAmerica fails to meet its obligations to policy holders. Because we remain primarily liable to the policy holders, the liabilities and obligations associated with the reinsured contracts remain on our Consolidated Balance Sheet with a corresponding reinsurance receivable from OneAmerica, which is classified in other noncurrent assets and totaled approximately \$1.8 billion as of December 31, 2005. We transferred approximately \$1.3 billion of investments and \$363 million in cash to OneAmerica in conjunction with the arrangement. We realized a small gain on the sale which has been deferred and is being amortized over the estimated remaining life of the reinsured contracts.

For the years ended December 31, 2005, 2004 and 2003, aggregate consideration paid or issued for smaller acquisitions accounted for under the purchase method was \$196 million, \$158 million and \$127 million, respectively. These acquisitions were not material to our consolidated financial statements.

4. Cash, Cash Equivalents and Investments

As of December 31, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments were as follows (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
2005				
Cash and Cash Equivalents	\$ 5,421	\$ —	\$ —	\$ 5,421
Debt Securities — Available for Sale	9,011	60	(52)	9,019
Equity Securities — Available for Sale	217	45	(1)	261
Debt Securities — Held to Maturity	281	—	—	281
Total Cash and Investments	\$14,930	\$ 105	\$ (53)	\$14,982
2004				
Cash and Cash Equivalents	\$ 3,991	\$ —	\$ —	\$ 3,991
Debt Securities — Available for Sale	7,723	205	(9)	7,919
Equity Securities — Available for Sale	199	10	(2)	207
Debt Securities — Held to Maturity	136	—	—	136
Total Cash and Investments	\$12,049	\$ 215	\$ (11)	\$12,253

As of December 31, 2005 and 2004, respectively, debt securities consisted of \$2,256 million and \$1,551 million in U.S. Government and Agency obligations, \$4,554 million and \$2,932 million in state and municipal obligations, and \$2,490 million and \$3,572 million in corporate obligations. At December 31, 2005, we held \$767 million in debt securities with maturities of less than one year, \$3,469 million in debt securities with maturities of one to five years, \$2,808 million in debt securities with maturities of five to 10 years and \$2,256 million in debt securities with maturities of more than 10 years.

As of December 31, 2005 we had only \$5 million of investments, mainly corporate obligations, in a continuous unrealized loss position for 12 months or greater. Gross unrealized losses of \$53 million were primarily a result of changes in interest rates and relate to debt securities with an aggregate fair value of \$3.8 billion at December 31, 2005. We evaluate the credit rating of the state and municipal obligations and the corporate obligations and do not believe that there has been any significant deterioration since purchase. The contractual cash flows of any U.S. Government and Agency obligations are either guaranteed by the U.S. Government or an agency of the U.S. Government. The equity securities were evaluated for duration of unrealized loss and other market factors. After taking into account these and other factors, we determined the unrealized losses on our investments were temporary and, as such, no impairment was required.

We recorded realized gains and losses on sales of investments, excluding the UnitedHealth Capital disposition described below, as follows:

(in millions)	For the year ended December 31,		
	2005	2004	2003
Gross Realized Gains	\$ 54	\$ 37	\$ 45
Gross Realized Losses	(50)	(18)	(23)
Net Realized Gains (Losses)	\$ 4	\$ 19	\$ 22

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

5. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by segment, during the years ended December 31, 2005 and 2004, were as follows:

(in millions)	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Consolidated
Balance at December 31, 2003	\$ 1,770	\$698	\$409	\$632	\$ 3,509
Acquisitions and Subsequent Payments	5,724	205	—	32	5,961
Balance at December 31, 2004	7,494	903	409	664	9,470
Acquisitions and Subsequent Payments	6,340	14	323	59	6,736
Balance at December 31, 2005	<u>\$13,834</u>	<u>\$917</u>	<u>\$732</u>	<u>\$723</u>	<u>\$16,206</u>

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

(in millions)		December 31, 2005			December 31, 2004		
		Weighted- Average Useful Life	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization
Customer Contracts and							
Membership Lists	15 years	\$1,830	\$(106)	\$1,724	\$1,153	\$ (46)	\$1,107
Patents, Trademarks and							
Technology	10 years	221	(62)	159	86	(39)	47
Other	16 years	161	(24)	137	69	(18)	51
Total	15 years	<u>\$2,212</u>	<u>\$(192)</u>	<u>\$2,020</u>	<u>\$1,308</u>	<u>\$(103)</u>	<u>\$1,205</u>

Amortization expense relating to intangible assets was \$94 million in 2005, \$62 million in 2004 and \$18 million in 2003. Estimated future amortization expense relating to intangible assets for the years ending December 31 are as follows: \$175 million in 2006, \$168 million in 2007, \$164 million in 2008, \$156 million in 2009, and \$148 million in 2010.

6. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2005	2004	2003
Medical Costs Payable, Beginning of Period	\$ 5,540	\$ 4,152	\$ 3,741
Acquisitions	1,469	1,040	165
Reported Medical Costs			
Current Year	33,125	27,210	20,864
Prior Years	(400)	(210)	(150)
Total Reported Medical Costs	<u>32,725</u>	<u>27,000</u>	<u>20,714</u>
Claim Payments			
Payments for Current Year	(27,985)	(23,173)	(17,411)
Payments for Prior Years	(4,448)	(3,479)	(3,057)
Total Claim Payments	<u>(32,433)</u>	<u>(26,652)</u>	<u>(20,468)</u>
Medical Costs Payable, End of Period	<u>\$ 7,301</u>	<u>\$ 5,540</u>	<u>\$ 4,152</u>

The increase in favorable medical cost development in 2005 was driven primarily by lower than anticipated medical costs as well as growth in the size of the medical cost base and related medical payables due to organic growth and businesses acquired since the beginning of 2004.

7. Commercial Paper and Debt

Commercial paper and debt consisted of the following as of December 31:

(in millions)	2005		2004	
	Carrying Value	Fair Value ¹	Carrying Value	Fair Value ¹
Commercial Paper	\$ 2,829	\$ 2,829	\$ 273	\$ 273
3.0% Convertible Subordinated Debentures	432	432	—	—
7.5% Senior Unsecured Notes due November 2005	—	—	400	417
5.2% Senior Unsecured Notes due January 2007	400	402	400	413
3.4% Senior Unsecured Notes due August 2007	550	537	550	546
3.3% Senior Unsecured Notes due January 2008	500	485	500	493
3.8% Senior Unsecured Notes due February 2009	250	242	250	247
4.1% Senior Unsecured Notes due August 2009	450	438	450	452
4.9% Senior Unsecured Notes due April 2013	450	448	450	453
4.8% Senior Unsecured Notes due February 2014	250	245	250	248
5.0% Senior Unsecured Notes due August 2014	500	498	500	503
4.9% Senior Unsecured Notes due March 2015	500	490	—	—
Total Commercial Paper and Debt	7,111	7,046	4,023	4,045
Less Current Maturities	(3,261)	(3,261)	(673)	(690)
Long-Term Debt, less current maturities	\$ 3,850	\$ 3,785	\$3,350	\$3,355

¹ Estimated based on third-party quoted market prices for the same or similar issues

In November and December 2005, we issued \$2.6 billion of commercial paper, primarily to finance the cash portion of the purchase price of the PacifiCare acquisition described above, to retire a portion of the PacifiCare debt upon closing of the acquisition as well as to refinance maturing long term debt. As of December 31, 2005, our outstanding commercial paper had interest rates ranging from 4.2% to 4.4%.

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

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

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

To more closely align the floating interest rate received on our cash and cash equivalent balances, we have entered into interest rate swap agreements to convert the majority of our interest rate exposure from a fixed rate to a variable rate. These interest rate swap agreements qualify as fair value hedges. The interest rate swap agreements have aggregate notional amounts of \$3.4 billion with variable rates that are benchmarked to the London Interbank Offered Rate (LIBOR). At December 31, 2005, the rates used to accrue interest expense on these agreements ranged from 4.3% to 5.0%. The differential between the fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as an adjustment to interest expense in the Consolidated Statements of Operations.

In December 2005, we amended and restated our \$1.0 billion five-year revolving credit facility supporting our commercial paper program. We increased the capacity to \$1.3 billion and extended the maturity date to

December 2010. In October 2005, we executed a \$3.0 billion 364-day revolving credit facility to support a \$3.0 billion increase in our commercial paper program. As of December 31, 2005, we had no amounts outstanding under either of these credit facilities.

PacifiCare had approximately \$100 million par value of 3% convertible subordinated debentures (convertible notes) which were convertible into approximately 5.2 million shares of UnitedHealth Group's common stock and \$102 million of cash as of December 31, 2005. In December 2005, we initiated a consent solicitation to all of the holders of outstanding convertible notes pursuant to which we offered to compensate all holders who elected to convert their notes in accordance with existing terms and consent to an amendment to a covenant in the indenture governing the convertible notes. The compensation consisted of the present value of interest through October 18, 2007, the earliest mandatory redemption date, plus a pro rata share of \$1 million. On January 31, 2006, approximately 91% of the convertible notes were tendered pursuant to the offer, for which we issued approximately 4.8 million shares of UnitedHealth Group common stock and cash of \$99 million.

Our debt arrangements and credit facilities contain various covenants, the most restrictive of which require us to maintain a debt-to-total-capital ratio below 45% and to exceed specified minimum interest coverage levels. We are in compliance with the requirements of all debt covenants.

Maturities of commercial paper and debt for the years ending December 31 are as follows: \$3,261 million in 2006, \$950 million in 2007, \$500 million in 2008, \$700 million in 2009, and \$1,700 million thereafter.

We made cash payments for interest of \$219 million, \$100 million and \$94 million in 2005, 2004 and 2003, respectively.

8. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

We conduct a significant portion of our operations through companies that are subject to standards established by the National Association of Insurance Commissioners (NAIC). These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity's level of statutory net income and statutory capital and surplus. At December 31, 2005, approximately \$270 million of our \$15.0 billion of cash and investments was held by non-regulated subsidiaries and available for general corporate use, including acquisitions and share repurchases.

The agencies that assess our creditworthiness also consider capital adequacy levels when establishing our debt ratings. Consistent with our intent to maintain our senior debt ratings in the "A" range, we maintain an aggregate statutory capital and surplus level for our regulated subsidiaries that is significantly higher than the minimum level regulators require. As of December 31, 2005, our regulated subsidiaries had aggregate statutory capital and surplus of approximately \$6.4 billion, which is significantly more than the aggregate minimum regulatory requirements.

Stock Repurchase Program

Under our board of directors' authorization, we maintain a common stock repurchase program. Repurchases may be made from time to time at prevailing prices, subject to certain restrictions on volume, pricing and timing. During 2005, we repurchased 53.6 million shares at an average price of approximately \$48 per share and an aggregate cost of approximately \$2.6 billion. As of December 31, 2005, we had board of directors' authorization to purchase up to an additional 55.5 million shares of our common stock.

Common Stock Split

In May 2005, our board of directors declared a two-for-one stock split. The stock split was effective on May 27, 2005 for shareholders of record on May 20, 2005. All share and per share amounts have been restated to reflect the stock split.

Preferred Stock

At December 31, 2005, we had 10 million shares of \$0.001 par value preferred stock authorized for issuance, and no preferred shares issued and outstanding.

9. Stock-Based Compensation Plans

As of December 31, 2005, we had approximately 96.9 million shares available for future grants of stock-based awards under our stock-based compensation plan including, but not limited to, incentive or non-qualified stock options, stock appreciation rights and restricted stock.

Stock options are granted at an exercise price not less than the fair value of our common stock on the date of grant. They generally vest ratably over four years and may be exercised up to 10 years from the date of grant. Activity under our stock-based compensation plan is summarized in the tables below (shares in millions):

	2005		2004		2003	
	Shares	Weighted-Average Exercise Price	Shares	Weighted-Average Exercise Price	Shares	Weighted-Average Exercise Price
Outstanding at Beginning of Year	176.3	\$ 18	174.6	\$ 14	172.8	\$ 11
Granted	26.2	\$ 51	34.1	\$ 36	36.9	\$ 22
Assumed in Acquisitions	10.9	\$ 16	15.2	\$ 17	—	\$ —
Exercised	(23.6)	\$ 15	(43.5)	\$ 12	(30.7)	\$ 8
Forfeited	(3.0)	\$ 28	(4.1)	\$ 18	(4.4)	\$ 15
Outstanding at End of Year	<u>186.8</u>	<u>\$ 23</u>	<u>176.3</u>	<u>\$ 19</u>	<u>174.6</u>	<u>\$ 14</u>
Exercisable at End of Year	<u>110.7</u>	<u>\$ 14</u>	<u>89.6</u>	<u>\$ 11</u>	<u>85.4</u>	<u>\$ 8</u>

As of December 31, 2005

Range of Exercise Prices	Options Outstanding			Options Exercisable	
	Number Outstanding	Weighted-Average Remaining Option Term (years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
\$ 0-\$10	49.7	3.7	\$ 6	49.5	\$ 6
\$11-\$20	50.9	6.1	\$ 17	35.1	\$ 16
\$21-\$40	58.9	7.8	\$ 30	24.8	\$ 27
\$41-\$65	27.3	9.5	\$ 50	1.3	\$ 46
\$ 0-\$65	<u>186.8</u>	<u>6.5</u>	<u>\$ 23</u>	<u>110.7</u>	<u>\$ 14</u>

We also maintain a 401(k) plan and an employee stock purchase plan. Activity related to these plans was not significant in relation to our consolidated financial results in 2005, 2004 and 2003.

To determine compensation expense related to our stock-based compensation plans under the fair value method, the fair value of each option grant is estimated on the date of grant using an option-pricing model. For purposes of estimating the fair value of our employee stock option grants, we utilized a binomial model. The principal assumptions we used in applying the option pricing models were as follows:

	<u>2005</u>	<u>2004</u>	<u>2003</u>
Risk-Free Interest Rate	4.3%	3.3%	2.6%
Expected Volatility	23.5%	28.5%	30.9%
Expected Dividend Yield	0.1%	0.1%	0.1%
Expected Life in Years	4.1	4.2	4.1

Information regarding the effect on net earnings and net earnings per common share had we applied the fair value expense recognition provisions of FAS 123 is included in Note 2.

In December 2004, the Financial Accounting Standards Board (FASB) issued FAS 123R, which amended FAS 123 and 95. FAS 123R requires all companies to measure compensation expense for all share-based payments (including employee stock options) at fair value and recognize the expense over the related service period. Additionally, excess tax benefits, as defined in FAS 123R, are recognized as an addition to paid-in-capital and are reclassified from operating cash flows to financing cash flows in the Consolidated Statements of Cash Flows. We adopted this standard as of January 1, 2006, and the adoption did not result in any change to the pro forma compensation amounts historically disclosed under FAS 123.

10. Income Taxes

The components of the provision for income taxes are as follows:

<u>Year Ended December 31, (in millions)</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>
Current Provision			
Federal	\$1,638	\$1,223	\$ 932
State and Local	106	78	46
Total Current Provision	1,744	1,301	978
Deferred Provision	88	85	37
Total Provision for Income Taxes	<u>\$1,832</u>	<u>\$1,386</u>	<u>\$1,015</u>

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

<u>Year Ended December 31, (in millions)</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>
Tax Provision at the U.S. Federal Statutory Rate	\$1,796	\$1,391	\$ 994
State Income Taxes, net of federal benefit	77	54	29
Tax-Exempt Investment Income	(40)	(33)	(30)
Other, net	(1)	(26)	22
Provision for Income Taxes	<u>\$1,832</u>	<u>\$1,386</u>	<u>\$1,015</u>

The components of deferred income tax assets and liabilities are as follows:

<u>As of December 31, (in millions)</u>	<u>2005</u>	<u>2004</u>
Deferred Income Tax Assets		
Accrued Expenses and Allowances	\$ 317	\$ 227
Unearned Premiums	44	57
Medical Costs Payable and Other Policy Liabilities	208	85
Long Term Liabilities	87	78
Net Operating Loss Carryforwards	110	123
Other	87	31
Subtotal	<u>853</u>	<u>601</u>
Less: Valuation Allowances	<u>(28)</u>	<u>(28)</u>
Total Deferred Income Tax Assets	<u>825</u>	<u>573</u>
Deferred Income Tax Liabilities		
Capitalized Software Development	(270)	(223)
Net Unrealized Gains on Investments	(19)	(72)
Intangible Assets	(776)	(406)
Property and Equipment	(5)	(63)
Other	—	(16)
Total Deferred Income Tax Liabilities	<u>(1,070)</u>	<u>(780)</u>
Net Deferred Income Tax Assets (Liabilities)	<u>\$ (245)</u>	<u>\$ (207)</u>

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss carryforwards. Federal net operating loss carryforwards expire beginning in 2018 through 2024, and state net operating loss carryforwards expire beginning in 2006 through 2025.

We made cash payments for income taxes of \$1,377 million in 2005, \$898 million in 2004 and \$783 million in 2003. We recorded a tax benefit upon the exercise of non-qualified stock options of \$320 million in 2005, \$358 million in 2004, and \$222 million in 2003.

Consolidated income tax returns for fiscal years 2003 and 2004 are currently being examined by the Internal Revenue Service. We do not believe any adjustments that may result from the examination will have a significant impact on our consolidated financial statement position or results of operations.

11. AARP

In January 1998, we entered into a 10-year contract to provide health insurance products and services to members of AARP. These products and services are provided to supplement benefits covered under traditional Medicare. Under the terms of the contract, we are compensated for transaction processing and other services as well as for assuming underwriting risk. We are also engaged in product development activities to complement the insurance offerings under this program. Premium revenues from our portion of the AARP insurance offerings were approximately \$4.9 billion in 2005, \$4.5 billion in 2004 and \$4.1 billion in 2003.

The underwriting gains or losses related to the AARP business are directly recorded as an increase or decrease to a rate stabilization fund (RSF). The primary components of the underwriting results are premium revenue, medical costs, investment income, administrative expenses, member service expenses, marketing expenses and premium taxes. Underwriting gains and losses are recorded as an increase or decrease to the RSF and accrue to the overall benefit of the AARP policyholders, unless cumulative net losses were to exceed the balance in the RSF. To the extent underwriting losses exceed the balance in the RSF, we would have to fund the deficit. Any

deficit we fund could be recovered by underwriting gains in future periods of the contract. To date, we have not been required to fund any underwriting deficits. The RSF balance is reported in Other Policy Liabilities in the accompanying Consolidated Balance Sheets. We believe the RSF balance is sufficient to cover potential future underwriting or other risks associated with the contract.

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

<u>(in millions)</u>	Balance as of December	
	2005	2004
Accounts Receivable	\$ 414	\$ 389
Assets Under Management	\$1,792	\$1,883
Medical Costs Payable	\$1,001	\$ 899
Other Policy Liabilities	\$ 939	\$1,162
Other Current Liabilities	\$ 266	\$ 211

The effects of changes in balance sheet amounts associated with the AARP program accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, we do not include the effect of such changes in our Consolidated Statements of Cash Flows.

Pursuant to our agreement, AARP assets under management are managed separately from our general investment portfolio and are used to pay costs associated with the AARP program. These assets are invested at our discretion, within investment guidelines approved by AARP. We do not guarantee any rates of investment return on these investments and, upon transfer of the AARP contract to another entity, we would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Interest earnings and realized investment gains and losses on these assets accrue to the overall benefit of the AARP policyholders through the RSF. As such, they are not included in our earnings. Interest income and realized gains and losses related to assets under management are recorded as an increase to the AARP RSF and were \$90 million, \$103 million and \$101 million in 2005, 2004 and 2003, respectively. Assets under management are reported at their fair market value, and unrealized gains and losses are included directly in the RSF associated with the AARP program. As of December 31, 2005 and 2004, the amortized cost, gross unrealized gains and losses, and fair value of cash, cash equivalents and investments associated with the AARP insurance program, included in Assets Under Management, were as follows (in millions):

	<u>Amortized Cost</u>	<u>Gross Unrealized Gains</u>	<u>Gross Unrealized Losses</u>	<u>Fair Value</u>
2005				
Cash and Cash Equivalents	\$ 409	\$ —	\$ —	409
Debt Securities — Available for Sale	1,390	6	(13)	1,383
Total Cash and Investments	<u>\$1,799</u>	<u>\$ 6</u>	<u>\$ (13)</u>	<u>\$1,792</u>
2004				
Cash and Cash Equivalents	\$ 184	\$ —	\$ —	\$ 184
Debt Securities — Available for Sale	1,664	37	(2)	1,699
Total Cash and Investments	<u>\$1,848</u>	<u>\$ 37</u>	<u>\$ (2)</u>	<u>\$1,883</u>

As of December 31, 2005 and 2004, respectively, debt securities consisted of \$779 million and \$809 million in U.S. Government and Agency obligations, \$19 million and \$20 million in state and municipal obligations and \$585 million and \$870 million in corporate obligations. At December 31, 2005, the AARP assets under management included debt securities of \$149 million with maturities of less than one year, \$459 million with maturities of one to five years, \$435 million with maturities of five to 10 years and \$340 million with maturities of more than 10 years. As of December 31, 2005, we had no investments under the AARP agreement in a continuous unrealized loss position for 12 months or greater.

12. Commitments and Contingencies

Leases

We lease facilities, computer hardware and other equipment under long-term operating leases that are noncancelable and expire on various dates through 2026. Rent expense under all operating leases was \$152 million in 2005, \$137 million in 2004 and \$133 million in 2003.

At December 31, 2005, future minimum annual lease payments, net of sublease income, under all noncancelable operating leases were as follows: \$167 million in 2006, \$159 million in 2007, \$128 million in 2008, \$107 million in 2009, \$76 million in 2010, and \$172 million thereafter.

Service Agreements

We have noncancelable contracts for certain support services, which expire on various dates through 2010. Expenses incurred in connection with these agreements were \$239 million in 2005, \$265 million in 2004 and \$256 million in 2003. At December 31, 2005, future minimum obligations under our noncancelable contracts were as follows: \$151 million in 2006, \$33 million in 2007, \$12 million in 2008, \$3 million in 2009 and \$3 million in 2010.

Legal Matters

Because of the nature of our businesses, we are routinely made party to a variety of legal actions related to the design and management of our service offerings. We record liabilities for our estimates of probable costs resulting from these matters. These matters include, but are not limited to, claims relating to health care benefits coverage, medical malpractice actions, contract disputes and claims related to disclosure of certain business practices.

Beginning in 1999, a series of class action lawsuits were filed against both UnitedHealthcare and PacifiCare, and virtually all major entities in the health benefits business. In December 2000, a multidistrict litigation panel consolidated several litigation cases involving UnitedHealth Group and our affiliates in the Southern District Court of Florida, Miami division. Generally, the health care provider plaintiffs allege violations of ERISA and RICO in connection with alleged undisclosed policies intended to maximize profits. Other allegations include breach of state prompt payment laws and breach of contract claims for failure to timely reimburse providers for medical services rendered. The consolidated suits seek injunctive, compensatory and equitable relief as well as restitution, costs, fees and interest payments. The trial court granted the health care providers' motion for class certification and that order was reviewed by the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the class action status of the RICO claims, but reversed as to the breach of contract, unjust enrichment and prompt payment claims. During the course of the litigation, there have been co-defendant settlements. Through a series of motions and appeals, all direct claims against us have been compelled to arbitration. A trial date has been set for April 2006. The trial court has ordered that the trial be split into separate liability and damage proceedings. In August 2005, the capitation related claims were dismissed from litigation. On January 31, 2006, the trial court dismissed all remaining claims against PacifiCare. A March 14, 2006 hearing date has been scheduled for our summary judgment motion.

On March 15, 2000, the American Medical Association filed a lawsuit against the company in the Supreme Court of the State of New York, County of New York. On April 13, 2000, we removed this case to the United States District Court for the Southern District of New York. The suit alleges causes of action based on ERISA, as well as breach of contract and the implied covenant of good faith and fair dealing, deceptive acts and practices, and trade libel in connection with the calculation of reasonable and customary reimbursement rates for non-network providers. The suit seeks declaratory, injunctive and compensatory relief as well as costs, fees and interest payments. An amended complaint was filed on August 25, 2000, which alleged two classes of plaintiffs, an ERISA class and a non-ERISA class. After the Court dismissed certain ERISA claims and the claims brought by

the American Medical Association, a third amended complaint was filed. On October 25, 2002, the court granted in part and denied in part our motion to dismiss the third amended complaint. On May 21, 2003, we filed a counterclaim complaint in this matter alleging antitrust violations against the American Medical Association and asserting claims based on improper billing practices against an individual provider plaintiff. On May 26, 2004, we filed a motion for partial summary judgment seeking the dismissal of certain claims and parties based, in part, due to lack of standing. On July 16, 2004, plaintiffs filed a motion for leave to file an amended complaint, seeking to assert RICO violations.

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

Government Regulation

Our business is regulated at federal, state, local and international levels. The laws and rules governing our business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. State legislatures and Congress continue to focus on health care issues as the subject of proposed legislation. Existing or future laws and rules could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, and increase our liability in federal and state courts for coverage determinations, contract interpretation and other actions. Further, we must obtain and maintain regulatory approvals to market many of our products.

We typically are involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by the Centers for Medicare & Medicaid Services (CMS), state insurance and health and welfare departments and state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Department of Justice, and U.S. Attorneys. Such government actions can result in assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs. We record liabilities for our estimate of probable costs resulting from these matters. In addition, public perception or publicity surrounding routine governmental investigations may adversely affect our stock price, damage our reputation in various markets or make it more difficult for us to sell products and services. Although the results of pending matters are always uncertain, we do not believe the results of any of the current investigations, audits or reviews, currently threatened or pending, individually or in aggregate, will have a material adverse effect on our consolidated financial position or results of operations.

13. Segment Financial Information

Factors used in determining our reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the company's chief operating decision-maker to evaluate our results of operations.

Our accounting policies for business segment operations are the same as those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between business segments principally consist of customer service and transaction processing services that Uniprise provides to Health Care Services, certain product offerings sold to Uniprise and Health Care Services customers by Specialized Care Services, and sales of medical benefits cost, quality and utilization data and predictive modeling to Health Care Services and Uniprise by Ingenix. These transactions are recorded at management's best estimate of fair value, as if the services were purchased from or sold to third parties. All intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each segment using estimates of pro-rata usage. Cash and investments are assigned such that each segment has minimum specified levels of regulatory capital or working capital for non-regulated businesses.

Substantially all of our operations are conducted in the United States. In accordance with accounting principles generally accepted in the United States of America, segments with similar economic characteristics may be combined. The financial results of UnitedHealthcare, Ovation and AmeriChoice have been combined in the Health Care Services segment column in the following tables because these businesses have similar economic characteristics and have similar products and services, types of customers, distribution methods and operational processes, and operate in a similar regulatory environment, typically within the same legal entity.

The following table presents segment financial information as of and for the years ended December 31, 2005, 2004 and 2003 (in millions):

	Health Care Services	Uniprise	Specialized Care Services	Ingenix	Intersegment Eliminations	Consolidated
2005						
Revenues - External Customers	\$39,583	\$3,060	\$1,686	\$ 537	\$ —	\$44,866
Revenues - Intersegment	—	752	1,095	257	(2,104)	—
Investment and Other Income	436	38	25	—	—	499
Total Revenues	\$40,019	\$3,850	\$2,806	\$ 794	\$(2,104)	\$45,365
Earnings From Operations	\$ 3,815	\$ 799	\$ 582	\$ 177	\$ —	\$ 5,373
Total Assets ¹	\$35,734	\$2,599	\$2,179	\$1,057	\$ (841)	\$40,728
Net Assets ¹	\$22,483	\$1,414	\$1,449	\$ 849	\$ (841)	\$25,354
Purchases of Property, Equipment and Capitalized Software	\$ 238	\$ 134	\$ 88	\$ 49	\$ —	\$ 509
Depreciation and Amortization	\$ 227	\$ 110	\$ 54	\$ 62	\$ —	\$ 453
2004						
Revenues - External Customers	\$32,333	\$2,688	\$1,363	\$ 446	\$ —	\$36,830
Revenues - Intersegment	—	647	914	224	(1,785)	—
Investment and Other Income	340	30	18	—	—	388
Total Revenues	\$32,673	\$3,365	\$2,295	\$ 670	\$(1,785)	\$37,218
Earnings From Operations	\$ 2,810	\$ 677	\$ 485	\$ 129	\$ —	\$ 4,101
Total Assets ¹	\$23,799	\$2,366	\$1,269	\$ 971	\$ (879)	\$27,526
Net Assets ¹	\$13,138	\$1,385	\$ 765	\$ 795	\$ (879)	\$15,204
Purchases of Property, Equipment and Capitalized Software	\$ 147	\$ 112	\$ 56	\$ 35	\$ —	\$ 350
Depreciation and Amortization	\$ 173	\$ 95	\$ 44	\$ 62	\$ —	\$ 374
2003						
Revenues - External Customers	\$24,592	\$2,496	\$1,077	\$ 401	\$ —	\$28,566
Revenues - Intersegment	—	583	787	173	(1,543)	—
Investment and Other Income	215	28	14	—	—	257
Total Revenues	\$24,807	\$3,107	\$1,878	\$ 574	\$(1,543)	\$28,823
Earnings From Operations	\$ 1,865	\$ 610	\$ 385	\$ 75	\$ —	\$ 2,935
Total Assets ¹	\$13,597	\$2,024	\$1,191	\$ 919	\$ (366)	\$17,365
Net Assets ¹	\$ 5,008	\$1,116	\$ 710	\$ 766	\$ (347)	\$ 7,253
Purchases of Property, Equipment and Capitalized Software	\$ 122	\$ 130	\$ 48	\$ 52	\$ —	\$ 352
Depreciation and Amortization	\$ 116	\$ 86	\$ 40	\$ 57	\$ —	\$ 299

¹ Total Assets and Net Assets exclude, where applicable, debt and accrued interest of \$7,161 million, \$4,054 million and \$1,993 million, income tax-related assets of \$646 million, \$353 million and \$269 million, and income tax-related liabilities of \$1,106 million, \$786 million and \$401 million as of December 31, 2005, 2004 and 2003, respectively.

14. Quarterly Financial Data (Unaudited)

(in millions, except per share data)	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2005				
Revenues	\$10,887	\$11,111	\$11,322	\$12,045
Medical and Operating Costs	\$ 9,631	\$ 9,801	\$ 9,944	\$10,616
Earnings From Operations	\$ 1,256	\$ 1,310	\$ 1,378	\$ 1,429
Net Earnings	\$ 779	\$ 809	\$ 842	\$ 870
Basic Net Earnings per Common Share	\$ 0.61	\$ 0.64	\$ 0.67	\$ 0.69
Diluted Net Earnings per Common Share	\$ 0.58	\$ 0.61	\$ 0.64	\$ 0.65
2004				
Revenues	\$ 8,144	\$ 8,704	\$ 9,859	\$10,511
Medical and Operating Costs	\$ 7,268	\$ 7,759	\$ 8,767	\$ 9,323
Earnings From Operations	\$ 876	\$ 945	\$ 1,092	\$ 1,188
Net Earnings	\$ 554	\$ 596	\$ 698	\$ 739
Basic Net Earnings per Common Share	\$ 0.46	\$ 0.49	\$ 0.55	\$ 0.57
Diluted Net Earnings per Common Share	\$ 0.44	\$ 0.47	\$ 0.52	\$ 0.54

¹ UnitedHealth Group acquired PacifiCare in December 2005 for total consideration of approximately \$8.8 billion, Oxford in July 2004 for total consideration of approximately \$5.0 billion and MAMSI in February 2004 for total consideration of approximately \$2.7 billion. These acquisitions affect the comparability of 2005 and 2004 financial information to prior fiscal years. The results of operations and financial condition of PacifiCare, Oxford and MAMSI have been included in UnitedHealth Group's consolidated financial statements since the respective acquisition dates. See Note 3 to the consolidated financial statements for a detailed discussion of these acquisitions.

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, 2005 and 2004, and the related consolidated statements of operations, changes in shareholders’ equity, and cash flows for each of the three years in the period ended December 31, 2005. These consolidated financial statements are the responsibility of the Company’s management. Our responsibility is to express an opinion on these 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 financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the 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, 2005 and 2004, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2005, 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 effectiveness of the Company’s internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2006, expressed an unqualified opinion on management’s assessment of the effectiveness of the Company’s internal control over financial reporting and an unqualified opinion on the effectiveness of the Company’s internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Minneapolis, Minnesota
February 24, 2006

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

As of December 31, 2005, an evaluation was carried out under the supervision and with the participation of the company's management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934). Based upon that evaluation, the Chief Executive Officer and the Chief Financial Officer concluded that the design and operation of these disclosure controls and procedures were effective.

Internal Control Over Financial Reporting

Report of Management

The management of UnitedHealth Group is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. The company's internal control over financial reporting includes those policies and procedures that:

- Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company;
- Provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and
- Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the company's internal control over financial reporting as of December 31, 2005. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated Framework*. Based on our assessment and those criteria, we believe that, as of December 31, 2005, the company maintained effective internal control over financial reporting.

Management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting the internal controls of PacifiCare Health Systems, Inc. (PacifiCare) which was acquired by the Company on December 20, 2005, and is included in the Company's consolidated financial statements for the period from that date through yearend. Such exclusion was in accordance with Securities and Exchange Commission guidance that an assessment of a recently acquired business may be omitted in management's report on internal controls over financial reporting in the year of acquisition. Total assets and total liabilities of

PacifiCare represented approximately 29% and 13%, respectively, of the Company's consolidated assets and liabilities as of December 31, 2005, and less than 1% of consolidated revenues and operating income for the year then ended.

Changes to certain processes, information technology systems, and other components of Internal Control resulting from the acquisition of PacifiCare may occur and will be evaluated by management as such integration activities are implemented. Other than the impact of the acquisition, there were no changes in Internal Control that have materially affected, or are reasonably likely to materially affect, the Company's Internal Control during the year ended December 31, 2005.

The company's independent registered public accounting firm has audited management's assessment of the effectiveness of the company's internal control over financial reporting as of December 31, 2005, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A, which expresses unqualified opinions on management's assessment and on the effectiveness of the company's internal controls over financial reporting as of December 31, 2005.

February 24, 2006

/s/ WILLIAM W. MCGUIRE, MD

William W. McGuire, MD
Chairman and Chief Executive Officer

/s/ STEPHEN J. HEMSLEY

Stephen J. Hemsley
President and Chief Operating Officer

/s/ PATRICK J. ERLANDSON

Patrick J. Erlandson
Chief Financial Officer

New York Stock Exchange Certification

Pursuant to Section 303A.12(a) of the NYSE listed company manual, the company submitted an unqualified certification of its Chief Executive Officer to the NYSE in 2005. We have also filed as exhibits to this Annual Report on Form 10-K, the Chief Executive Officer and Chief Financial Officer Certifications required under the Sarbanes-Oxley Act.

Report of Independent Registered Public Accounting Firm

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

We have audited management's assessment, included in the accompanying Report of Management, that UnitedHealth Group Incorporated and Subsidiaries (the "Company") maintained effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in the Report of Management, management excluded from their assessment the internal control over financial reporting at PacifiCare Health Systems, Inc. (PacifiCare), which was acquired on December 20, 2005 and whose financial statements reflect total assets and revenues constituting approximately 29 and 1 percent, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2005. Accordingly, our audit did not include the internal control over financial reporting at PacifiCare. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit 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 effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management's assessment that the Company maintained effective internal control over financial reporting as of December 31, 2005, is fairly stated, in all material respects, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2005, based on the criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements as of and for the year ended December 31, 2005 of the Company and our report dated February 24, 2006 expressed an unqualified opinion on those financial statements.

/s/ DELOITTE & TOUCHE LLP
Minneapolis, Minnesota
February 24, 2006

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

Code of Ethics

We have adopted a Code of Business Conduct and Ethics which applies to all of our employees and directors. The Code of Ethics is published on our Web site at www.unitedhealthgroup.com. Any amendments to the Code of Ethics and waivers of the Code of Ethics for our Chief Executive Officer, Chief Financial Officer or Controller will be published on our Web site. We will provide a copy of our Code of Business Conduct and Ethics, free of charge, upon request. To request a copy, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary.

The information included under the headings "Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Board of Directors and Committees of the Board

William C. Ballard, Jr.

Of Counsel
Greenebaum Doll & McDonald PLLC

Richard T. Burke

Director of Meritage Homes Corporation
and First Cash Financial Services, Inc.

Stephen J. Hemsley

President and Chief Operating Officer
UnitedHealth Group

James A. Johnson

Vice Chairman of Perseus, LLC

Thomas H. Kean

Former President of Drew University
Former Governor of New Jersey

Douglas W. Leatherdale

Former Chairman and
Chief Executive Officer of
The St. Paul Companies, Inc.

William W. McGuire, MD

Chairman and
Chief Executive Officer
UnitedHealth Group

Mary O. Munding, DrPH, RN

Dean, School of Nursing and Centennial
Professor in Health Policy, and Associate
Dean, Faculty of Medicine
Columbia University

Robert L. Ryan

Former Senior Vice President and
Chief Financial Officer Medtronic, Inc.

Donna E. Shalala, PhD

President of University of Miami

William G. Spears

Senior Principal
Spears Grisanti & Brown LLC

Gail R. Wilensky, PhD

Senior Fellow, Project HOPE

Committees of the Board

Audit Committee

William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale

Compensation and Human Resources Committee

James A. Johnson
Mary O. Munding
William G. Spears

Compliance and Government Affairs Committee

Donna E. Shalala
Gail R. Wilensky

Nominating Committee

William C. Ballard, Jr.
Thomas H. Kean
Douglas W. Leatherdale
William G. Spears

Executive Committee

William C. Ballard, Jr.
Douglas W. Leatherdale
William W. McGuire
William G. Spears

ITEM 11. EXECUTIVE COMPENSATION

The information included under the heading “Executive Compensation” in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information included under the heading “Security Ownership of Certain Beneficial Owners and Management” in our definitive proxy statement for our Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

Equity Compensation Plan Information

<u>Plan Category</u>	<u>(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights</u>	<u>(b) Weighted-average exercise price of outstanding options, warrants and rights</u>	<u>(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))</u>
Equity compensation plans approved by shareholders ⁽¹⁾	174,030,671	\$23.60	102,707,501 ⁽³⁾
Equity compensation plans not approved by shareholders ⁽²⁾	—	—	—
Total	<u>174,030,671</u>	<u>\$23.60</u>	<u>102,707,501</u>

- (1) Consists of the UnitedHealth Group Incorporated 2002 Stock Incentive Plan, as amended, and the 1993 Qualified Employee Stock Purchase Plan, as amended.
- (2) Excludes 12,752,378 shares underlying stock options assumed by us in connection with our acquisition of the companies under whose plans the options originally were granted. These options have a weighted-average exercise price of \$16.20 and an average remaining term of approximately 5.74 years. The options are administered pursuant to the terms of the plan under which the option originally was granted. No future options or other awards will be granted under these acquired plans.
- (3) Includes 5,834,475 shares of common stock available for future issuance under the Employee Stock Purchase Plan as of December 31, 2005, and 96,873,026 shares available under the 2002 Stock Incentive Plan as of December 31, 2005. Shares available under the 2002 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards, except that only 26,233,466 of these shares are available for future grants of awards other than stock options or stock appreciation rights.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Information regarding certain relationships and related transactions that appears under the heading “Certain Relationships and Transactions” in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

Information regarding accountant fees and services that appears under the heading “Independent Registered Public Accounting Firm” in our definitive proxy statement for the Annual Meeting of Shareholders to be held May 2, 2006, is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

Consolidated Statements of Operations for the years ended December 31, 2005, 2004, and 2003.

Consolidated Balance Sheets as of December 31, 2005 and 2004.

Consolidated Statements of Changes in Shareholders' Equity for the years ended December 31, 2005, 2004 and 2003.

Consolidated Statements of Cash Flows for the years ended December 31, 2005, 2004 and 2003.

Notes to Consolidated Financial Statements.

Reports of Independent Registered Public Accounting Firm.

(a) 2. *Financial Statement Schedules*

None

(a) 3. *Exhibits***

- 3(a) Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Current Report on Form 8-K dated May 24, 2005)
- 3(b) Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)
- 3(c) Articles of Merger amending the Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
- 3(d) Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1995)
- 3(e) Second Amended and Restated Bylaws of the Company (incorporated by reference to Exhibit 3(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
- 4(a) Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, filed on January 11, 1999)
- 4(b) Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
- *10(a) UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
- *10(b) Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 31, 2006)
- *10(c) Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 24, 2004).
- *10(d) Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 24, 2004)
- *10(e) Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated September 24, 2004)

- *10(f) Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated January 31, 2006)
- *10(g) Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated September 24, 2004)
- *10(h) Form of Restricted Stock Unit Award Agreement under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated September 24, 2004)
- *10(i) Form of Stock Appreciation Rights Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 of the Company's Current Report on Form 8-K dated January 31, 2006)
- *10(j) Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 of the Company's Current Report on Form 8-K dated January 31, 2006)
- *10(k) UnitedHealth Group Incorporated Executive Incentive Plan (incorporated by reference to Exhibit 10(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
- *10(l) UnitedHealth Group Executive Savings Plans (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
- *10(m) UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(d) of the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
- *10(n) First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(g) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
- *10(o) Employment Agreement, dated as of October 13, 1999, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(f) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
- *10(p) Letter to William W. McGuire, M.D., dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(h) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
- *10(q) Amendment to Employment Agreement, dated as of August 5, 2005, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(c) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
- *10(r) Employment Agreement dated as of October 13, 1999, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(g) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
- *10(s) Letter to Stephen J. Hemsley, dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(j) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
- *10(t) Amendment to Employment Agreement, dated August 5, 2005, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(d) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
- *10(u) Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
- *10(v) Employment Agreement, dated as of November 1, 2004, between United HealthCare Services, Inc. and Richard H. Anderson (incorporated by reference to Exhibit 10(p) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)

- *10(w) Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and Tracy L. Bahl (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
- *10(x) Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and Patrick J. Erlandson (incorporated by reference to Exhibit 10(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
- *10(y) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and David J. Lubben, as amended (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
- *10(z) Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and William A. Munsell, as amended (incorporated by reference to Exhibit 10(t) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
- *10(aa) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Lois E. Quam, as amended, and Memorandum of Understanding, effective as of October 11, 1999, between Lois E. Quam and United HealthCare Services, Inc. (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
- *10(bb) Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Robert J. Sheehy, as amended (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)
- *10(cc) Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10(o) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
- †10(dd) AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company dated as of February 26, 1997 (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K/A for the year ended December 31, 1996)
- †10(ee) First Amendment to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company effective January 1, 1998 (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter period ended June 30, 1998)
- †10(ff) Second Amendment to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company effective January 1, 1998 (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1998)
- †10(gg) Amendments to the AARP Health Insurance Agreement by and among American Association of Retired Persons, Trustees of the AARP Insurance Plan and United HealthCare Insurance Company (incorporated by reference to Exhibit 10(s) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
- †10(hh) Amendments to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, entered into between April and October 2003 (incorporated by reference to Exhibit 10(v) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
- †10(ii) 10th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2004 (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2004)
- †10(jj) 11th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(dd) to the Company's Annual Report on Form 10-K for the year ended December 31, 2004)

- 10(kk) 12th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of January 1, 2005 (incorporated by reference to Exhibit 10(a) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
- 10(ll) 13th Amendment to the AARP Health Insurance Agreement by and between AARP Services, Inc. and United HealthCare Insurance Company, effective as of December 21, 2005
- 11 Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 to the Notes to Consolidated Financial Statements included under Item 8)
- 12 Ratio of Earnings to Fixed Charges
- 21 Subsidiaries of the Company
- 23 Consent of Independent Registered Public Accounting Firm
- 24 Powers of Attorney
- 31 Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
- 32 Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

† Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of these Exhibits have been deleted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

**Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 24, 2006

UNITEDHEALTH GROUP INCORPORATED

By /s/ WILLIAM W. MCGUIRE, M.D.
William W. McGuire, M.D.
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
/s/ WILLIAM W. MCGUIRE, M.D. William W. McGuire, M.D.	Director, Chief Executive Officer (principal executive officer)	February 24, 2006
/s/ PATRICK J. ERLANDSON Patrick J. Erlandson	Chief Financial Officer (principal financial and accounting officer)	February 24, 2006
* William C. Ballard, Jr.	Director	February 24, 2006
* Richard T. Burke	Director	February 24, 2006
* Stephen J. Hemsley	Director	February 24, 2006
* James A. Johnson	Director	February 24, 2006
* Thomas H. Kean	Director	February 24, 2006
* Douglas W. Leatherdale	Director	February 24, 2006
* Mary O. Munding	Director	February 24, 2006
* Robert L. Ryan	Director	February 24, 2006
* Donna E. Shalala	Director	February 24, 2006
* William G. Spears	Director	February 24, 2006
* Gail R. Wilensky	Director	February 24, 2006

*By /s/ DAVID J. LUBBEN
David J. Lubben
As Attorney-in-Fact

EXHIBIT INDEX

<u>Item</u>	<u>Description</u>
<i>Exhibits**</i>	
3(a)	Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Current Report on Form 8-K dated May 24, 2005)
3(b)	Articles of Amendment to Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)
3(c)	Articles of Merger amending the Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
3(d)	Second Restated Articles of Incorporation of the Company (incorporated by reference to Exhibit 3(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 1995)
3(e)	Second Amended and Restated Bylaws of the Company (incorporated by reference to Exhibit 3(d) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
4(a)	Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, filed on January 11, 1999)
4(b)	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the Company and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
*10(a)	UnitedHealth Group Incorporated 2002 Stock Incentive Plan, Amended and Restated Effective May 15, 2002 (incorporated by reference to Exhibit 10(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10(b)	Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated January 31, 2006)
*10(c)	Form of Agreement for Stock Option Award to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 24, 2004)
*10(d)	Form of Agreement for Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 24, 2004)
*10(e)	Form of Agreement for Initial Stock Option Award to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated September 24, 2004)
*10(f)	Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated January 31, 2006)
*10(g)	Form of Restricted Stock Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated September 24, 2004)
*10(h)	Form of Restricted Stock Unit Award Agreement under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated September 24, 2004)

<u>Item</u>	<u>Description</u>
*10(i)	Form of Stock Appreciation Rights Award Agreement to Officers under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 of the Company's Current Report on Form 8-K dated January 31, 2006)
*10(j)	Form of Stock Appreciation Rights Award Agreement to Non-Employee Directors under the Company's 2002 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 of the Company's Current Report on Form 8-K dated January 31, 2006)
*10(k)	UnitedHealth Group Incorporated Executive Incentive Plan (incorporated by reference to Exhibit 10(b) to the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10(l)	UnitedHealth Group Executive Savings Plans (2004 Statement) (incorporated by reference to Exhibit 10(e) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10(m)	UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(d) of the Company's Annual Report on Form 10-K for the year ended December 31, 2002)
*10(n)	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (2002 Statement) (incorporated by reference to Exhibit 10(g) of the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
*10(o)	Employment Agreement, dated as of October 13, 1999, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(f) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
*10(p)	Letter to William W. McGuire, M.D., dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(h) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(q)	Amendment to Employment Agreement, dated as of August 5, 2005, between the Company and William W. McGuire, M.D. (incorporated by reference to Exhibit 10(c) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
*10(r)	Employment Agreement dated as of October 13, 1999, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(g) to the Company's Annual Report on Form 10-K for the year ended December 31, 1999)
*10(s)	Letter to Stephen J. Hemsley, dated as of February 13, 2001, regarding Employment Agreement (incorporated by reference to Exhibit 10(j) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(t)	Amendment to Employment Agreement, dated August 5, 2005, between the Company and Stephen J. Hemsley (incorporated by reference to Exhibit 10(d) of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2005)
*10(u)	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10(v)	Employment Agreement, dated as of November 1, 2004, between United HealthCare Services, Inc. and Richard H. Anderson (incorporated by reference to Exhibit 10(p) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
*10(w)	Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and Tracy L. Bahl (incorporated by reference to Exhibit 10(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

<u>Item</u>	<u>Description</u>
*10(x)	Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and Patrick J. Erlandson (incorporated by reference to Exhibit 10(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(y)	Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and David J. Lubben, as amended (incorporated by reference to Exhibit 10(p) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(z)	Employment Agreement, dated as of October 1, 1998, between United HealthCare Services, Inc. and William A. Munsell, as amended (incorporated by reference to Exhibit 10(t) of the Company's Annual Report on Form 10-K for the year ended December 31, 2004)
*10(aa)	Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Lois E. Quam, as amended, and Memorandum of Understanding, effective as of October 11, 1999, between Lois E. Quam and United HealthCare Services, Inc. (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2000)
*10(bb)	Employment Agreement, dated as of October 16, 1998, between United HealthCare Services, Inc. and Robert J. Sheehy, as amended (incorporated by reference to Exhibit 10(l) to the Company's Annual Report on Form 10-K for the year ended December 31, 2001)
*10(cc)	Employment Agreement, dated as of October 1, 1998, as amended, between United HealthCare Services, Inc. and David S. Wichmann (incorporated by reference to Exhibit 10(o) to the Company's Annual Report on Form 10-K for the year ended December 31, 2003)
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APPENDIX B – HWT STAFF RESUMES

Andrew Gattine, JD

Project Advisor

Qualifications

Mr. Gattine has over 12 years of experience focusing on helping Medicaid agencies deliver quality services and operate efficiently. As Director of Client Services, Mr. Gattine is responsible for coordinating client management activities across all clients, leading business development initiatives and enterprise-wide business planning and leadership. His range of professional experience includes:

- Algorithm management and analysis
- Medicaid policy
- Drug Rebate analysis
- Negotiation and legal representation

Relevant Experience

Mr. Gattine has gained the following professional experience.

HWT, an Ingenix Company: As Director of Client Services, Mr. Gattine is responsible for ensuring solutions deployed to HWT’s clients bring the maximum value. He provides thorough coordination of resources and project planning across HWT clients while providing supervision and mentoring to all HWT’s client managers. A founding member of the HWT team in 1998, Mr. Gattine delivers leadership and management throughout HWT projects, and has the lead HWT initiatives in Washington, Florida, Missouri and Rhode Island and serves as a Subject Matter Expert, developing successful HWT algorithms in areas focusing on pharmacy, physician, DME and hospital overpayments.

Department of the Attorney General, State of Maine: Mr. Gattine represented all health and medical issues before the Maine Department of Human Services as the Assistant Attorney General, of the Health and Institutional Services Unit. He served as a Department Representation at administrative proceedings and in judicial proceedings before state and federal courts. Mr. Gattine served as a representative for the Department’s Medicaid Program, Licensing and Certification Division, Medicaid Audit Unit, Certification of Need Program and Bureau of Rehabilitation.

Professional History

HWT, Inc., an Ingenix Company, Portland, Maine, Director of Client Services, 1998 – Present

Department of the Attorney General, State of Maine, Assistant Attorney General, Health and Institutional Services, Unit, 1992 – 1998

Friedman & Babcock, Attorney, 1992

Castaldo, Hanna & Malmberg, Attorney, 1991

Richards & O’Neil, 1987 - 1990

John Steel Judicial Services, Private Investigator and Process Server, 1983 – 1985

Education

Columbia University School of Law, J.D.

Colgate University, B.A., Classics, Departmental Honors, Magna cum laude

Certifications

Bar Admissions -Maine, New York, S.D.N.Y., E.D.N.Y., District of Maine, First Circuit Court of Appeals

Maureen Custodio
Contract Manager

Qualifications

Ms. Custodio has extensive experience focusing on managing and implementing cost-saving initiatives, identifying cost recovery opportunities through algorithm development and developing processes for business efficiencies much of which is accredited to participating in the variety of projects within the organization. Her range of professional experience includes:

- Project management
- Algorithm development
- Complex data analysis, validation and reporting

Relevant Experience

HWT, Inc.: As a Project Manager, Ms. Custodio is responsible for ensuring deployment of solutions to company-wide clients. Bringing the maximum value to client needs, Ms. Custodio is responsible for client relationship, project management, policy analysis, algorithm development, technical coordination, quality assurance, and business development. Ms. Custodio worked closely on the partial audit performed on behalf of The State of Vermont, Office of the State Auditor identifying claims where post payment review would have been beneficial. As a project manager for the State of Washington, Social Services Payment System project, she is responsible for client relationship, project management, policy analysis, algorithm development, and technical coordination. Ms. Custodio ensures the success of the project by managing and strategically organizing internal capabilities.

Closely supporting on a daily basis new project developments within the organization, Ms. Custodio coordinates technical support, provides clear communication with the client and delivers results allowing for seamless operations. She is significantly involved with new projects using the learned knowledge and experience from previous projects to efficiently establish client relations and secure the foundation needed to commence client activities. Much of her time is allocated to the client focusing on exceptional results in the allotted time period.

Providing client management to the company, Ms. Custodio is also engaged in strategically marketing the services HWT and Ingenix offers by participating in accredited conferences held annually.

Professional History

HWT, an Ingenix Company, Chicago, IL, Project Manager, 2004 – Present

Education

B.S., Health Care Planning and Administration, University of Illinois Urbana-Champaign

David Falk, MD
 Medical Director

Qualifications

Dr. Falk is an expert in medical data analysis, utilization management, and quality assurance based on his professional knowledge. His range of professional experience includes:

- Medical Review and Analysis
- Innovative data mining techniques
- Recommendations on reducing health care expenditures through medical analysis and review

Relevant Experience

Ingenix: As a Medical Director for Ingenix Anti-Fraud Recovery Solutions, Dr. Falk is responsible for providing informed medical clinical review on physician and professional claims with the added aspect of the interplay between claim submission and eligibility for coverage according to the member benefit plan for HWT’s data analysis findings. Additionally, he supports other Subject Matter Experts in the area of Pharmacy and Facility Contracting has yielded synergies in recovery algorithms. Working closely with all of HWT’s customers, Dr. Falk will join the team designed to provide the State of Vermont the experience and expertise needed to exceed the state’s expectations, providing informed medical clinical oversight review for HWT’s overpayment findings and provider dispute resolutions. **Government Programs Planning and Development for Garden State Medical Group,** Dr. Falk was responsible for development, implementation and oversight of Medicaid and Medicare programs for a group model HMO. **UnitedHealthcare of New York, New Jersey, Inc.,** as Medical Director, he provided utilization management for commercial program and served as Chairman of the NY/NJ Credentialing Committee from 1997-2002. Dr. Falk was responsible for file review and presentation to committee of physicians with malpractice, sanction or administrative issues. His understanding in benefit interpretation attributed to his development of benefit document wording to facilitate administration of Certificates of Coverage in the regulatory environment of New York and New Jersey and with self insured customers. Dr. Falk’s responsibilities were also focused on Clinical Operations and Medical Expense Management, primarily on Hospital Data Sharing, Physician Data Sharing and optimization of the relationship with the Warwick Rhode Island Optum Care Management in order to leverage our combined skill set to reduce hospital utilization. The 2004 bed day result was 242 days per thousand for the fully insured commercial membership. Dr. Falk developed a pharmacy modeling tool to identify groups that are expected to incur higher than average medical benefit costs in their renewal year based on their drug utilization. Implementing this tool in Colorado, Dr. Falk and members of the Medical Expense Management team, trained the Colorado Clinical Operations team. **Lead Medical Director, Dr. Falk is** responsible for utilization management oversight for New York, New Jersey and Connecticut for the UnitedHealthcare fully insured membership as part of the Oxford integration. He was also the physician lead for the Onsite Nurse program in high volume New York and New Jersey hospitals. Much of his responsibilities were dedicated to acting as the interface for the New Jersey physician network for medical policy and claims issues. Currently serving as a Clinical Healthcare Consultant, his responsibilities include developing customer specific recommendations with goal

of improving health and well-being and additionally reducing health care expenditures by large employer based on review and analysis of medical claim data. To assist in achieving his goal on this project, Dr. Falk developed a data query tool, which performs original data mining to start the process.

Professional History

Ingenix, Minneapolis, MN, Medical Director for Ingenix Business Solutions, 2007 - current

UnitedHealthcare of New York, New Jersey, Inc., Clinical Healthcare Consultant, 2005 – 2007

- Medical Director, 1996-2005.

Acting Network Medical Director for IPA network product, February 1996-November 1996

Government Programs Planning and Development for Garden State Medical Group, Medical Director, September 1995-November 1996.

Central New Jersey Medical Group, Internal Medicine Department Chief, 1992-1995

- Chairman, Internal Medicine Quality Assurance Subcommittee, 1989-1992.

Education

BS Chemistry Cum Laude, 1980, University of Texas, Austin, Texas

Doctorate of Medicine, 1984, Baylor College of Medicine, Houston, Texas

Internal Medicine Residency, 1984-1987, Baylor College of Medicine, Houston, Texas

Clinical Practice in Internal Medicine, Edison, New Jersey 1987-1996

Memberships

Member of Board of Directors, Central New Jersey Medical Group, 1992-1995.

Member of Editorial Board, for the journal *HMO Practice*, 1990-1996

Member, American Medical Association, 1987-present

Member American College of Physicians 1987-present

Certifications

Fellow, New Jersey Academy of Medicine, 1999-present

Board Certified, Internal Medicine 1987

Licensure

New Jersey, 1987

New York, 1996

Carmen Steck, Pharm D

Pharmacy Specialist

Qualifications

Ms. Steck has over 14 years experience in pharmaceutical program administration in both commercial and Medicaid. Specializing in maintaining the highest levels of Quality throughout all aspects of the algorithm production, from database to algorithm development, to letter generation.

Her professional experience includes:

- Clinical pharmacy data analysis and interpretation
- Clinical program development and implementation
- Health care policy analysis
- Quality assurance

Relevant Experience

Ms. Steck has gained the following professional experience.

Ingenix: As the Pharmacy Director of the Fraud Analytic team, Ms. Steck is responsible for maintaining the highest levels of Quality provided to company wide clients. Ms. Steck performs research and interpretation on healthcare claims payment policy to identify potential revenue recovery opportunities She conducts analysis of healthcare claims related to fraud, waste, abuse, and/or inappropriate utilization of healthcare services – primarily focusing on pharmacy claims, but including related services. Ms. Steck provides support and management to all HWT clients and will be responsible for reviewing and editing the algorithm result sets to match logic, client policy, and other necessary criteria. She is responsible to define data-mining strategies and algorithms – with an eye toward pattern identification, repeatable processes and cross-client applications. **Affiliated Computer Services (ACS),** Ms. Steck was a member of the development team responsible for web based health management applications that provide consumers and health care providers with opportunities and specific steps to take in order to improve health care. Key responsibilities included application requirements and design specification, liaison between clinical and technical teams, definition of reporting and database requirements. **Clinical Business Lead for the Medicare D PDP development project,** Ms. Steck's primary responsibilities included data analysis, clinical reporting and clinical program development for the Medication Therapy Management Program (MTMP) and utilization review (UR). She was also a key participant in the design, development & implementation of a Clinical Program Suite (which included Prior Authorization, Intensive Benefits Management, Therapeutic Academic Intervention, and Retrospective Drug Utilization Review); and in the development & implementation of a web-based Clinical Information System (a parameter-driven front end business intelligence tool which allowed end users to easily initiate criteria driven queries of drug & medical data). Ms. Steck provided extensive experience with pharmacy and medical claims data analysis and was responsible for translating Business User needs to technical (universe & database) requirements; including universe design, complex query & report development, and in-depth data analysis. **First Health Group Corp.,** Applying her knowledge as an Account Director, Ms. Steck advised on the impact of benefits design features, reimbursement methodologies, formulary alternatives, value-added clinical programs (cognitive reimbursement, therapeutic

intervention, disease management). She was responsible for four Medicaid Managed Care clients in California, providing quarterly program evaluations, clinical & trends analyses including retrospective DUR, formulary and prior authorization program recommendations to each of the separate Pharmacy & Therapeutics Committees. Her experience includes designing programs assessing clinical and financial goals of clients, population demographics, and drug utilization trends. She advised on impact of benefit design changes and supplied forecasting of financial impact of proposed strategies and performed retrospective drug utilization analyses; provided clinical support to regional sales employees; developed and presented programs to internal and external customers. **Director of Pharmacy Programs**, Ms. Steck was accountable for the oversight of a \$113 million drug program for the company's largest client, the United Mine Workers Health and Retirement Funds. Responsibilities included creation, development, and management of cost containment programs; provider relations; provider audit and beneficiary utilization review program management; ongoing implementation and analysis of cost management efforts on prescription drug utilization and expenditures. Accomplishments included development and implementation of a formulary program which yielded over \$5 million in savings in fiscal year 1993; implementation of a wholesaler-backed reimbursement and provider purchasing program which extended discounts to the Funds' drug benefit program and generated savings in excess of \$4 million annually; and development, implementation, and management of an academic detailing and physician education program.

Professional History

Ingenix, Salt Lake City, UT, Director, Fraud Analytics – Pharmacy, 2007 - Present

Consultant Pharmacist, Principal, July 2006 – 2007

Affiliated Computer Services (ACS), State Healthcare, August 2000 – June 2006.

- Director, Reporting and Analytics (ACS-Heritage), Jan 2005 – June 2006.
- Health Outcomes Scientist, PBM, March 2003 – December 2004
- Independent Consultant, PBM, August 2000 – March 2003

Antelope Valley Hospital, Pharmacist, May 1999 – May 2000

First Health Group Corp, September 1991 – April 1999

- Account Director, May 1996 – April 1999
- Clinical Account Manager, May 1993 - May 1996
- Director of Pharmacy Programs, September 1991 - May 1993

Henry Mayo Newhall Memorial Hospital, Acting Assistant Director, November 1986 - September 1991

Education

Pharm. D, University of the Pacific, 1984

Management Development Program, University of Southern California, 1990

Alison J. Moore, RN, MBA
 Analytic/Identification Lead, SME

Qualifications

Ms Moore has more than 18 years of experience in healthcare analysis and service delivery. Her range of professional experience includes:

- Policy analysis
- Provider reimbursement
- Claims processing
- Medical audit

Relevant Experience

Ms. Moore has gained the following professional experience.

HWT, Inc.: As Product Manager, Ms. Moore is responsible for project management, policy analysis, algorithm development, coordination with technical team, quality assurance and ad hoc results. She is responsible for the development and delivery of client training on HWT’s iQSuite of products. In her role as a subject matter expert Ms. Moore is responsible for policy analysis, algorithm development, coordination with technical team, quality assurance, and ad hoc results. She subject matter expertise in resolving provider dispute and management of daily working relationship with state staff at state offices. In addition, Ms. Moore has worked as a client manager at HWT where she was responsible for overall project management, financial accountability and quality assurance for a number of state Medicaid projects. Particularly, leading the activities for the partial audit performed on behalf of The State of Vermont, Office of the State Auditor identifying claims where post payment review would have been beneficial.

Bureau of Medical Services, State of Maine, Augusta, Maine: As the Director of the Division of Benefits Management, Ms. Moore was responsible for Provider/Consumer Relations, Managed Care Program Enrollment and Tracking (MCO & PCCM), Long Term Care Quality Improvement and Prior Authorization Units. In her capacity as Director, she was the Project Manager for the MECAPS development team; she managed coordination of systems development for the Managed Care Enrollment System for the Maine Medicaid Program. She also participated in the design and development of Maine Medicaid Decision Support System.

Ms. Moore worked as the Case Mix Project Director prior to the Division of Benefits Management. In this role, she had direct responsibility for the implementation and coordination of the Multi-State Nursing Home Case Mix and Quality Demonstration Project. The Project is a combined Medicare and Medicaid nursing home payment and quality monitoring system.

Ms. Moore began her work at the State of Maine in the role of Comprehensive Health Planner. She was responsible for research, policy analysis & writing, planning & preparing legislation, fiscal notes & budgets. She also develops and conducts analyses on the following programs: Maine Council on Alcohol and Drug Abuse Prevention and Treatment, Commission on Access to Health Care.

Idexx (formerly Agritech Systems), Westbrook, Maine: As a Project Coordinator, Ms. Moore was responsible for coordination of major biological

research project for new diagnostic product development. She also was responsible for project design, data collection, and statistical analyses for final report submitted to USDA.

Professional History

HWT, an Ingenix Company, Portland, Maine, Product Manager, Subject Matter Expert, 1998 – Present

Bureau of Medical Services, State of Maine, Director Division of Benefits Management, Case Mix Project Director, Comprehensive Health Planner, 1988 – 1998

Idexx (formerly Agritech Systems), Project Coordinator 1987 – 1988

Education

MBA, University of South Florida

B.A. Political Science, University of Southern Maine

AAS Nursing, Nassau College, New York

Licenses and Certifications

Registered Nurse, States of Maine, New York & Florida

Anar Aliyev, MS, Ph.D.
Data Operations

Mr. Aliyev has more than 11 years experience working in a senior technical capacity. He is an Oracle Certified Professional. His range of professional experience includes:

- Database administration
- Complex data analysis
- Complex database modeling

Mr. Aliyev has gained the following professional experience.

Relevant Experience

HWT, an Ingenix Company: As Manager of Information Systems, Mr. Aliyev is responsible for managing and administering all aspects of HWT's customized Medicaid data warehouses including: setup, loading, maintaining and tuning several data warehouses for multiple clients, backup and replication; installing, maintaining and upgrading database software; suggesting design changes for data storage infrastructure; troubleshooting and supporting algorithm code. In addition he executes ad hoc queries on an Oracle database to test ideas associated with Medicaid fraud, abuse, and billing mistakes. He also performs statistical analysis of Medicaid data using artificial intelligence and neural nets — developing, testing and implementing data model changes to achieve optimal performance. Mr. Aliyev loads Medicaid data daily in Oracle database using SQL Loader, customized loading routines with integrated data integrity checkpoints and QA procedures, while performing complex data analysis and database modeling.

International Bank of Azerbaijan, Baku, Azerbaijan: As a senior software developer, Mr. Aliyev developed a database application for a system processing up to 500,000 transactions a day, and developed and administrated a Domestic Clearing and Settlement Data Warehouse. He also developed an interface between the processing center host application and banking applications and designed a co-branded credit card program covering 200,000 new customers for payment collections and time packets distribution with the biggest GSM provider in the country.

Medical Diagnostic Center, Baku Azerbaijan: In his role as Database Engineer/Technician, Mr. Aliyev designed and managed the center's database of approximately 4MM patients and providers. He managed the computer network, software and hardware installations and maintenance. He also ensured operations and servicing of CT, ultrasonic scanners and endoscopes.

Professional History

HWT, an Ingenix Company, Chicago, IL, Manager, Information Systems, 2002 – Present

International Bank of Azerbaijan, Baku, Azerbaijan, Senior Software Developer, 1996 - 2001

Medical Diagnostic Center, Baku Azerbaijan, Database Engineer/Technician, 1994 – 1995

Education

Doctorate in Electrical Engineering, Specialization: Electronics, Informational and Computing Devices, Azerbaijan Industrial University

Master of Science in Electrical Engineering, Specialization: Electronics,
Informational and Computing Devices, Azerbaijan Industrial University

Certifications/Training

Oracle 9i Database Administrator Certified Professional
Oracle 10g Database Administrator Certified Professional
Statistical analysis using Clemintine, SPSS
Oracle Performance Tuning, Oracle University
Oracle Advanced Backup, Oracle University
Oracle 10g New Features for Administrators, Oracle University

Nicole Moore, CBCS
Analytic/Identification Team

Qualifications

Ms. Moore has more than 4 years experience working as an analyst of healthcare policy documents. Her range of professional experience includes:

- Policy review and support
- Algorithm development team
- Utilization review
- Quality Assurance

Relevant Experience

Ms. Moore has gained the following professional experience.

HWT, an Ingenix Company: As a Policy Analyst, Ms. Moore is actively reviewing medical and state policies, ensuring the algorithms abide by current policies. She provides support to the algorithm team, creating and implementing new logic and developing the appropriate overpayment recovery logic according to state policies. Her comprehensive knowledge includes medical documentation review, policy and analysis review, quality assurance and team training.

Previously as a Case Analyst at HWT, Ms. Moore frequently communicated with providers, providing assistance with dispute documentation and the accuracy of the original claim. Maintaining each case, she updated claims in HWT database and assisted the provider disputes in a timely way consistent with the goals of HWT and its clients. She managed to manage to conduct case work load and ensure expedient resolution for all provider disputes.

Aetna Life Insurance, As a Maintenance Analyst/Long Term Disability, Ms. Moore was responsible for managing a case load of over 2000 claims. She configured Social Security awards, pension awards, cost of living adjustments and Worker's Compensation awards. Ms. Moore acted as a liaison to claimants and policy holders. Assisting co-workers with back logged diaries and mail, acted as Call center support.

Insight Premier Health, As a Billing Representative, Ms. Moore was responsible for billing MRI procedures for 6 facilities within Maine and ICD-9 diagnosis coding. She also provided customer service, follow-up on claims with insurance companies and maintain cash logs and bank deposit.

Aetna USHealthcare, Ms. Moore provided superior customer service to medical providers, members and HR personal. She served as a Service Consultant/Medical/HMO and worked directly with Provider Relations department. She also processed medical claims in several medical specialties and receive training in ICD9 and CPT coding in HCFA and UB92 billing forms.

State Farm Insurance, Ms. Moore's efficiency and organizational skills assisting clients and potential clients with Personal Lines Insurance needs. She provided administrative duties for the insurance agent and support creation of marketing tools to promote company and increase client status.

Professional History

HWT, an Ingenix Company, Portland, Maine, Policy Analyst, 2005 – Present

- Case Analyst, 2003 – 2005

Insight Premier Health, Billing Representative

Aetna USHealthcare, Service Consultant/Medical/HMO
State Farm Insurance, Insurance Representative

Education

Windham High School of Maine

Certifications

Certified Medical Billing and Coding Specialist, CBCS

Suzanna Chen
 Analytic/Identification Team

Qualifications

Ms. Chen has more than 6 years experience working as an analyst of healthcare claims data. Her range of professional experience includes:

- Claims processing
- Algorithm design and development
- Statistical analysis
- Drug Rebate analysis

Relevant Experience

Ms. Chen has gained the following professional experience.

HWT, an Ingenix Company: As a Subject Matter Expert and Analyst, Ms. Chen is responsible for building algorithms in PL/SQL to analyze databases for healthcare fraud and abuse. She maintains engineering systems, which enable staff to generate demand letters, respond to provider inquires and recover monies associated with fraudulent claims. Ms. Chen executes ad hoc queries on an Oracle database to test ideas associated with Medicaid fraud, waste and abuse, utilizing industry standard software tools for complex data analysis of data and reporting needs. She also develops and maintains applications that allow staff to search and view the Medicaid data.

State of Maine, Department of Human Services, Bureau of Medical Services: Ms. Chen wrote and executed SAS programs as a Computer Programmer in the State of Maine. These programs were used to analyze data where she also created searchable database that utilizes multiple criteria.

Professional History

HWT, an Ingenix Company, Portland, Maine, Analyst and Subject Matter Expert, 1999 – Present

State of Maine, Department of Human Services, Bureau of Medical Services, Computer Programmer

University of Maine at Farmington, Math and Computer Tutor,

Education

Bachelor of Arts in Mathematics and Bachelor of Computer Science University of Maine at Farmington

Certifications

Windows, Unix, Linus, MSDOs, Mac, NT
 C, C++, HTML, SQL, Assembler Language, Oracle, Pascal, Java, GQL
 Coral WP 6.1, Mathematica, Systat, SAS, MS Excel, MS Access

Ali Gasimov
Analytic/Identification Team

Qualifications

Mr. Gasimov has more than 5 years experience working as an analyst of healthcare claims data. His range of professional experience includes:

- Claims processing
- Algorithm design and development
- Statistical analysis

Relevant Experience

Mr. Gasimov has gained the following professional experience.

HWT, an Ingenix Company: As a Developer and Analyst, Mr. Gasimov is responsible for building algorithms in PL/SQL to analyze databases for healthcare fraud and abuse. He executes ad hoc queries on an Oracle database to test ideas associated with Medicaid fraud, waste and abuse, utilizing industry standard software tools for complex data analysis of data and reporting needs. He works with a variety of data types including Medicaid, Social Services and Workers Compensation data. In addition, Mr. Gasimov is responsible for developing and maintaining a variety of neural net and outlier models in HWT's iQAI product. These models encompass a number of providers and paid claims types including: pharmacy, nursing homes, physicians and economic services assistance programs.

Medical Diagnostic Center, Baku, Azerbaijan: As a Software Developer, Mr. Gasimov provided support application development and ad-hoc queries on the center's Oracle database. He was responsible for the development and implementation of algorithms in PL/SQL, analyzed healthcare statistics and to prepared reports describing and analyzing the results. Mr. Gasimov specialized in identifying patterns in diseases and providers' behavior, healthcare quality, financial and medical outcomes through data analyses.

Professional History

HWT, an Ingenix Company, Chicago, IL, Developer and Analyst, 2003 – Present
Medical Diagnostic Center, Baku, Azerbaijan, Software Developer, 1997 – 2003
Itochu Oil Exploration, Inc., Baku, Azerbaijan,

- Chief Expert, 1997 – 2003
- Senior Expert, 1996 – 1997

Education

American University of London, B.A., in Business Administration

Certifications

Oracle database programming using PL/SQL and Java, Tacis, KOSIA-SMEDA

 Patricia Carlson, RN

Qualifications

 Recovery Team

Ms. Carlson has more than 18 years of healthcare delivery, utilization review and policy analysis experience. Her professional experience includes:

- Provider relations
- Medical audit
- Utilization review
- Quality improvement

Relevant Experience

Ms. Carlson has gained the following professional experience.

HWT, an Ingenix Company: As a Case Analyst, Ms. Carlson reviews provider dispute documentation for accuracy of original claims and reviews and resolves provider disputes, using state specific and national regulations and guidelines, in a timely fashion consistent with the goals of HWT and its clients. As part of the review process, she frequently educates providers on the intricacies of different state Medicaid billing policies. She is responsible for managing a case workload and ensuring expedient resolution for all provider disputes. Ms. Carlson also prepares medical or pharmaceutical documentation for requested appeals and acts as a liaison for settlement conference at client request.

CIGNA HealthCare, Freeport, Maine: As a Pre-Certification Nurse and a Case Manager, Ms. Carlson coordinated review activity of Maine hospitals and telephonic utilization reviews. She managed medical referrals and pre-certification for surgical procedures and coordinated discharge planning for patient caseload. Ms. Carlson also consulted with hospitals to ensure compliance with health plan and NCQA requirements.

Hawthorne House, Freeport, Maine: As a Clinical Care Coordinator, Ms. Carlson coordinated skilled care services on a 24-bed unit. She supervised and trained a staff of 15 – 20 employees, administered the department budget and managed admission screening.

Medical Synergy: Ms. Carlson was a Utilization/Quality Review Coordinator. In this role, she consulted with hospitals relating to various review regulations, HCFA/PRO guidelines and pattern analysis project implementation and results. She collected data using various collection tools for focused audits and communicated and documented action steps required if an UR/Quality pattern was noted through chart review. She also assisted in development and evaluation of outcome criteria of pattern analysis study.

Health Resource Limited: As an Independent Nurse Consultant, Ms. Carlson conducted various health screenings for employer groups and developed, documented and evaluated patient care plans.

Professional History

HWT, an Ingenix Company, Portland, Maine, Case Analyst, 2003 – Present
 CIGNA HealthCare, Freeport, Maine, Pre-Certification Nurse, 1999-2003, Case Manager, 1998-2003

Hawthorne House, Freeport, Maine, Clinical Care Coordinator, 1996-1997

Medical Synergy, Utilization/Quality Review Coordinator, 1986-1996

Health Resource Limited, Independent Nurse Consultant, 1986

Education

Registered Nurse, Westbrook College of School of Nursing

Christopher H. Eldridge
Recovery Team

Qualifications

Mr. Eldridge has more than 8 years experience working as a Recovery Specialist and more than 25 years experience working with the State of Maine as a rehabilitation counselor and trainer. His range of professional experience includes:

- Policy analysis
- Quality assurance
- Administrative Hearings representative

Relevant Experience

Mr. Eldridge has gained the following professional experience.

HWT, an Ingenix company: As a Provider Relations Manager, Mr. Eldridge is responsible for training Provider Relations Specialists on algorithm logic, understanding and provider relations’ practices. He manages policy analysis and algorithm development, while assuring coordination with clients and technical teams. He provides data and algorithm analysis and identifies potential recovery issues prior to mailing of overpayment recovery letters. He identifies and documents trends, promotes quality assurance and is responsible for administration of HWT’s Recovery Management process. The Recovery Management process includes: direct contact with providers, conducting informal resolution meetings, reviewing medical records, consultations with clients and Assistant Attorneys General. Mr. Eldridge provides expert witness testimony at Administrative Hearings and negotiates financial settlements.

State of Maine, Bureau of Rehabilitation: As a Rehabilitation Specialist, Mr. Eldridge provided public and private agency training. He was responsible for Rehabilitation Policy Development and for Worker’s Compensation Policy Development. He also served as a Rehabilitation Counselor and taught case management statewide to Rehabilitation Counselors to improve their job development and placement efforts.

For the Bureau of Rehabilitation, Mr. Eldridge was involved with the development and implementation of agency policies.

Professional History

HWT, an Ingenix Company, Portland, Maine, Provider Relations Manager, 1998 - Present

State of Maine, Bureau of Rehabilitation

- Rehabilitation Specialist, 1973 – 1998
- Rehabilitation Counselor, 1973 – 1998

Portland Public Schools, Secondary School Teacher, 1966 - 1972

Education

B.S., Education, University of Maine, Orono

Graduate Level Courses: Medical Aspects of Disability, Psychological Aspects of Disability

Certifications

Rehabilitation Counselor



SAMPLE
[Client name] R0045
Inhaler/Nasal Spray Errors

LOGIC:

Inhalers and nasal sprays are dispensed in fixed packages that cannot be altered. The contents are measured in milliliters (ml) and the package size identified for the drug indicates the number of ml per inhaler container. Reimbursement for the drug is based on a drug price established per ml. The pharmacy is instructed to bill the number of ml dispensed as the drug quantity billed. Therefore the quantity billed should be equal to the package size if one container was dispensed or a multiple of the package size if more than one was dispensed.

This algorithm identifies instances where the pharmacy may have billed an incorrect quantity for an inhaler or nasal spray, resulting in an overpayment. There appear to be various reasons why this may have occurred:

- A. The pharmacy billed for the number of puffs or actuations instead of the correct drug quantity.
- B. The pharmacy billed an unreasonable quantity, exceeding the maximum normal dosage for a 34-day supply. The quantities identified in this result set appear to be a variety of pharmacy data entry errors or quantities excessive for the drugs identified.
- C. The pharmacy billed the quantity of another inhaler or nasal spray instead of the appropriate quantity of the drug code billed. (e.g. quantity billed was 17 but the package size of the drug was 7).
- D. The pharmacy billed the medication strength instead of the correct quantity dispensed.
- E. The pharmacy billed for the package size multiplied by the days supplied instead of the amount dispensed.
- F. The pharmacy billed a quantity that was 10 times or a multiple of 10 times the package size.



POLICY/CITATION:

According to [State name] Pharmacy Filing Instructions, Chapter 5, pg. 31, in the Quantity field: "Enter the quantity or number of units dispensed. Please note there are five (5) spaces on the claim form for quantity. All five spaces must be completed. There are three dispensing units:

- Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021.
- Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005.
- Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045.

Provider Notice 03-07: Effective August 8, 2003, the [State name] Medicaid Agency will no longer allow Medicaid Providers to bill drugs on an NCPDP claim with decimal package sizes rounded up. Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed.

OVERPAYMENT CALCULATION/ASSUMPTIONS:

To determine the overpayment an assumption is made that the pharmacist dispensed at least one package or container of the product. Therefore, the correct quantity is equal to the package size of the product. If more than one package was dispensed, the provider will be requested to send a copy of the prescription to HWT, and once validated, HWT will adjust the overpayment as supported by the script.

We used the following formula to calculate overpayment:

OVERPAYMENT CALCULATION:

Overpayment = [Reimbursement Amount] - (([Drug Price]*[Correct Quantity] + [Dispense Fee]) - Copay) - [TPL Amt]

Drug Price = Lower of AEAC or MAC.

If Overpayment > Reimbursement Amt, then Overpayment = Reimbursement Amt.

Correct Quantity = Package Size in this algorithm.

REPORTS:

- Detail Report
- Drug Summary Report
- Provider Summary Report